Court File No. CV-24-00732861-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES, KATHARINE RESENDES and JEAN-PIERRE AUBRY FORGUES

Applicants

and

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondent

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

FACTUM OF THE APPLICANTS

March 5, 2025

LAX O'SULLIVAN LISUS GOTTLIEB LLP
Suite 2750, 145 King Street West
Toronto, ON M5H 1J8

Rahool P. Agarwal LSO#: 54528I
ragarwal@lolg.ca

STOCKWOODS LLP
Suite 4130, 77 King Street West
Toronto, ON M5K 1H1

Carlo Di Carlo LSO #: 62159L
carlodc@stockwoods.ca
Spencer Bass LSO#: 75881S
spencerb@stockwoods.ca
Olivia Eng LSO #: 84895P
oliviae@stockwoods.ca

NANDA & COMPANY
10007 80 Avenue NW
Edmonton, AB T6E 1T4

Avnish Nanda LSA #: 18732
avnish@nandalaw.ca

Lawyers for the Applicants

TO: **THE ATTORNEY GENERAL OF ONTARIO**
Constitutional Law Branch
720 Bay Street – 4th Floor
Toronto, ON M5G 2K1
Email: clbsupport@ontario.ca

S. Zachary Green LSO #: 48066K
zachary.green@ontario.ca
Tel: 416 992 2327

Andrea Bolieiro LSO #: 60034K
andrea.bolieiro@ontario.ca
Tel: 437 551 6263

Emily Owens LSO #: 80144G
emily.owens@ontario.ca
Tel: 416 937 3687

AND TO: **LENCZNER SLAGHT LLP**
Barristers
130 Adelaide Street West, Suite 2600
Toronto, ON M5H 3P5

J. Thomas Curry LSO #: 25740V
tcurry@litigate.com
Tel: 416 865 3096

Jaan E. Lilles LSO #: 49598O
jlilles@litigate.com
Tel: 416 865 3552

Zachary Rosen LSO #:75231Q
zrosen@litigate.com
Tel: 416 865 2944

Amy Goudge LSO #: 84344H
agoudge@litigate.com
Tel: 416 238 7449

Lawyers for the Respondent, His Majesty the King in Right of Ontario

TABLE OF CONTENTS

PART I - INTRODUCTION

1. The Applicants, Katharine Resendes and Jean-Pierre Aubry Forgues, have battled opioid use disorder their entire adult lives. They have suffered injuries and infections. They have overdosed countless times. They have lost friend after friend to the drug overdose crisis that kills thousands of people in Ontario every year. They have tried repeatedly to stop using drugs. But recovery is a long road, and too many people's lives are cut short before they reach the end of it.

2. For Ms. Resendes and Mr. Forgues, supervised consumption sites (**"SCSs"**) like the kind operated by the Applicant, The Neighbourhood Group Community Services (**"TNG"**), have changed – and saved – their lives. As the unregulated drug supply becomes increasingly deadly, SCSs have provided Ms. Resendes and Mr. Forgues with a means to protect their own lives and health, and a gateway to a host of other harm reduction, healthcare, and social services.

3. Beginning in 2017, SCSs emerged in Ontario as a vital public health intervention to combat the drug overdose crisis. SCSs have overwhelmingly been located in neighbourhoods hardest hit by this crisis, where there are high rates of opioid overdoses and overdose mortality. While the experts who study the data and the people who rely on these life-saving services are able to see the positive impacts of SCSs—which include preventing overdose deaths and the spread of infectious diseases—the drug crisis is still complex and will not be solved overnight.

4. The social ills arising from this drug crisis continue to affect communities, including communities where SCSs operate. Some residents feel the SCS has had a positive impact in combatting these harms, but others still feel less safe. Parents worry about their child seeing drug use on the street, or picking up a used needle on the playground. There are many residents who attribute these issues to the SCS in their area.

5. In response to these concerns, Ontario enacted the *Community Care and Recovery Act, 2024* ("***CCRA***") which comes into force on April 1, 2025.[1] Its immediate effect will be to shutter almost half of the SCSs in Ontario, resulting in thousands of vulnerable Ontarians like Ms. Resendes and Mr. Forgues losing access to life-saving care.

6. The central flaw of the *CCRA* is that the evidence shows that SCSs are not part of the problem: they are part of the solution. There is no way around the fact that the loss of access to SCS will increase the risk of death and disease. The *CCRA* is an ill-conceived and disproportionate attempt to deal with the drug crisis and all of its externalities. It misguidedly targets a vital tool within the broader public health toolkit that has been proven to be effective in keeping people alive. The ostensible gains to be achieved are marginal and ambiguous.

7. As a result of its flawed approach and design, the *CCRA* is also unconstitutional. It violates the Applicants' rights under s. 7 of the *Canadian Charter of Rights and Freedoms* (the **"*Charter*"**) to life, liberty and security of the person. Removing effective access to SCSs increases the Applicants' risk of death and serious physical and psychological suffering. It heightens their risk of criminal prosecution, interfering with their right to liberty. The effects of the *CCRA* are arbitrary, overbroad and grossly disproportionate to the objective it ostensibly seeks to obtain, namely, the protection of the public, including children, from exposure to anti-social behaviours associated with drug use. Indeed, the *CCRA* is likely to cause *increased* public drug use (among other issues).

8. The *CCRA* also violates the Applicants' s. 15 *Charter* right to equality. The *CCRA* imposes disproportionate burdens on those experiencing substance use disorder, a recognized disability, by removing access to SCSs. The manner in which this burden is being imposed perpetuates and

[1] *Community Care and Recovery Act, 2024*, S.O. 2024, c. 27, Sched. 4.

exacerbates existing disadvantages that this group already experiences, including the false and pernicious stereotype that these individuals are dangers to the community, not members of it.

9. Neither the s. 7 violation nor the s. 15 violation can be saved under s. 1.

10. Finally, the *CCRA* is either *ultra vires* Ontario or violates the doctrine of paramountcy and thus should be rendered inoperative. The *CCRA* is an overreach by Ontario. It is aimed at denouncing and suppressing conduct which, in Ontario's view, is harmful to public safety and social order. This is the exclusive purview of the Federal Government, using its criminal law power. Even if this Court is not prepared to agree with that submission, the act nonetheless frustrates the purpose of the exemption regime the Federal Government created under the *Controlled Drugs and Substances Act* (**"*CDSA*"**).[2] The *CCRA* prohibits the operation of SCSs in certain locations, despite the federal Minister's determination that allowing them to operate in those same locations is necessary to advance the *CDSA*'s dual public health and safety goals.

11. This Application should be granted and the *CCRA* should be declared unconstitutional and/or inoperative.

PART II - SUMMARY OF FACTS

A. What Are Supervised Consumption Sites?

12. Since at least 2016, Ontario (and Canada) has been mired in a drug overdose crisis—a leading cause of preventable deaths that is worsening amidst changes in the illegal drug supply.[3]

---

[2] *Controlled Drugs and Substances Act,* S.C. 1996, c. 19, s. 56.1.
[3] Affidavit of Dr. Ahmed Bayoumi sworn January 8, 2024 (**"Dr. Bayoumi Affidavit"**), Ex A, paras 26, 28, Application Record ("**AR**"), Tab 11, p 674.

13. Almost two-thirds of all opioid-related deaths in Ontario occur among people with a diagnosis of opioid use disorder (**"OUD"**), a form of a substance use disorder (**"SUD"**).[4] The DSM-5-TR recognizes OUD (and SUD) as a diagnosable condition. The diagnostic criteria for OUD include (but are not limited to) unsuccessful efforts to cut down or control opioid use, continued use despite persistent social or interpersonal problems caused by the opioids and recurrent use in situations in which it is physically hazardous.[5]

14. Relapse is a part of all SUDs. People experiencing this disorder will, over time, move between stages of substance use and recovery.[6] Ontario's experts agree.[7] Indeed, one of Ontario's experts, Dr. Julian Somers, acknowledged that it would be "unrealistic" to expect people who are socially and economically marginalized in society to move directly from addiction to abstinence.[8]

15. Because relapse is part of the disorder, the need to anticipate and plan for substance use becomes part of treatment.[9] SCSs developed as a public health response to the drug overdose crisis. SCSs seek to reduce the harms associated with substance use without requiring a commitment to abstinence. Such strategies fit within the "harm reduction" approach to treatment. The ultimate objective remains recovery, but harm reduction acknowledges the need to engage people in care "where they are at"—and to keep them alive along the way.[10]

16. SCSs provide people with an environment where they can use drugs under observation by

---

[4] Dr. Bayoumi Affidavit, Ex A, para 24, AR, Tab 11, p 673.
[5] Dr. Bayoumi Affidavit, Ex A, paras 20, 22, AR, Tab 11, p 672.
[6] Transcript of Cross-Examination of Dr. Sharon Koivu, February 11, 2025 (**"Koivu Transcript"**), pp 13-14, qq 45-48, Amended Joint Supplementary Application Record ("**JSAR**"), Tab 17.
[7] Koivu Transcript, p 14, q 48, JSAR, Tab 17.
[8] Transcript of Cross-Examination of Dr. Julian Somers, February 11, 2025 (**"Somers Transcript"**), p 21, q 65, p 27, q 76, JSAR, Tab 16.
[9] Affidavit of Dr. Jennifer Wyman, sworn February 6, 2025 (**"Dr. Wyman Affidavit"**), para 17, Reply Application Record (**"RAR"**), Tab 25, p 332.
[10] Dr. Wyman Affidavit, para 28, RAR, Tab 25, p 334.

trained personnel, who can immediately intervene to reverse an overdose to prevent death or disability (including through naloxone, a drug that temporarily reverses the effects of opioid overdoses). They also provide sterile supplies to clients to prevent the spread of infectious disease.[11] However, in Ontario, these sites do even more. They provide a host of other services, including pathways to substance use treatment services, primary care, mental health care, housing and other social supports, harm reduction education and supplies, and removal of inappropriately discarded drug use equipment in the area of the SCS.[12]

17. SCSs operate under formal exemptions to federal criminal prohibitions on drug possession granted under s. 56.1 of the *CDSA*. But for this exemption, both clients' possession of drugs on the premises and staff's supervisory services would attract criminal liability under the *CDSA*.[13]

18. The Applicant, TNG, runs the Kensington Market Overdose Prevention Site (**"KMOPS"**). KMOPS is an SCS that opened in April 2018 in the Kensington Market neighbourhood of Toronto, in a building located at 260 Augusta Avenue that TNG has owned since 2000.[14] KMOPS has three booths where clients can consume drugs under supervision and a "chill out" area where people can wait under observation after consumption. It keeps oxygen and naloxone on site to administer to individuals experience a drug overdose. KMOPS also offers a drug checking service which can assess whether drugs are contaminated with unexpected substances.[15]

19. TNG also provides services for people experiencing homelessness (the "**Drop-In**") out of the same building. TNG's predecessor began operating the Drop-In in 1984 out of a different

---

[11] Dr. Bayoumi Affidavit, Ex A, para 29, AR, Tab 11, p 674.
[12] Dr. Bayoumi Affidavit, Ex A, para 46, AR, Tab 11, pp 677.
[13] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, paras 88-91.
[14] Affidavit of Bill Sinclair, sworn January 9, 2024 (**"Sinclair Affidavit"**), para 33, AR, Tab 3, p 36.
[15] Sinclair Affidavit, paras 81, 96, 109, 124, Ex R, AR, Tab 3, pp 48, 51, 54, 58, 235-240.

building.[16] By 1999, TNG was having difficulties finding a lease, as landlords did not want to host homelessness services on their property. As such, in 2000, TNG bought the building at 260 Augusta and has operated the Drop-In there ever since.[17] Today, individuals come to 260 Augusta for a number of services, including: nutritious meals, shelter from the elements, access to facilities such as mail, telephone services, washrooms, showers and laundry, the provision of legal services, assistance with obtaining identification, a financial trusteeship program that helps people manage their money, and medical care (including access to a physician, nurse, and psychiatrist).[18] Beginning in 2018, individuals can now also access supervised consumption services.

B. History of Supervised Consumption Sites in Ontario

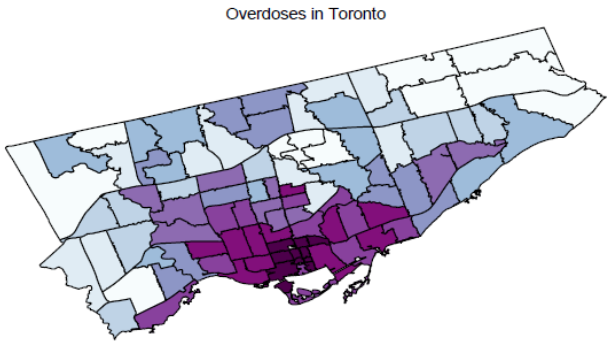
20. The first sanctioned SCS in Canada was the Insite Safe Injection Facility (**"Insite"**) in Vancouver, which opened in September 2003.[19] In *PHS,*[20] the Supreme Court reversed the federal Minister's decision to shut down Insite on constitutional grounds, opening the door for future sites.

21. The year after the *PHS* decision, in 2012, Dr. Ahmed Bayoumi (one of the Applicants' experts) and Dr. Carol Strike released a report looking at the feasibility of SCSs in Toronto and Ottawa entitled the "Toronto and Ottawa Supervised Consumption Assessment Report" (the **"TOSCA Report"**). The TOSCA Report concluded that, based on the nature of drug use by marginalized communities (and, particularly drug use in public spaces), there was a need for SCSs in Toronto and Ottawa and that providing these services would be feasible.[21]

---

[16] Sinclair Affidavit, paras 27-30, AR, Tab 3, p 35. They began offering these services as a result of a request from a nearby hospital that was looking for assistance in dealing with individuals experiencing homelessness and SUD.
[17] Sinclair Affidavit, paras 32-33, AR, Tab 3, p 36.
[18] Sinclair Affidavit, paras 35, 38, 39, AR, Tab 3, p 36-38.
[19] Dr. Bayoumi Affidavit, Ex A, para 33, AR, Tab 11, p 675.
[20] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, para 136.
[21] Dr. Bayoumi Affidavit, Ex A, para 35, AR, Tab 11, p 675. Ontario did not cross-examine Dr. Bayoumi on this conclusion or adduce any evidence to challenge it.

22. The TOSCA Report concluded that SCSs should be located "close to where people use drugs, particularly where drug use is visible or where people who use drugs are homeless or unstably housed".[22] The authors then went on to produce a map of Toronto that showed where overdoses were occurring in the city based on Emergency Medical Services data from 2002 to 2008 (darker shading indicates a higher number of overdoses per square kilometre)[23]:



23. The history of KMOPS mirrors the TOSCA Report's discussion of the need for SCSs in Toronto. People experiencing SUD and homelessness have long been a part of Kensington Market. The park in the middle of the neighbourhood, Bellevue Square, has been a site where drug dealing has happened openly for years, well before the introduction of the KMOPS.[24] In 2017, various residents of the Kensington Market community approached TNG after bodies of people who had passed away from fatal overdoses were discovered in local parks. These residents were concerned with the public drug use and overdoses and wanted TNG to open an SCS.[25]

---

[22] TOSCA Report, p 182, Transcript of Cross-Examination of Dr. Bayoumi, February 12, 2025 (**"Dr. Bayoumi Transcript"**), Ex 1, JSAR, Tab 2(1).
[23] TOSCA Report, p 190, Dr. Bayoumi Transcript, Ex 1, JSAR, Tab 2(1).
[24] Sinclair Affidavit, paras 47, 50-51 AR, Tab 3, p 40-41; Affidavit of Dominique Russell, sworn February 7, 2025, para 7, 9-11, RAR, Tab 4, p 76-7. As Ms. Russell, who has lived in Kensington Market for over 35 years put it, when you live in Kensington Market, people experiencing homeless, "are your neighbours". Given the high rate of drug use and overdoses, TNG staff were trained on the use of Naloxone, even before KMOPS existed.
[25] Sinclair Affidavit, para 54, AR, Tab 3, p 42.

24. The first sanctioned SCS opened in Toronto in August 2017. By June 2018, nine sites had opened in Toronto, including KMOPS, under a provincial funding program.[26] These SCSs were concentrated in the areas indicated in the TOSCA Report as having the greatest need for them.[27]

25. As of December 2, 2024, Health Canada lists 39 sites operating in 19 cities across Canada.[28] In Ontario, 23 SCSs that serve community clients have received exemptions.[29] Overall, from March 2020 until August 2024, there were a total of 1,180,815 visits to SCSs in Ontario. This works out to an average of nearly 22,000 visits per a month. The number of unique clients per month was 3,476. Of these visits, 1.6% resulted in an accidental overdose, none of which were fatal. Put differently, SCSs have successfully reversed 21,979 overdoses over this period.[30]

C. Who Uses Supervised Consumption Services?

26. The client base of SCSs is largely compromised of some of the most marginalized populations in our society. People with SUD and/or who experience other forms of marginalization are most likely to utilize these services. In Toronto, 90.5% of SCS clients were experiencing homelessness or were unstably housed; 38% were recently incarcerated.[31]

27. That SCSs are primarily relied on by marginalized populations is not surprising. This is inherent to their service model and is consistent with the TOSCA Report's recommendation that SCSs be located close to where people already use drugs to optimize access and uptake.[32] Even

---

[26] Sinclair Affidavit, para 59, AR, Tab 3, p 44; Reply Affidavit of Dr. Dan Werb, sworn February 7, 2025 (**"Dr. Werb Reply Affidavit"**), Ex A, para 49, RAR, Tab 24, p 314.
[27] Reply affidavit of Dr. Ahmed Bayoumi, sworn February 7, 2025 (**"Dr. Bayoumi Reply Affidavit"**), Ex A, para 35, RAR, Tab 26, p 372.
[28] This figure does not include Urgent Public Health Needs Sites, which offer more limited supervised consumption services and are generally operated on a more temporary basis.
[29] Dr. Bayoumi Affidavit, Ex A, para 48, AR, Tab 11, p 677.
[30] Dr. Bayoumi Affidavit, Ex A, para 56, 58, AR, Tab 11, pp 678, 679. Affidavit of Dr. Dan Werb, sworn January 9, 2025 (**"Dr. Werb Affidavit"**), Ex A, AR, Tab 12, p 928.
[31] Dr. Bayoumi Affidavit, Ex A, para 74, AR, Tab 11, p 682.
[32] Dr. Bayoumi Reply Affidavit, Ex A, para 35, RAR, Tab 26, p 372.

Ontario's experts acknowledged pre-existing drug use and homelessness were a factor in determining SCS locations (at least in Toronto and London).[33] Ontario's expert, Dr. Platt, published an article on supervised injection wherein he noted that for this service to be effective, it will have to be convenient for the clients it seeks to attract (*i.e.*, marginalized populations).[34]

28. The (uncontested) evidence of the individual Applicants provides a more illustrative view of who SCS clients are and the value of SCSs to people experiencing SUD.

29. Ms. Resendes is thirty-six years old and has been living with OUD for sixteen years. She tried cocaine as a twenty-year-old university student, which soon led to a heroin addiction and to her dropping out of school. About six years ago, she switched to using fentanyl. Ms. Resendes treats her OUD by taking methadone, an opioid agonist treatment that suppresses physical cravings. While methadone has successfully reduced the frequency of her consumption of street-sourced opioids, it has not eliminated it. Ms. Resendes has overdosed multiple times. In one incident, she describes the terrifying experience of waking up in the hospital; but for her boyfriend administering naloxone and calling an ambulance, she is not sure she would be alive today.[35]

30. Mr. Resendes spoke about her efforts with abstinence and detox programs. These programs did not work at that time in her life. She explained that, "[a]t the time I was not fully ready to quit using drugs. Although I wanted to stop using, my need to self-medicate through drugs was stronger". She also spoke about the stigma and judgment she experienced in abstinence-based programs because she was treating her OUD with methadone. As she noted: "[g]oing to an

---

[33] Koivu Transcript, p 58, q 192, p 61, qq 208-209.
[34] Transcript of cross-examination of Dr. Robert Platt, February 18, 2025 (**"Platt Transcript"**) p 31, q 110 to p 32, q 114, JSAR, Tab 19.
[35] Affidavit of Katharine Resendes, sworn January 9, 2025 (**"Resendes Affidavit"**), paras 6, 11, 13, 14, 19, 26, 29, 30, 31, AR, Tab 3, pp 284-289.

abstinence-based treatment before I was ready did not work for me, and in some ways was actually a negative experience". In contrast, Ms. Resendes described her experiences with SCSs as follows:

> I had a very positive experience at The Works. […] The environment was very non-judgmental, which is incredibly important to me. As an intravenous drug user, I have experienced a lot of judgment and stigma […]
>
> Like with The Works, KMOPS is a very non-judgmental atmosphere and I feel a strong sense of community there. I have had a lot of meaningful conversations with staff and clients, sharing our experiences. I have learned a great deal through those conversations about different substance use treatment options, mental health supports, harm reduction methods, and other information to keep myself safe (like being warned about particularly dangerous/potent substances circulating and what they look like). For example, through using KMOPS I learned about a medication called SUBLOCADE, which is an opioid agonist treatment option that you take once a month (unlike methadone, which I have to take every single day).[…][36]

31. Mr. Forgues, who is also thirty-six, presents a slightly different picture of an SCS client. From as early as he could remember, Mr. Forgues' stepfather abused him. This started a lifelong dependency on substances, which started with alcohol when Mr. Forgues was eight, moved to crack cocaine when he was fifteen, then heroin, and eventually fentanyl in 2018.[37] As Mr. Forgues put it, the emergence of fentanyl "changed everything". He started overdosing "regularly". By his late twenties he was unstably housed, often sleeping outside or in shelters, and "injecting opioids multiple times a day" while being afraid that "every dose would be my last".[38] But he could not stop. Because of his fear of being arrested, Mr. Forgues injected opioids in unsafe places, such as alone in alleys and stairwells. He often reused or shared syringes, and acquired Hepatitis C.[39]

32. Like Ms. Resendes, Mr. Forgues tried to stop many times. Detox and abstinence-based programs were not a solution for him. He found that they only increased his harm given the nature

---

[36] Resendes Affidavit, paras 19-21, 37, 41, 50, AR, Tab 3, pp 287, 291, 292, 294.
[37] Affidavit of Jean-Pierre Aubry Forgues, sworn January 3, 2025 (**"Forgues Affidavit"**), paras 4-7, 10, AR, Tab 5, p 300.
[38] Forgues Affidavit, paras 7, 12, AR, Tab 5, p 301.
[39] Forgues Affidavit, para 8, AR, Tab 5, p 300.

of the following relapses.[40] In 2019, He discovered SCSs and they "transform[ed]" his life:

> They provided a safe, monitored space for me to use substances, along with clean, sterile equipment to consume them. […]
>
> At the Kitchener CTS, I received medical monitoring while consuming substances, where they reversed countless overdoses and near deaths. I also accessed other support services to help address the health and social aspects of my substance use. I received wound care to treat serious abscess that developed from injecting substances into my body for so long and treatment for my hepatitis C. I also decreased my street-sourced substance use dramatically and was encouraged to address the underlying reasons for my substance use. I ended up securing housing through my recovery efforts and landing a job. The Kitchener CTS stabilized my opioid use and health and put me in a position to access housing and obtain employment.[41]

33. Mr. Forgues candidly noted that his journey "is not a straight line". However, SCSs allowed him to improve his health and continue to help him stay alive so he can continue his recovery.[42]

34. Ms. Resendes' and Mr. Forgues' experiences reflect the expert evidence of Dr. Wyman, the Medical Director for the Substance Use Service at Women's College Hospital. Dr. Wyman noted the importance of treating patients "where they are at".[43]

D. Ontario Enacts the Impugned Legislation

35. On November 18, 2024, Ontario introduced the *Safer Streets, Stronger Communities Act, 2024*. The Act amended pre-existing acts and enacted two new acts, one of which was the *CCRA*. Despite its title, there is nothing in the *CCRA* regarding recovery at all. The *CCRA* does two things:

- s. 2 mandates the closure of any "supervised consumption site"—a term that is defined broadly (as discussed further below) within 200m of designated premises; and
- s. 3 prevents municipalities and local boards[44] (creatures of the province), from

[40] Forgues Affidavit, para 15, 16, AR, Tab 5, p 302.
[41] Forgues Affidavit, para 19, 23, AR, Tab 5, p 303-304.
[42] Forgues Affidavit, para 33, AR, Tab 5, p 303-304.
[43] Dr. Wyman Affidavit, para 27-29, RAR, Tab 25, p334-335.
[44] Among other things, this term includes local boards of health.

applying to Health Canada for certain *CDSA* exemptions, without ministerial approval.

36. Ontario fast-tracked the passage of *Safer Streets, Stronger Communities Act*. Despite only being introduced on November 18, 2024, by December 2, 2024, Ontario had passed the bill.[45]

E. Overview of the Expert Evidence

37. Only the Applicants led expert evidence on the efficacy and impacts of SCSs in Ontario, and what the impact will be if the *CCRA* comes into effect, that was based in the actual data from the Ontario experience. The substance of this expert evidence was not seriously challenged on cross-examination. In brief, the Applicants' experts gave the following evidence:

- **SCSs have a broad ameliorative health effect on the neighbourhoods in which they are located.** The experts on both sides agree that SCSs have a direct impact on the individuals who attend those sites.[46] The Applicants' experts also put forward evidence (by way of an epidemiological study they conducted, which was published in a peer-reviewed journal) that outside of these direct benefits, neighbourhoods that were closest to SCSs saw statistically significant decreases in their overdose mortality rate (up to 67% in areas within 250 meters, 500 meters, and 1 kilometer of an SCS).[47] SCSs are associated with other positive health outcomes, including (but not limited to) ameliorating risky injection practices, such as syringe sharing/reuse or rushed injection, which reduces the transmission of bloodborne infections.[48]

- **SCSs do not affect the crime rate.** The Applicants' expert, Dr. Werb, was the only expert who analyzed crime data to assess the impact that the SCSs in Toronto had on crime. Dr. Werb conducted an epidemiological analysis of 9 years of crime data from the Toronto Police Services (2014 to 2023) and compared several categories of crime rates in downtown Toronto neighbourhoods that did and did not implement SCSs. Overall, Dr. Werb concluded that the implementation of SCSs did not result in a statistically significant change in the overall crime rate.[49] Similarly, Dr. Werb is the only expert before this Court who conducted an analysis into the question of whether

---

[45] Costoff Affidavit, Ex A, AR, Tab 10, pp 435-500. Due to the speed with which the bill was passed, it did not even go to committee for review.

[46] Transcript of Dr. Nathaniel Day, February 21, 2025 (**"Dr. Day Transcript"**), p 51-52, qq 203-204, JSAR, Tab 18; Affidavit of Dr. Robert Platt, sworn January 24, 2025 (**"Dr. Platt Affidavit"**), para 17, Responding Record ("**RR**"), Tab 32, p 1673.

[47] Dr. Werb Affidavit, Ex A, AR, Tab 12, p 925; Dr. Bayoumi Affidavit, Ex A, para 71, AR, Tab 11, p 681.

[48] Dr. Bayoumi Affidavit, Ex A, para 72, AR, Tab 11, p 681-682.

[49] Dr. Werb Affidavit, Ex A, AR, Tab 12, p 919-922. This article was published in peer-reviewed journal after Dr. Werb swore his affidavit. See Dr. Platt Transcript, Ex B, JSAR, Tab 19(b). Dr. Werb's analysis suggests that neighbourhoods with SCS experienced a downward shift in the incidence of both assault and robbery.

SCS sites increase homicide rates in the communities in which they are located. Dr. Werb concluded that there was no evidence that homicides increased near SCSs.[50]

- **The *CCRA* is likely to increase the overdose mortality rate.** Only the Applicants' experts conducted analyses into what is likely to occur under the *CCRA*. Both Dr. Werb and Dr. Bayoumi concluded that the result will be loss of access to supervised consumption services and their benefits for marginalized communities, higher overdose mortality rate in neighbourhoods in which the SCSs were located, a higher prevalence of public injections, fewer referrals to social services and clinical care; and the potential for increased transmission of infectious diseases such as HIV and hepatitis C.[51]

38. Ontario's experts did not conduct any studies of the effects of SCSs in Ontario and therefore could not provide any positive evidence about this issue; they only critiqued the evidence of the Applicants' experts. There were several issues with these critiques. To the extent this Court feels it needs to resolve conflicting evidence between the parties' experts, those disputes should be resolved in favour of the Applicants' experts. The Applicants' experts were candid and noted where their opinions had limitations. In contrast, Ontario's experts lacked similar candour and several of them seemed to misunderstand the appropriate role of an expert. For example:

- **Dr. Koivu,** an addiction treatment physician with no criminology experience, gave opinion evidence on bias in the reporting of crime. When confronted with the fact that this was an opinion that was outside of her area of expertise, Dr. Koivu asserted that she felt it was within her duty to give such opinions.[52]

- **Dr. Platt** also gave his opinion on the ease with which an SCS could relocate, despite having not had any discussions with any of the operators of SCSs in Ontario, having no expertise on the real estate or rental market in Toronto and not having reviewed the map in Ontario's record setting out the *CCRA* restricted locations. Even Dr. Platt conceded that this opinion was "probably outside [his] expertise".[53]

---

[50] Dr. Werb Affidavit, Ex A, AR, Tab 12, p 923.

[51] Dr. Werb Affidavit, Ex A, AR, Tab 12, p 933; Dr. Bayoumi Affidavit, Ex A, para 101-107, 111, AR, Tab 11, p 689, 690.

[52] Dr. Koivu Transcript, p 108, qq 414-416, JSAR, Tab 17.

[53] Dr. Platt Transcript, p 65, q 236, p 70, q 254 to p 72, q 263, JSAR, Tab 19. These are not the only examples. Dr. Day gave his opinion on an article despite the fact that he admitted that he found it complex and required assistance from "a couple" of unnamed colleagues to appreciate it (Dr. Day Transcript, p 83, qq 326, 327, p 90, q 351, JSAR, Tab 18). Dr. Somers' evidence was riddled with omissions and selective quotations from sources. As an example, he only partially quoted a sentence from a publication assessing supervised injection facilities in Sydney, Australia,

PART III - STATEMENT OF ISSUES, LAW & AUTHORITIES

39. The *CCRA* is unconstitutional. It violates the *Charter* and is *ultra vires* the provincial government. Specifically, the Applicants take the following positions: (a) the *CCRA* violates ss. 7 and 15 of the *Charter*, and cannot be saved by s. 1; (b) the CCRA is *ultra vires* Ontario or frustrates the purpose of the federal *CDSA* and thus should be rendered inoperative pursuant to the doctrine of paramountcy; and, (c) to the extent necessary, this Court should grant an interlocutory injunction enjoining the effects of s. 2 of the *CCRA* until it releases its decision in this Application.

A. The Impact of the *CCRA*

40. The *CCRA* mandates the closure of at least ten SCSs, constituting 43% of service providers in Ontario. Five of those SCSs are the sole provider in their municipality.[54] Dr. Bayoumi estimates that in Toronto, where at least five out of ten sites will be required to close, approximately 38% of SCS clients would lose access to supervised consumption services within 500m, and 20-22% of SCS clients would lose access to services within 2,000m. These distances pose a significant challenge for the populations SCSs serve, many of whom face structural barriers in accessing transportation due to homelessness.[55] These figures assume that remaining sites will accommodate the additional clients, however, the record suggests that these sites lack the capacity to do so.[56]

---

leaving the reader with an incorrect and misleading impression of the authors' conclusion (Dr. Somers Transcript, p 51, qq 166-169, p 62, q 209, p 102, q 382 to p 103, q 384, JSAR, Tab 16).

[54] Sinclair Affidavit, Ex W, AR, Tab 3, p 255. The SCSs in Guelph, Hamilton, Thunder Bay, and Kitchener that will be required to cease operations as of April 1, 2025 are the sole providers in their municipalities. The Thunder Bay SCS is the sole provider of supervised consumption services in the entirety of northern Ontario.

[55] Dr. Bayoumi Affidavit, Ex A, paras 80, 103-104, AR, Tab 11, pp 683, 688-689.

[56] Dr. Bayoumi Affidavit, Ex A, para 103, AR, Tab 11, p 688; Street Health, a Toronto SCS that will remain open, estimates that it will only be able to accommodate a 10-20% increase in demand. Whereas Street Health saw approximately 8,000 visits between March 2020 and May 2024, the three nearby SCSs that are slated for closure (Regent Park, The Works, and KeepSix) together had nearly 140,000 over the same period: Affidavit of Lin Sallay, sworn January 9, 2025 ("**Sallay Affidavit**"), para 32, Ex E, AR, Tab 9, p 361; see also Affidavit of Gab Laurence affirmed January 9, 2025 ("**Laurence Affidavit**"), paras 32-36, AR, Tab 13, pp 1011-1012.

41. In addition, the *CCRA* is mandating the closure of five of the ten collection sites for Toronto's Drug Checking Service ("**TDCS**").[57] This will significantly impact the availability and effectiveness of drug checking services. This is a critical tool that allows people who use drugs to protect themselves from contaminated drugs. It also provides a key source of information to public health officials, allowing them to identify emerging trends in the street drug supply.[58]

42. Ontario will likely argue that the *CCRA* does not engage *Charter* rights because an SCS can relocate to a place that is not 200m from a school of child care centre. This elides the new reality the *CCRA* creates. Relocating affected sites—and establishing new ones—will be difficult, if not impossible, to achieve in practice.[59] This is apparent from the maps that Ontario has produced, showing the restricted areas created by the *CCRA*. Effectively all of Toronto is blanketed by overlapping circles in which no SCS can operate. Only a few slivers of land here and there are left uncovered; and that is without considering zoning issues or pre-existing structures on that land. For the five Toronto SCSs that are forced to close, finding available real estate in a location permitted under the *CCRA* will be akin to finding a needle in a haystack:[60]

[57] These sites are Parkdale Queen West Community Health Centre (Queen West), Regent Park Community Health Centre, South Riverdale Community Health Centre (KeepSix), KMOPS, and The Works: see Sinclair Affidavit, Ex AA, AR, Tab 3, p 277.
[58] Sinclair Affidavit, Ex AA, AR, Tab 3, p 277. These trends include increased presence of benzodiazepines (a depressant) in fentanyl and the introduction of higher-potency opioids like fluorofentanyl or carfentanil.
[59] *Canadian Council of Refugees v. Canada (Citizenship and Immigration)*, 2023 SCC 17, para 158.
[60] Affidavit of William McGarry, affirmed January 24, 2025 (**"McGarry Affidavit"**), Ex B, RR, Tab 37, p 2328.

43. Beyond the immediate loss of services on April 1, 2025, s. 2(4) will require SCSs to close within 30 days upon a new private school or child care centre beginning to operate within 200m, creating the ever-present threat of sudden closure for all remaining and future SCSs in the province. This exacerbates the burdens of the law and makes relocation – and buying or leasing new space to operate an SCS that could be forced to close at any moment – even more impossible.

44. Further, certain sites are not permitted to simply relocate. Subsection 3(2)1 prohibits municipalities and local boards from applying for federal *CDSA* exemptions to operate an SCS without the Minister's approval. This would apply to The Works, which is operated by the City of Toronto and is the busiest site in Ontario. Because s. 56.1 exemptions are tied to specific locations, any relocating site will have to apply for a new exemption. While the Minister can technically approve an application by a municipality or local board for an exemption, the balance of the evidence indicates that the prospect of such approval is illusory.[61] The Minister has said that she has no intention of approving any further SCSs.[62]

45. More fundamentally, relocation is no answer to the core of the problem: SCSs are located where they are most desperately needed. As noted above, SCS were established in communities with high rates of pre-existing public drug use and homelessness. Moving these services to more sparsely-populated outskirts, with lower concentrations of schools and child care centres, would leave high-needs communities without access. TNG established KMOPS in its current location precisely because of how deeply the drug overdose crisis was affecting Kensington Market.[63] If it

[61] Nothing in the *CCRA* points to an actual intention to establish an approval process for municipalities and local boards to establish supervised consumption sites. There are no criteria specified in the *CCRA* that the Minister is to consider, nor any subordinate regulation dealing with any such process.
[62] Costoff Affidavit, para 9, Ex G, 21:53-22:25, AR, Tab 10, p 431.
[63] Sinclair Affidavit, paras 48-60, AR, Tab 3, pp 40-44.

goes into effect, the *CCRA* will mean that SCS locations will be dictated by the need to avoid the *CCRA*'s restricted areas, and not where they will be most effective in saving lives.

B. The *CCRA* Infringes the Section 7 Rights of SCS Clients

46. For a s. 7 *Charter* claimant to succeed, they must show: (i) a deprivation to their life, liberty or security of the person, and (ii) that this deprivation occurred in a manner that fails to accord with the principles of fundamental justice.

47. To establish a s. 7 deprivation, the claimant must demonstrate a "sufficient causal connection" between the state-caused effect and the prejudice suffered. This does not require that the impugned legislation be the only, or even the dominant, cause of the deprivation. The standard can be satisfied through a reasonable inference, drawn on a balance of probabilities.[64] The Supreme Court has repeatedly affirmed that a claimant's choice to engage in an inherently risky activity does not negate the causal connection between the law and the deprivation. In *PHS*, the Court expressly rejected the argument that the health risks to Insite's clients were the consequence of the clients' decision to use illegal drugs, and not the impugned legislation. Accordingly, for people with SUD, the "choice" to use drugs does not disrupt the causal connection between the legislation and the increased risk of death and disease that they face when they are prevented from accessing supervised consumption services.[65] This applies equally to the facts of this case.

48. Here, the evidence is clear that the *CCRA* will restrict access to life-saving services for thousands of people in Ontario who use drugs, including people with SUD. This will cause

---

[64] *Canada (Attorney General) v. Bedford*, 2013 SCC 72, para 75, 76.
[65] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, paras 97-106. See also *Canada (Attorney General) v. Bedford*, 2013 SCC 72, paras 79, 85-89, where the Supreme Court accepted that even a truly free choice to engage in an inherently risky activity did not negate the causal connection between the impugned legislation and the safety risks sex workers faced.

deprivations of life, liberty, and security of the person. These deprivations do not accord with principles of fundamental justice: they are arbitrary, overbroad, and grossly disproportionate. The *CCRA* will not only fail to achieve its goals of enhancing community safety, but will actively make those same communities *less* safe for all involved.

(i) The CCRA deprives SCS clients of their right to life and security of the person

49. Sections 2 and 3 of the *CCRA* squarely engage the life and security interests of SCS clients, including Mr. Forgues and Ms. Resendes. The *CCRA* will impair access to SCSs across the province, which will in turn lead to an increased risk of death and infectious disease.

50. The right to life under s. 7 is engaged where the impugned legislation imposes death or an increased risk of death on a person, directly or indirectly.[66] The right to security of the person is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering."[67]

51. In *PHS*, the Supreme Court held that the denial of a *CDSA* exemption to Insite deprived that SCS's clients of their s. 7 rights to life and security of the person. Because the evidence showed that the SCS saved lives and helped reduce health risks such as infections, the Court found that the closing of Insite through the denial of the exemption increased the risk of death and disease for its clients, thereby engaging their rights to life and security of the person under s. 7 of the *Charter*.[68]

52. The mechanism employed by the *CCRA* is different than that in *PHS*—which concerned the denial of a *CDSA* exemption to a single SCS—but the practical effect on SCS clients will ultimately be the same. The *CCRA*'s restrictions on SCSs will hamper the ability of people who

---

[66] *Carter v. Canada (Attorney General)*, 2015 SCC 5, para 62.
[67] *Carter v. Canada (Attorney General)*, 2015 SCC 5, para 64.
[68] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, paras 92-93.

use drugs to take steps to protect their own health and safety, increasing their risk of death and serious bodily and psychological harm.

53. As discussed above, the CCRA will mandate the closure of nearly half the SCSs in Ontario, immediately reducing service availability and eliminating it from some communities entirely. In Toronto, the evidence of Dr. Bayoumi suggests that 31 to 34% of current clients would be more than 1 kilometre away from an SCS. The results are even more drastic where the *CCRA* will shut down the only SCS in a city.[69] The immediate impact of the *CCRA* will be a total loss of access for all residents of Kitchener, Guelph, and Hamilton. The same goes for Thunder Bay—also set to lose its only SCS—where the next closest site will be an 8-hour drive away in Winnipeg, Manitoba.[70] For clients of these SCSs, simply travelling to the next closest open site is not merely difficult, it is a physical impossibility. As noted above, this concern is compounded by the fact that s. 2 of the *CCRA* makes it unduly onerous to open or relocate a site.

54. The evidence is clear that by limiting access to supervised consumption services in this manner, the *CCRA* increases the risk of death and other harms including infectious disease. Both Dr. Werb and Dr. Bayoumi prepared studies looking at the likely ramifications of the *CCRA* and both opined that the likely result was (among other things) an increase in the overdose mortality rate in neighbourhoods in which SCSs are currently located.[71]

55. The above is inherently logical in light of the rest of the record. Even Ontario's experts agree that SCSs save the lives of the clients who consume drugs in the premises.[72] There are an average of 21,867 visits to Ontario SCSs each month, and none has ever resulted in a fatal

---

[69] Dr. Bayoumi Affidavit, Ex A, para 101-106, 108, AR, Tab 11, p 689.
[70] Affidavit of Holly Gauvin sworn January 8, 2025 ("**Gauvin Affidavit**"), para 13, AR, Tab 8, p 324.
[71] Dr. Werb Affidavit, Ex A, AR, Tab 12, p 933; Dr. Bayoumi Affidavit, Ex A, para 107, AR, Tab 11, p 689.
[72] Dr. Platt Affidavit, para 17, RR, Tab 32, p 1673; Dr. Day Transcript, p 51-52, qq 203-204, JSAR, Tab 18.

overdose. Indeed, there has never been a fatal overdose at any SCS in Canada.[73] In addition to preventing fatalities from overdoses on their premises, SCSs are associated with statistically significant reductions in overdose mortality in the surrounding areas.[74]

56. Without access to SCSs, clients are subject to an increased risk of death. Based on the proportion of injections at an SCS that result in an overdose, the estimated number of SCS clients in Toronto that would lose access to an SCS within 500m of an SCS (526) accounts proportionately for an estimated 496 overdoses per year. Without access to supervision and the immediate intervention it provides, there will be an increased risk of death.[75]

57. SCSs are also associated with a number of positive health impacts, including ameliorating risky injection practices (such as sharing or re-using needles) which are associated with the transmission of bloodborne infections; increased treatment of skin and soft tissue infections, as well as reduced risk of developing such infections; and increased referrals to social and health services, including detoxification, opioid agonist treatment, and other treatments for SUD.[76]

58. The expert evidence is clear that reducing access to SCSs means reducing the above health and safety benefits for SCS clients, in turn leading to a deprivation of security of the person. It will result in increased public drug use, likely in unsafe and unsanitary locations. It will result in fewer referrals of SCS clients to social services and clinical care, include treatment for SUD. It will result in increased transmission of infectious disease. It will deny individuals who overdose immediate intervention, like oxygen or naloxone, increasing the risk of brain injury. It will increase resort to

---

[73] Dr. Bayoumi Affidavit, Ex A, para 55, 56, AR, Tab 11, p 678. Between March 2020 and March 2024, SCSs in Ontario reversed 21,979 overdoses; approximately 36% occurred at SCSs that will be required to close under the CCRA. See: Sallay Affidavit, Ex E, p 8, AR, Tab 9, p 408.
[74] Dr. Werb Affidavit, Ex A, AR, Tab 12, p 925; Dr. Bayoumi Affidavit, Ex A, para 71, AR, Tab 11, p 681.
[75] Dr. Bayoumi Affidavit, Ex A, para 107, AR, Tab 11, p 689.
[76] Dr. Bayoumi Affidavit, Ex A, para 72, AR, Tab 11, p 681.

unsanitary and risky injection practices, increasing the risk of local infections of the skin, such as abscesses and infected skin ulcers.[77] All of this has the likely effect of seriously impairing a person's health, thereby engaging the right to security of the person.[78]

59. The uncontested evidence of Mr. Forgues and Ms. Resendes reflects these same concerns about the increased risk to life and security of the person that the *CCRA* will cause. Mr. Forgues candidly gave evidence about how pre-SCS he was injecting opioids alone in alleys and stairwells; how he injected without proper, sanitized equipment, often reusing or sharing syringes; how this led to him contracting hepatitis C. For Mr. Forgues, the Kitchener CTS provided a gateway to a host of other health and social services, which Mr. Forgues says have had a "profound impact" on his life and put him on his current path towards recovery.[79] For Ms. Resendes, using SCSs like KMOPS and The Works has helped her to reduce the frequency of her drug consumption and adopt safer practices while she works on improving her underlying mental health difficulties to set a stable foundation for longer-term recovery.[80]

(ii) The CCRA deprives SCS clients of their right to liberty

60. The availability of imprisonment for an offence is sufficient to trigger an individual's right to liberty.[81] By removing access to legal supervised consumption services, the *CCRA* drives people living with SUD to use drugs under conditions where they are at heightened risk of criminal prosecution and consequent deprivations of their liberty.

---

[77] Dr. Werb Affidavit, Ex A, AR, Tab 12, p 933; Dr. Bayoumi Affidavit, Ex A, paras 61, 63, 111, AR, Tab 11, pp 680, 690.
[78] *R. v. Monney*, [1999] 1 S.C.R. 652, para 55.
[79] Forgues Affidavit, para 8, 33, AR, Tab 5, p 300, 303-4.
[80] Resendes Affidavit, para 50, AR, Tab 4, p 294.
[81] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, para 90; *R. v. Malmo-Levine*, 2003 SCC 74, para 84.

61. SCSs operate with a s. 56.1 exemption to the application of s. 4 of the *CDSA*, which otherwise criminalizes the possession of a controlled substance. Indeed, possession of a Schedule I substance, such as heroin or fentanyl, is punishable by up to seven years imprisonment. [82]

62. But for the s. 56.1 exemption, the conduct that occurs at an SCS would be criminal. The SCS grants clients a reprieve from the looming threat of imprisonment in their day-to-day lives because their mental health condition drives them to repeatedly obtain and possess drugs, contrary to the *CDSA*. Indeed, the Court in *PHS* suggested that but for the availability of *CDSA* exemptions allowing for SCSs like Insite, there could be an available argument that the prohibition on possession under s. 4 of the *CDSA* might itself infringe s. 7 of the *Charter*.[83]

63. The onerous restrictions the *CCRA* imposes on where SCSs can be located will have the effect of reducing the availability of places where people with SUD can possess and consume drugs lawfully, without the risk of imprisonment. People with SUD will continue to use drugs. Many will end up using in public or at some other location that does not have a *CDSA* exemption, thereby exposing them to a risk of imprisonment. This suffices to engage their s. 7 right to liberty.

(iii) These deprivations do not accord with the principles of fundamental justice

64. The second stage of the s. 7 analysis is concerned with inherently bad laws which deprive people of these rights in a way that runs afoul of society's basic values.[84]

65. The three principles of arbitrariness, overbreadth, and gross disproportionality compare the infringement caused by the law with the law's objectives. The analysis does not consider how well the law achieves its objectives or how much of the population will benefit from it. Section 7 is also

---

[82] *Controlled Drugs and Substances Act*, S.C. 1996, c. 19, s. 4(3).
[83] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, paras
[84] *Canada (Attorney General) v. Bedford*, 2013 SCC 72, para 96.

not concerned with how much of the population is *adversely* affected—a grossly disproportionate, overbroad, or arbitrary effect on one person is sufficient to establish a breach of s. 7.[85]

a. Objectives of the CCRA *and the impugned provisions*

66. The starting point in the analysis is to determine the objective of the impugned provisions. To determine a law's purpose, courts look to (1) statements of purpose; (2) the text, context, and scheme of the legislation; and (3) extrinsic evidence such as legislative history and evolution.[86]

67. Here, the purpose of the *CCRA* as a whole is the protection of the public, including children, from exposure to anti-social behaviours associated with drug use. There is no purpose provision in the *CCRA*, but its public safety purpose is reflected in the broader legislative scheme, including the preamble to the *Safer Streets, Communities Act, 2024*, the omnibus legislation under which the *CCRA* was introduced and which contains a host of provisions relating to public safety and the administration of justice. The preamble states that Ontario: "***Is taking action to protect children, families and people struggling with addiction*** by restricting supervised consumption sites, in line with its belief that addictions treatment is the best way to achieve lasting recovery."[87]

68. The text and scheme of the *CCRA* sheds little light on the nature of the public safety risk being targeted by the *CCRA*, beyond a connection to drugs. In these circumstances, courts can look to extrinsic evidence such as legislative history, Hansard, and government publications, though such evidence may be rhetorical and imprecise and must be approached with caution.[88] However, statements of purpose by the Minister responsible for introducing the legislation can be relevant

---

[85] *Canada (Attorney General) v. Bedford*, 2013 SCC 72, para 123.
[86] *R. v. Safarzadeh-Markhali*, 2016 SCC 14, para 31; *R. v. Moriarity*, 2015 SCC 55, para 31.
[87] *An Act to enact two Acts and to amend various Acts with respect to public safety and the justice system* ("***Safer Streets, Stronger Communities Act***"), 2024, S.O. 2024, c. 27 (emphasis added).
[88] *R. v. Moriarity*, 2015 SCC 55, para 31; *R. v. Safarzadeh-Markhali*, 2016 SCC 14, para 36; *R. v. Sharma*, 2022 SCC 39, para 88-89.

to determining the purpose of the impugned provision.[89] Here, Minister Sylvia Jones introduced the *CCRA*, and made clear that the purpose of the legislation is to protect communities from safety risks such as discarded drug paraphernalia, disruptive behaviour, and drug-related crime. [90]

69. In short, the purpose of the *CCRA* overall is to protect the safety of the public from exposure to anti-social behaviours associated with drug use. The purpose of s. 2 of the *CCRA* is to protect children, specifically, from that exposure. Subsections 3(2)1. and 3. restricts the ability of municipalities and local boards to operate, or support the establishment of, a supervised consumption site regardless of proximity to children, and share the *CCRA*'s broader purpose of protecting the entire public from exposure to anti-social behaviours associated with drug use.

b. Arbitrariness

70. A law will be arbitrary either where the evidence demonstrates that its effects actually undermine its objective, or where, on the evidence, there is no connection between the effects of the law and its objective, such that the effect (with its deprivation of security) is therefore "unnecessary".[91] The restrictions under ss. 2 and 3(2) of the *CCRA* are arbitrary in both respects.

71. **Undermining its objective.** First, the closure of SCSs in densely populated neighbourhoods will not cause clients to discontinue their drug use. The Applicants' experts opine that the likely impacts of the *CCRA*'s restrictions will be increased public drug use and increased public intoxication[92]—the exact harms that the *CCRA* is supposed to guard against. This was the situation in Kensington Market well prior to the opening of KMOPS: residents routinely observed

---

[89] *R. v. Safarzadeh-Markhali*, 2016 SCC 14, para 36.
[90] Costoff Affidavit, Ex A, Ontario Hansard November 19, 2024, p 10394, AR, Tab 10, p 450.
[91] *Canada (Attorney General) v. Bedford*, 2013 SCC 72, para 100.
[92] Dr. Bayoumi Affidavit, Ex A, para 111, AR, Tab 11, p 690; Dr. Werb Affidavit, Ex A, AR, Tab 12, pp 933-935.

public drug use, drug dealing, and discarded drug paraphernalia;[93] parents and children steered clear of Belleville Square Park, just down the street, due to its reputation for drug activity.[94]

72. SCSs move a proportion of this public drug use into a controlled, private space where children and other community members are not exposed to it (and where trained staff are able to intervene immediately). In a cohort study of SCS clients in Toronto, accessing an SCS within the past 6 months was associated with a 50% reduction in the prevalence of high-frequency public injecting.[95] This is consistent with the experience of TNG, which observed a reduction in public injection drug use (and discarded drug paraphernalia) after it opened KMOPS in 2018.[96]

73. **No connection.** Second, ss. 2 and 3(2)1 of the *CCRA* are arbitrary because they target activities that are not rationally connected to the behaviours the provisions aim to suppress.

74. On its face, it is illogical to suggest that suppressing alternatives to public drug use will reduce public drug use in those areas. The record similarly fails to establish that these measures are capable of having their desired effect *at all* (*i.e.*, of reducing public drug use). The evidence also does not establish that SCSs cause increased public drug use or disorder in their immediate vicinity. Ontario relies largely on anecdotal evidence from a handful of individuals describing increases in various anti-social behaviours such as public drug use and selling after SCSs opened in their neighbourhoods. This anecdotal evidence is not a sound basis on which to draw causal conclusions regarding the impact of SCSs on safety of the surrounding area for a variety of reasons:

---

[93] Affidavit of Corina Death affirmed February 7, 2025 ("**Death Affidavit**"), paras 10-18, RAR, Tab 5, pp 85-88; Affidavit of Dominique Russell sworn February 7, 2025 ("**Russell Affidavit**"), paras 10-11, RAR, Tab 4, p 77; Affidavit of Patricia Au sworn February 5, 2025 ("**Au Affidavit**"), paras 8-13, RAR, Tab 3, pp 63-65.
[94] Au Affidavit, para 13, RAR, Tab 3, p 65; Death Affidavit, para 12, RAR, Tab 5, p 86.
[95] Dr. Werb Affidavit, Ex A, AR, Tab 12, p 932.
[96] Sinclair Affidavit, para 125, AR, Tab 3, p 58. See also: Affidavit of Maggie Helwig sworn February 6, 2025 ("**Helwig Affidavit**"), para 15, RAR, Tab 2, p 41; Russell Affidavit, para 15, RAR, Tab 4, p 78.

- Ontario's fact witnesses rely extensively on vague hearsay, often from unnamed sources, to support their observations of increased social disorder in their communities after the introduction of the SCS—matters which are contentious in this application.[97] This evidence is inadmissible as hearsay (contrary to r. 39.01(5)).

- This anecdotal evidence fails to address any other causes or contributors to the increase in anti-social behaviours, such as: the explosion of fentanyl into the street drug supply, in or around the mid- to late-2010s; the rise in inhalation as a method of drug consumption; the onset of the COVID-19 pandemic in March 2020 (which, among other impacts, led to job losses and people losing their housing, at the same time as reducing capacity in homeless shelters and SCSs); or the formation of large homeless encampments in public parks and other areas in their neighbourhoods.[98]

- The evidence cannot be used to support any connection between the implementation of the SCS and disorder. Several of Ontario's fact witnesses did not observe any changes in their neighbourhood for years after the SCS opened.[99] Others only began frequenting or living in that particular area years after the SCS opened (and after other intervening events, such as the COVID-19 pandemic, had occurred).[100]

- The affidavits of Ontario's fact witnesses were rife with speculation. They frequently assumed an intoxicated person was a client of the SCS because they were in the general area of the site, or attributed discarded drug paraphernalia to the SCS despite having no knowledge of its provenance, among other assumptions.[101]

- There were also serious credibility concerns with some of Ontario's evidence.[102]

75. Ontario's expert evidence similarly does not establish that SCSs create social disorder and

---

[97] To provide just a few examples: Affidavit of Derek Finkle sworn January 14, 2025 ("**Finkle Affidavit**"), paras 51, 58, 68, RR, Tab 5, pp 99, 100, 103; Affidavit of Andrea Nickel sworn January 21, 2025 ("**Nickel Affidavit**"), paras 9-10, 44, 46, 65, 67, RR, Tab 12, pp 744-745, 752, and 756-757.

[98] Dr. Werb Reply Affidavit, Ex A, para 31, RAR, Tab 24, p 304; Sinclair Reply Affidavit, paras 10, 16, 18, RAR, Tab 1, p 5; see Resendes Affidavit, paras 26-27, AR, Tab 4, p 288; Helwig Affidavit, paras 17-19, RAR, Tab 2, pp 41-42.

[99] E.g. Affidavit of Mike Shepherd sworn January 24, 2025 ("**Shepherd Affidavit**"), paras 7-8, RR, Tab 4, p 80; Affidavit of Brook Coatsworth sworn January 14, 2025 ("**Coatsworth Affidavit**"), paras 2, 9-13, RR, Tab 10, pp 676-678.

[100] E.g. Affidavit of Nigel Fick sworn January 14, 2025 ("**Fick Affidavit**"), paras 9, 11-12, RR, Tab 8, p 677-678; Affidavit of Anya Fraser affirmed January 24, 2025 ("**Fraser Affidavit**"), paras 1, 6, RR, Tab 22, p 1274.

[101] E.g. Transcript of Cross-Examination of Anthony Aarts, February 10, 2025 ("**Aarts Transcript**"), pp 23-24, 36, qq 75-77, 113, JSAR, Tab 5; Transcript of Cross-Examination of Grey Coyote, February 10, 2025 ("**Coyote Transcript**"), pp 48-49, qq 184-186.

[102] For example, one of Ontario's witnesses, Grey Coyote, stated that he "never observed any open drug use or drug dealing" in Kensington Market before KMOPS opened, but eventually admitted in cross-examination that prior to KMOPS opening, he had actually observed both open drug use and drug dealing in the area repeatedly, and that problems with people loitering and doing drugs on properties along Augusta Avenue had been getting "worse and worse as the years pass" ever since 2000. Coyote Transcript, pp 24-25, qq 82-89, JSAR, Tab 7.

other drug-related anti-social behaviours in the surrounding areas that is harmful to children:

- **Dr. Ratcliffe,** a U.S. criminologist, opined on the impacts of SCSs on crime. Dr. Ratcliffe's opinion relies on the high-level theoretical proposition that people who use drugs are themselves linked to increased crime and disorder, and because SCS clients are people who use drugs, locating SCS near facilities with high concentrations of children will expose children to a population that has a higher than normal propensity to crime.[103] However, this proposition assumes that the presence of the SCS increases the number of people who use drugs in that particular area, which is not supported by the evidence.[104] Also, Dr. Ratcliffe did not refer to any studies showing an impact of Ontario SCSs on crime or drug-related social disorder, nor did he analyze or interpret Ontario data beyond referencing anecdotal evidence reported in a review of SRCHC.[105]

- **Dr. Guerra,** who opined on the impacts of repeated exposure to anti-social and disruptive behaviours on children, clarified in cross-examination that her expertise does not extend to whether SCSs lead to an increase in criminal or anti-social behaviour and her report does not purport to address that question.[106]

76. There is also no rational connection between targeting SCSs and reducing improperly discarded drug paraphernalia. Paraphernalia used at a SCS is discarded safely and securely on-site, such that it cannot end up in the community. While many SCSs provide free harm reduction supplies for off-site use, this conduct is not actually covered by the *CCRA*; the provision of harm reduction supplies (such as clean syringes) does not require a *CDSA* exemption.[107] What the *CCRA* does do is remove one of the key benefits of needle exchange programs: getting people in the door and thereby facilitating their access to other harm reduction, health, and social services.

---

[103] Affidavit of Dr. Jerry Ratcliffe affirmed January 23, 2025 ("**Dr. Ratcliffe Affidavit**"), paras 9-11, RR, Tab 33, p 1797.
[104] See Dr. Bayoumi Reply Affidavit, Ex A, para 78, RAR, Tab 26, p 380.
[105] Transcript from Cross-examination of Dr. Jerry Ratcliffe, February 17, 2025 (**"Dr. Ratcliffe Transcript"**), p 9 qq 22-25, p 32, q 104, p 58, qq 189-192, JSAR, Tab 20. This is in direct contrast to Dr. Werb, who referred to a number of peer-reviewed studies on the association between SCS implementation and crime and conducted his own study on the matter. See: Dr. Werb Affidavit, Ex A, AR, Tab 12, pp 918-920.
[106] Transcript of Cross-Examination of Dr. Nancy Guerra ("**Dr. Guerra Transcript**"), pp 12-13, qq 34-40, JSAR, Tab 21.
[107] Ontario's guidelines for the SCSs that it funds also requires such sites remove "inappropriately discarded harm reduction supplies" surrounding the CTS area: Dr. Bayoumi Affidavit, Ex A, para 46, AR, Tab 11, p 677.

c. Overbreadth

77. Sections 2 and 3(2)1 of the *CCRA* also offend the principle of overbreadth. They capture conduct that bears no relationship to the objective of protecting children or the broader public from exposure to disorder associated with drug use. Overbreadth as a principle of fundamental justice deals with a law that is so broad in scope that it includes *some* conduct that bears no relation to its purpose. Overbroad laws may be rational in some cases, but overreaches in its effect in others. The focus of the inquiry is not the overall rationality of the law, but on the individual, and whether the law's effect on the individual is rationally connected to its purpose.[108]

78. The *CCRA* is overbroad in at least three distinct respects: (1) it closes sites that have been operating without posing any safety risks to children, depriving those clients of access to life-saving services; (2) it closes and/or prohibits "closed" sites that are not open to the public; (3) it applies to sites engaged in activities that have nothing to do with supervised consumption and bear no connection to the objective of protecting children.

79. First, s. 2 of the *CCRA* prohibits the operation of any SCS within 200m of a school or child care centre regardless of whether the site has created or contributed to any safety risks in the vicinity. Ontario has not put forward any evidence of safety issues at *four* of the nine SCSs that the *CCRA* will close on April 1, 2025. This issue is most apparent with respect to Ottawa's SCSs. Ottawa currently has four SCSs: three in the Lowertown/Sandy Hill neighbourhood, and one in Hintonburg (over 3km away from the other sites). Ontario's affiants speak only to witnessing disorder at the Lowertown/Sandy Hill sites, which will remain open under the *CCRA*—there is no evidence regarding conditions near the Hintonberg site, which the *CCRA* will close.

---

[108] *Canada (Attorney General) v. Bedford*, 2013 SCC 72, paras 112-113; *Carter v. Canada (Attorney General)*, 2015 SCC 5, para 85.

80. Similarly, Ontario adduced no evidence of any issues in the vicinity of the Path 525 CTS in Thunder Bay, the only service provider in Northern Ontario, which will be required to close.[109] Notably, neither of these sites are located in proximity to other SCSs. Clients of these sites will be subjected to an increased risk of death and harms to their health and safety, despite there being no evidence that the sites they have been relying on were creating any safety risks at all.

81. Second, the *CCRA* is overbroad because both s. 2 and 3(2)1. apply to SCSs that are not open to the public and therefore do not logically create the risks that the *CCRA* aims to address. Section 2 is aimed at behaviours which take place outside of the site, because that is where they are observable by children. However, the *CCRA* would also restrict the operation or establishment of SCSs that are not open to the general public, such as a hospital that provides supervised consumption services exclusively to inpatients (if they fall within the 200 metre "buffer zone").[110]

82. Third, ss. 2 and 3(2)1 of the *CCRA* rely on a definition of a "supervised consumption site" that expressly extends beyond sites offering supervised consumption services:

> "supervised consumption site" means a site in respect of which the federal Minister of Health has granted an exemption to allow activities at the site in relation to a controlled substance or precursor that is obtained in a manner not authorized under the *Controlled Drugs and Substances Act* (Canada),
>
> (a) under section 56.1 of the *Controlled Drugs and Substances Act* (Canada), in circumstances where the federal Minister of Health is of the opinion that the exemption is necessary for a medical purpose, or
>
> (b) under subsection 56 (1) of the *Controlled Drugs and Substances Act* (Canada), in circumstances where the federal Minister of Health is of the opinion that the exemption is necessary for a scientific purpose or is otherwise in the public interest. ("site de consommation supervisée")

[109] There is arguably also no evidence of safety issues near the Guelph Community Health Centre or the Kitchener CTS (which were visited by Ontario's PIs): Laurence Affidavit, para 8, AR, Tab 13, p 1004.

[110] For example, Casey House, a Toronto hospital, has a SCS that provides supervised consumption services only to inpatients of the hospital, but would fall within the *CCRA*'s definition of a "supervised consumption site".

83. Section 56.1 of the *CDSA* deals specifically with exemptions for the purpose of operating an SCS. In contrast, the scope of s. 56(1) includes activities that have no nexus with (and no rational connection to) harm reduction at all, such as scientific research. The *CCRA*'s expansive definition of a supervised consumption site directly results in "a law that is so broad in scope that it includes some conduct that bears no relation to its purpose."[111]

84. One of the activities captured by the *CCRA*'s broad scope is drug checking via the TDCS.[112] Drug samples are collected from clients at collection sites and are transported to laboratories at the Centre for Addiction and Mental Health and St. Michael's Hospital for analysis. The laboratories then send the results to clients identifying the composition of the substance. Because these laboratories deal with these controlled substances pursuant to a s. 56(1) class exemption, they are "supervised consumption sites" within the meaning of the *CCRA* even though they do not provide supervised consumption services to clients. Restricting access to these services—whether the laboratories providing the testing or the collection sites where clients drop off their samples—leaves people who use drugs at increased risk of death and harm to their health.

d. Gross disproportionality

85. The deprivations of life, liberty, and security caused by the *CCRA* are also grossly disproportionate to its objectives of protecting children and other members of the public from exposure to anti-social behaviours. The inquiry into gross disproportionality compares the objective of the measure, taken at face value, with its negative effects on the individual, and asks if this impact is completely out of sync with the object of the law.[113]

---

[111] *Canada (Attorney General) v. Bedford*, 2013 SCC 72, para 112.
[112] See Sinclair Affidavit, paras 96-97, AR, Tab 3, p 51.
[113] *Carter v. Canada (Attorney General)*, 2015 SCC 5, para 89.

86. The impacts on the rights of SCS clients are serious. SCSs are a critical tool for people who use drugs to guard against the significant risk of death and other bodily harm each time they consume drugs. For those living with SUD, simply discontinuing their drug use is not a real option. SCS clients will be forced to return to or increase the frequency of unsafe practices that directly contribute to their risk of dying from an accidental overdose; brain damage or other bodily harm from a non-fatal overdose; bloodborne infections from re-using or sharing needles, or simply being unable to keep that equipment clean while living on the street; injection injuries such as abscesses, which are more likely when consumption has to take place in rushed conditions due to fear of discovery by law enforcement; and other risks to their safety from using in public.[114]

87. The gross disproportionality inquiry does not look to how many people will be benefitted by the law, nor how many people will be adversely affected. As the Court held in *Bedford*, a grossly disproportionate effect on *one person* is sufficient to establish a breach of s. 7.[115] Accordingly, the analysis does not ask what proportion of SCS clients will lose access to services under the law, or whether there are more children who will benefit than SCS clients who will suffer. The focus at the infringement stage remains on the purpose of the law, and its effect on the individual.

88. While s. 2's objective of protecting children from safety risks is to be considered on its face, the analysis must still be sensitive to the actual nature of those risks.[116] The record suggests that the nature of the risk to children which the *CCRA* targets is not direct and severe, but incremental and indirect. The underlying theory is that repeated exposure to adverse childhood experiences is associated with a more elevated risk for various kinds of difficulties over one's

---

[114] Dr. Bayoumi Affidavit, Ex A, paras 62, 72, 111, AR, Tab 11, pp 679, 681, 690.
[115] *Canada (Attorney General) v. Bedford*, 2013 SCC 72, para 123.
[116] *Canada (Attorney General) v. Bedford*, 2010 ONSC 4264, paras 427, 429, 432.

lifespan. Repeated exposure to people using, buying or selling drugs may "normalize" drug use and increase children and youth's likelihood of engaging in risky behaviours. However, the expert evidence is not clear on the scale of the impact.[117]

89. Ultimately, the *CCRA* aims to reduce the frequency with which children are exposed to adverse experiences that have the potential to increase their risk factors over time, but it does so in a manner that materially increases the risk of imminent death and/or serious bodily injury for people who are among the most vulnerable and marginalized in our society.

90. In *PHS*, the Court held that closing Insite would subject its clients to an increased risk of death and disease, when Insite had had no discernible negative impact on public safety. The Court concluded this was "grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics".[118] Like Insite, several Ontario SCSs have been operating for years, with no evidence that their operations have harmed public safety. The severe deprivations of life, liberty, and security of the person to which they are subjected under the *CCRA* are grossly disproportionate and would shock the conscience of the community.

C. The *CCRA* Infringes the Section 15 Rights of People with Substance Use Disorder

91. Sections 2 and 3 of the *CCRA* violate the equality guarantee under s. 15 of the *Charter*. The *CCRA* sacrifices the wellbeing of an already marginalized group at the altar of vague and unproven benefits to community safety.

92. Section 15(1) reflects a profound commitment to promote substantive equality.[119] To prove

---

[117] Affidavit of Dr. Nancy Guerra affirmed January 23, 2025 ("**Dr. Guerra Affidavit**"), para 6(a)-(b), RR, Tab 34, pp 1865-1867.
[118] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, paras 133, 136.
[119] *Quebec (Attorney General) v. A*, 2013 SCC 5, para 332; *Kahkewistahaw First Nation v. Taypotat*, 2015 SCC 30, paras 19-20.

a violation of s. 15(1), a claimant must demonstrate that the impugned law or state action: (i) on its face or in its impact, creates differential treatment of individuals based on a ground enumerated in s. 15(1), or an analogous ground; and (ii) imposes burdens or denies a benefit in a manner that has the effect of reinforcing, perpetuating, or exacerbating disadvantage.[120]

93. The differential treatment may be the consequence of the express terms of the challenged legislation, or it may arise in the impact or effect of facially neutral legislation.[121] Whether the legislature intended to create a disparate impact is irrelevant.[122] It is similarly unnecessary for the law to be responsible for creating the background social or physical barriers that make the particular rule disadvantageous for the claimant group.[123]

(i) Step one: the CCRA creates a distinction based on disability

94. This is an adverse impact case, as the law is neutral on its face. As such, at the first stage, the question is whether the law *creates or contributes to* a disproportionate impact based on a protected ground.[124] This "is not a preliminary merits screen, nor an onerous hurdle designed to weed out claims on technical bases".[125] The impugned provisions "need not be the only or dominant cause" of the impact; there must merely be a "link or nexus" between them.[126]

95. Two types of evidence can be helpful at step one: (i) evidence about the circumstances of the claimant group; and (ii) evidence about the results produced by the challenged law. Ideally, claims of adverse impact discrimination should be supported by both, as the Applicants have

---

[120] *Fraser v. Canada (Attorney General),* 2020 SCC 28, para 27.
[121] *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 SCR 625, para 77.
[122] *Fraser v. Canada (Attorney General),* 2020 SCC 28, paras 69-72.
[123] *Fraser v. Canada (Attorney General),* 2020 SCC 28, paras 69-72.
[124] *R. v. Sharma*, 2022 SCC 39, paras 42, 45.
[125] *Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux*, 2018 SCC 17, para 26; *Ontario (Attorney General) v. G*, 2020 SCC 38, para 41.
[126] *R. v. Sharma*, 2022 SCC 39, paras 44-45. See also *Fraser v Canada (Attorney General)*, 2020 SCC 28, para 71.

presented in this case.[127] At the same time, the evidentiary burden at step one should not be undue and the causal connection may be satisfied by a reasonable inference.[128]

96. The *CCRA* distinguishes on the enumerated ground of "disability" by imposing disproportionate burdens on those with the disability of SUD. In *PHS*, the Supreme Court relied on the trial judge's findings to conclude that addiction is an "illness" and a "disease".[129] In the context of a claim regarding the provision of safe injection equipment to inmates, this Court already concluded that "addiction is a disability" for the purposes of s. 15.[130] Further, the Court of Appeal has recognized addiction, substance abuse, and drug dependency as disabilities.[131]

97. This is consistent with the uncontested expert evidence in this case. Dr. Bayoumi explained that SUD is a chronic health condition – recognized in the DSM-5-TR – that can be considered a disability when it impairs an individual's ability to function.[132]

98. In some respects, the *CCRA* is neutral on its face since all Ontarians will be deprived of access to the SCSs that will be forced to close. However, Ontarians with SUD will be impacted disproportionately by the law and will face more acute harms because of the law, when assessed against the reasonable comparator group of Ontarians who do not suffer from SUD.

99. Most people who access SCSs suffer from SUD.[133] This is hardly surprising, given that

---

[127] *Fraser v. Canada (Attorney General),* 2020 SCC 28, paras 56-60.
[128] *R. v. Sharma*, 2022 SCC 39, para 49.
[129] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, para 27, 101.
[130] *Simons et al v. Minister of Public Safety et al*, 2020 ONSC 1431, para 80. See also: *Black v. Alberta,* 2023 ABKB 123, para 120; *Selkirk et. al. v. Trillium Gift of Life Network et. al.*, 2021 ONSC 2355, para 115-116.
[131] *Ontario (Disability Support Program) v. Tranchemontagne*, 2010 ONCA 593, para 120-121, 126; *Entrop v. Imperial Oil Limited*, 2000 CanLII 16800 (ONCA), para 89, 118.
[132] Dr. Bayoumi Affidavit, Ex A, para 18, 20-22, AR, Tab 11, pp 671-673.
[133] Dr. Bayoumi Affidavit, Ex A, para 18, 73, AR, Tab 11, pp 671, 682. The majority of KMOPS clients describe having a physical and/or emotional dependence on substances and an inability to stop: see Sinclair Affidavit, para 104, 138, AR, Tab 3, pp 53, 61. See also: Sallay Affidavit, para 17, AR, Tab 3, p 355-356.

these services are designed to help these people reduce the harms they experience because of their disability. The individual Applicants, who are SCS clients, have also discussed their experiences living with SUD.[134] Regardless of whether all clients of SCSs suffer from SUD, these are the clients who will be disproportionately and most acutely impacted by the restriction or elimination of these services. Because of their disorder, these clients will be unable to easily choose not to consume drugs if they cannot access an SCS or if they must travel long distances to do so.

100. The impugned provisions of the *CCRA* will result in adverse impacts on those suffering from SUD. As noted above, the effect of the *CCRA* is that SCSs in Ontario will close, and realistically will be unable to reopen to serve the same communities.[135] This means that clients with SUD will be effectively denied the life-saving care that they have been relying on. As the evidence demonstrates, due to their disabilities (as well as other intersecting disabilities and marginalizations) these individuals will be unable to simply make the lengthy trip to other SCSs that may remain open. Individuals suffering from SUD – many of whom may also be experiencing homelessness and suffering other physical or mental disabilities – will not be able to choose to delay their consumption to travel long distances to another SCS.[136] This inability to stop drug consumption, despite a desire to do so, is a core feature of SUD. For others, they may be left without an SCS at all in their city or region – or, when the SCS in Thunder Bay is forced to close, for more than 700 kilometres in any direction.[137] For them, travelling to another site is impossible.

---

[134] Resendes Affidavit, para 14, AR, Tab 4, p 286; Forgues Affidavit, para 7, AR, Tab 5, p 300.
[135] Sinclair Affidavit, paras 129-131, AR, Tab 3, pp 59-60.
[136] Sinclair Affidavit, para 149-151, AR, Tab 3, pp 65-66; Resendes Affidavit, para 39, 43, AR, Tab 4, pp 291-293; Forgues Affidavit, para 32, AR, Tab 5, p 307; Laurence Affidavit, para 11, 38, AR, Tab 13, p 1006, 1012; Dr. Bayoumi Affidavit, Ex A, para 18, 79, AR, Tab 11, pp 671, 683.
[137] Forgues Affidavit, para 31, AR, Tab 5, p 307 (the Kitchener SCS is the only SCS in that city, which will be forced to close as a result of the *CCRA*); Sinclair Affidavit, Ex W, AR, Tab 3, p 255; Dr. Bayoumi Affidavit, Ex A, para 108, AR, Tab 11, p 689; Gauvin Affidavit, para 13, AR, Tab 8, p 324.

101. Even for those who are able and willing to travel to obtain supervised consumption services, the *CCRA* will make access to these services more onerous. Because of the added burden, these people will likely attend SCSs less often. Further, the SCSs that remain open will not be able to handle the excess volume from the closed sites.[138] Therefore, even people who are able to travel to another site may be turned away or forced to wait long periods of time. The prospect of having to queue outside of an SCS also subjects clients to privacy risks of being "outed" as someone who uses drugs, exposing their personal health information and putting them at risk of discrimination.[139]

102. Ultimately, the impact of the *CCRA* is a restriction and denial of SCS services to the people who use and need them the most: people suffering from the disability of SUD. This is an adverse effect that will disproportionately impact a specific population on the basis of their disability.

103. As discussed above, the result of this restriction and denial of service is that those suffering from SUD are, because of their illness, likely to use their drugs elsewhere, in more rushed, less sanitary, and more dangerous situations. This poses a real risk to the safety and lives of this already vulnerable population through the spreading of diseases, infections, abscesses, and deadly overdoses that will not be reversed.[140] These are the harms that the law disproportionately places on individuals with SUD.

(ii) Step two: the CCRA is discriminatory

104. The second step of s. 15 requires the claimants to establish that the impugned law imposes burdens or denies benefits in a manner that has the effect of reinforcing, perpetuating, or exacerbating the group's disadvantage. The analysis must remain flexible and can consider a broad

---

[138] Sallay Affidavit, paras 21, 31, AR, Tab 3, pp 357, 360-361; Laurence Affidavit, paras 32-34, AR, Tab 13, p 1011.
[139] Dr. Bayoumi Affidavit, Ex A, para 111(i), AR, Tab 11, p 690.
[140] Sinclair Affidavit, paras 136-143, AR, Tab 3, pp 61-63.

range of harms.[141] Where government conduct "widens the gap between the historically disadvantaged group and the rest of society rather than narrowing it, then it is discriminatory".[142]

105. The analysis is "contextual, not formalistic" and "grounded in the actual situation of the group and the potential of the impugned law to worsen their situation". There is no "rigid template" of relevant factors.[143] The goal is to examine the impact of the harm caused, which may include economic exclusion or disadvantage, social exclusion, psychological harms, physical harms, or political exclusion.[144] Further, the harm must be viewed in light of any systemic or historical disadvantages faced by the claimant group.[145] The presence of arbitrariness, prejudice, and stereotyping point towards discrimination, although they are not necessary components.[146]

106. To determine whether a distinction is discriminatory, courts should also consider the broader legislative context.[147] Relevant considerations include: the objects of the scheme, whether a policy is designed to benefit a number of different groups, the allocation of resources, particular policy goals sought to be achieved, and whether the lines are drawn mindful as to those factors.[148]

107. Considering these factors, the *CCRA*, by terminating or seriously reducing access to SCSs for people with SUD, exacerbates their existing disadvantages.

108. The Supreme Court has already identified people who use drugs – and those suffering from addictions – as a "historically marginalized population", whose safety is put at risk because of their

---

[141] *Fraser v. Canada (Attorney General),* 2020 SCC 28, para 76.
[142] *Quebec (Attorney General) v. A.*, 2013 SCC 5, para 332.
[143] *Withler v. Canada (Attorney General)*, 2011 SCC 12, para 37, 66; *Quebec (Attorney General) v. A*, 2013 SCC 5, para 331; *Fraser v. Canada (Attorney General),* 2020 SCC 28, para 76.
[144] *Fraser v. Canada (Attorney General),* 2020 SCC 28, para 76.
[145] *R. v. Sharma*, 2022 SCC 39, para 52; *Ontario (Attorney General) v. G*, 2020 SCC 38, para 43.
[146] *R. v. Sharma*, 2022 SCC 39, para 52; *Quebec (Attorney General) v. A*, 2013 SCC 5, para 329; *Fraser v. Canada (Attorney General),* 2020 SCC 28, para 78.
[147] *R. v. Sharma*, 2022 SCC 39, para 56.
[148] *Withler v. Canada (Attorney General)*, 2011 SCC 12, para 67; *R. v. Sharma*, 2022 SCC 39, para 58.

illness.[149] Moreover, the Ontario Court of Appeal has stated that it is "well-known" that individuals suffering from addiction "have been, and continue to be, the subjects of stigma and prejudice".[150] Witnesses in this case have spoken to the stigmatization, stereotyping, and prejudice that people with SUD regularly face.[151] The *CCRA* will heighten that marginalization, stigma, stereotyping, and prejudice; it widens the gap between individuals with SUD and other Ontarians.

109. Substance users are already subject to higher mortality and morbidity rates due to their disability. As the Supreme Court pointed out, these people are difficult to bring within the reach of health care providers.[152] The evidence in this case is consistent with this fact that people with SUD often avoid or receive inadequate health care due to their conditions and the stigmatization that come with it.[153] However, Ontario has sought to make this problem worse by impeding or denying access to life-saving health care to this vulnerable population.

110. The claimants do not need to establish that the *CCRA*, or even the state more generally, is the cause of all the disadvantage that people with SUD face. Rather, for the purposes of s. 15, it is sufficient that the Act will make the situation worse; it widens the gap.

111. The *CCRA* will also reinforce, perpetuate, and exacerbate stereotypes and prejudices against people who suffer from SUD. The legislation bolsters the false and negative message that people with SUD are inherently dangerous to children, unsafe to others, and harmful to society, rather than being members of society who need help and safety. It falsely positions these

---

[149] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, para 10.
[150] *Ontario (Disability Support Program) v. Tranchemontagne*, 2010 ONCA 593, para 121, see also para 126.
[151] Sinclair Affidavit, para 110, AR, Tab 3, p 55; Resendes Affidavit, para 22, 37, AR, Tab 4, pp 287, 291; Dr. Bayoumi Affidavit, Ex A, para 66, AR, Tab 11, p 680.
[152] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, para 10.
[153] Sinclair Affidavit, para 42, AR, Tab 3, p 39; Resendes Affidavit, paras 22, 24, AR, Tab 4, pp 287-288; Forgues Affidavit, para 9, AR, Tab 5, p 300; Dr. Bayoumi Affidavit, Ex A, para 66, AR, Tab 11, p 680.

individuals – particularly those suffering from lack of or inadequate housing, which is the majority of SCS clients – as an 'other' that is 'invading' otherwise safe neighbourhoods, as opposed to themselves being members of these communities. The *CCRA* purports to be legislation about 'community' safety, but excludes people who use drugs from the conceptualization of that community and positions them as a threat to that safety, rather than being deserving of it.

112. This prejudicial framing is apparent in the very evidence that Ontario has brought forward to defend its discriminatory legislation. In support of the law, Ontario has adduced evidence from various residents of these communities who have spoken of SCS clients as an outside force (not members of the community) who are the source of disorder and need to go somewhere else.[154]

113. Further, Ontario retained private investigators to travel the province to photograph people who appear to be drug users (and may have SUD) without their consent in order to depict them as scary and dangerous: a 'problem' to be solved.[155] Such an approach shows a clear lack of respect for the dignity and self-worth of these human beings, many of whom were videotaped by Ontario's private investigators in moments of heightened vulnerability. Despite the fact that the mandate for the private investigators included to "ask residents … about their experience with neighbourhood [SCSs]",[156] they excluded apparent users of the SCSs or apparent drug users from their understanding of "residents" and did not bother to speak with them.[157]

114. Ontario's focus on abstinence-only drug treatment programs as opposed to SCSs, also sends the message that only some people with SUD are "worthy" of help or healthcare: those who

---

[154] Transcript of Cross-Examination of Anya Fraser, February 10, 2025 ("**Fraser Trancript**"), pp 51-55, qq 178-181, 186-187, JSAR, Tab 13; Aarts Transcript, pp 36-37, qq 113-117, JSAR, Tab 5.
[155] Transcript of Cross-Examination of Krishanthakumar Ganeshan, February 20, 2025, ("**Ganeshan Transcript**"), pp 16, 21, JSAR, Tab 22.
[156] Affidavit of Krishanthakumar (Krish) Ganeshan, sworn January 24, 2025, para 4, RR, Tab 38, p 2351.
[157] Ganeshan Transcript, pp 17-18, 26, qq 45-47, JSAR, Tab 22.

are willing and able to completely abstain from drug use.[158] All individuals with SUD are deserving of healthcare and respect, regardless of their goals or progress in their treatment.

115. Finally, the *CCRA* sends a very clear message to those with SUD – and Ontarians more generally – that people with this disability are less worthy of health and safety. It sends the message that the safety – and even the lives – of these people are less important than the feelings of other residents. As Mr. Forgues has stated:

> Cutting access to supervised consumption services to an entire region makes me feel like the government considers my life and the lives of people living with substance use disorder as not being worth anything. It makes me feel like my life is disposable; that it does not matter if I live or die.[159]

116. In these ways, the effects of the *CCRA* are sharply inconsistent with s. 15's purpose to "promote a society where all persons are considered worthy of respect and consideration".[160]

117. The disadvantage perpetuated by the *CCRA* is exacerbated when considered in the context of the intersecting forms of marginalization faced by drug users. As the Supreme Court has explained, "intersecting group membership tends to amplify discriminatory effects" and can "create unique discriminatory effects not visited upon any group viewed in isolation".[161] Many Ontarians living with SUD also experience other intersecting marginalized identities, including homelessness, racialization, Indigeneity, and other mental and physical disabilities.[162] Many of these group memberships render this population more vulnerable in terms of access to adequate

---

[158] Dr. Wyman Affidavit, sworn February 6, 2025, para 7, RAR. Tab 25, p 328
[159] Forgues Affidavit, para 35, AR, Tab 5, p 308.
[160] *Corbiere v. Canada (Minister of Indian and Northern Affairs)*, [1999] 2 S.C.R. 203, para 5.
[161] *Ontario (Attorney General) v. G*, 2020 SCC 38, para 47.
[162] Sinclair Affidavit, para 103, 105-106, AR, Tab 3, pp 53-54; Affidavit of Lin Sallay, sworn January 9, 2025, para 18, AR, Tab 9, p 356; Dr. Bayoumi Affidavit, Ex A, para 18, 88, AR, Tab 11, pp 671, 683 (SCS clients are disproportionately homeless and women, Indigenous, and racialized groups are overrepresented); Dr. Werb Affidavit, Ex A, AR, Tab 12, pp 930; Affidavit of Holly Gauvin, sworn January 8, 2025, para 8, AR, Tab 8, p 323.

health care. These intersecting identities compound the impacts of the discrimination of the *CCRA*.

118. Ultimately, the *CCRA* – by removing access to life-saving health care from an already marginalized and vulnerable group – is discriminatory by amplifying the disadvantage faced by this population, widening the gap between them and other Ontarians, and reinforcing the stereotypes and prejudices that they must face. By doing so, it violates s. 15 of the *Charter*.

D. The *CCRA* Is Not a Reasonable Limit Under Section One

119. The *CCRA*'s breaches of the *Charter* cannot be saved by s. 1. Under s. 1, a law may limit a *Charter* right only if it is a "reasonable limit prescribed by law" that can be "demonstrably justified in a free and democratic society." It is the limitation on rights that must be justified, not the legislative scheme as a whole.[163]

120. The test for a s. 1 justification is that established by *R. v. Oakes*.[164] The *Oakes* test has two components: (i) is the legislative goal pressing and substantial; and (ii) is there proportionality between that goal and the means used to achieve it? Proportionality has three parts: (a) is there a "rational connection" between the impugned measure and the pressing and substantial objective; (b) does the limit impair the right or freedom no more than is reasonably necessary (minimal impairment); and (c) do the salutary effects of the law outweigh its deleterious effects.

121. Ontario bears the burden under s. 1.[165] A "measure of deference" may be appropriate in assessing the government's decision as to means to adopt.[166] However, Ontario cannot rely on bare

---

[163] *Fraser v. Canada (Attorney General),* 2020 SCC 28, para 125.
[164] *R. v. Oakes*, [1986] 1 SCR 103.
[165] *R. v. Ndhlovu*, 2022 SCC 38, para 118.
[166] *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37, para 53; *Canada (Attorney General) v. JTI-Macdonald Corp.*, 2007 SCC 30, para 41.

assertions alone, but must present evidence, supplemented by common sense and inferences.[167]

122. Breaches of s. 7 in particular are difficult to justify under s. 1, absent exceptional circumstances. That is because of the close connection between the principles of fundamental justice and the proportionality analysis. For example, it is difficult to conceive of an overbroad law that is nonetheless minimally impairing.[168]

(i) Pressing and substantial objective

123. The threshold for what constitutes a pressing and substantial objective is relatively low.[169] The Applicants accept that the *CCRA*'s objective is sufficiently pressing and substantial.

(ii) Proportionality

a. Rational connection

124. Sections 2 and 3 of the *CCRA* are not rationally connected to Ontario's goal. To meet this step of the s. 1 analysis, it need only be "reasonable to suppose that the limit may further the goal".[170] The Supreme Court has described this test as "not particularly onerous".[171] However, the government must establish that the means it has chosen are linked to the objective. At the very least, it must be possible to argue that the means may help to bring about the objective.[172]

125. Ontario has failed to adduce sufficient evidence that the *CCRA*, by requiring the closure of SCSs, is rationally connected to its community safety purposes. At best, Ontario has presented mostly anecdotal evidence of a *correlation* between neighbourhoods with SCSs and various social disorder. However, this evidence suffers from a clear "cause and effect" problem, because, in order

---

[167] *R. v. Ndhlovu*, 2022 SCC 38, para 118.
[168] *R. v. Heywood*, [1994] 3 S.C.R. 761, at 802-803; *Carter v. Canada (Attorney General),* 2015 SCC 5, para 95.
[169] *R. v. Oakes*, [1986] 1 SCR 103, para 69.
[170] *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37, para 49.
[171] *Little Sisters Book and Art Emporium v. Canada (Minister of Justice),* 2000 SCC 69, para 228.
[172] *Canada (Attorney General) v. JTI-Macdonald Corp.*, 2007 SCC 30, para 40.

to be effective, SCSs were established in neighbourhoods that already had high numbers of injection drug users, which significantly overlap with high levels of crime and poverty.[173]

126. The expert evidence from Dr. Bayoumi and Dr. Werb is that the closure of SCSs will *not* enhance community safety. That is because there is no compelling evidence that SCSs *cause* or *increase* the conduct that Ontario is purporting to address. In fact, to the extent that it exists, the available evidence suggests that SCSs actually *decrease* such phenomena, for example by decreasing public injection drug use (as some people will consume inside the facilities), decreasing publicly discarded drug paraphernalia (as users can safely dispose of their items at the SCS and SCS staff sweep the area to collect such items), and even decreasing rates of assault and robbery.[174]

127. Thus, far from being rationally connected to its objective, the impugned provisions of the *CCRA* are likely to *undermine* its public safety goals (even putting aside the harmful impacts on the safety of SCS clients). Closing SCSs is likely to *increase* the amount of social disorder in the communities – including the probability of exposing children to these behaviours – as former or potential SCS clients will now have little choice but to use their drugs publicly, be intoxicated in public, and dispose of their drug paraphernalia publicly, rather than use the SCS.[175]

128. Even Ontario's own child development expert conceded that it would be better for children's development if people consumed their drugs inside a secure facility where children are not allowed, rather than out in public where children may stumble upon it.[176]

---

[173] Dr. Bayoumi Affidavit, Ex A, para 95, AR, Tab 11, p 687.
[174] Dr. Bayoumi Affidavit, Ex A, para 98, 100, AR, Tab 11, p 688; Dr. Werb Affidavit, Ex A, AR, Tab 12, pp 910-911, 932; Helwig Affidavit, para 15, RAR, Tab 2, p 41; Dr. Bayoumi Reply Affidavit, Ex A, para 93, RAR, Tab 26(a), p 383; Dr. Hyshka Affidavit, para 43, RAR, Tab 27, p 407.
[175] Dr. Bayoumi Affidavit, Ex A, para 111, AR, Tab 11, p 690; Dr. Werb Affidavit, Ex A, AR, Tab 12, pp 933, 935.
[176] Dr. Guerra Transcript, at pp 65, 77-81, JSAR, Tab 21. Dr. Guerra qualified her opinion in this regard by saying that it would not be beneficial to children if the facilities caused or concentrated the anti-social behaviour that

b. Minimal impairment

129. At the minimal impairment stage, Ontario must show that the limit impairs the right or freedom as little as reasonably possible in order to achieve the legislative objective.[177] The law must be "carefully tailored" so that rights are impaired no more than necessary.[178] Although some level of deference to the legislature will be warranted, the government is typically required to demonstrate a reasonable basis, on the evidence, for concluding that its chosen means were minimally impairing and that it had sound reasons for rejecting proposed alternatives.[179] While common sense and logical inferences can supplement evidence, courts must be cautious that deference is not substituted for the "reasoned demonstration" required by s. 1.[180]

130. Courts will typically look to evidence that the government explored options other than the impugned measure and evidence supporting its reasons for rejecting those alternatives. While legislators are not bound to consult with affected parties before passing legislation, it may be useful to consider, in the course of the s. 1 analysis, whether the government considered other options or engaged consultation with the affected parties, in choosing to adopt its preferred approach.[181]

131. There is no evidence that Ontario considered any more tailored alternatives before enacting the *CCRA*'s blanket prohibitions. There is no evidence that Ontario consulted with the operators of SCSs that it is forcing to close, or even with childcare centres close to those SCSs, to consider alternatives that would achieve its public safety goals while protecting the rights of SCS clients.[182]

---

children were exposed to, but readily admitted that she did not have the expertise to comment on whether this was the case with SCSs.

[177] *R. v. Oakes*, [1986] 1 SCR 103, para 70.
[178] *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 SCR 199, para 160.
[179] *R. v. Oakes*, [1986] 1 SCR 103, para 70.
[180] *Sauvé v. Canada (Chief Electoral Officer),* 2002 SCC 68, para 18.
[181] *Health Services and Support - Facilities Subsector Bargaining Association v. British Columbia,* 2007 SCC 27, [2007] 2 S.C.R. 391, para 157.
[182] Sinclair Affidavit, para 118, AR, Tab 3, p 57.

132. Ontario's choice to shut down all SCSs within 200m of a school or childcare centre, and to prohibit municipalities and local boards from applying or renewing a *CDSA* exemption to operate SCSs (without ministerial approval), is not the least restrictive means of achieving its goals. It is not a "carefully tailored" approach that impairs the rights at issue as little as reasonably possible, but a categorical prohibition that admits of no exceptions.

133. Even accepting that the *CCRA* will advance its community safety purposes (rather than undermine them), other alternatives were available to Ontario to achieve this goal, while being less restrictive of the s. 7 and s. 15 rights of SCS clients.

134. As discussed above in relation to overbreadth, Ontario has chosen a sledgehammer instead of a scalpel. In particular, Ontario has selected the blunt tool of shutting down all SCSs within 200m of schools/childcare centres, without any consideration of whether those specific sites actually cause or create any threats to children or community safety more generally, and without any consideration of whether closing those specific SCSs will alleviate those threats in any way. As noted earlier, this has resulted in a situation where Ontario is shutting down some SCSs where there is no evidence of any issues associated with the sites (like the sites in Thunder Bay, Guelph, and Somerset West (Ottawa)), while allowing other sites to remain open despite evidence of concerns from community members (regardless of whether those concerns are valid).

135. Rather than the indiscriminate approach of the *CCRA*, Ontario could have conducted an examination of SCSs and closed those sites that were shown to cause negative impacts on children and other residents, where closure of the SCS could reasonably be expected to alleviate those impacts. This approach would have been more effective at achieving its public safety goals, by closing SCSs that actually created public safety issues. In turn, it would have been less restrictive

of *Charter* rights, by allowing SCSs to continue to serve their clients, even if they are within the 'buffer zone' but pose no threat to the safety of children.

136. Indeed, this context-sensitive approach was already contemplated by Ontario's CTS guidelines through which it expressly considered proximity to schools/childcare centres as one factor among others in deciding whether to fund an SCS.[183] A similar approach to deciding which SCSs must close would have been less minimally impairing.

137. Further, as noted above, Ontario could have more carefully tailored the *CCRA* by more narrowly defining "supervised consumption site". Instead, under Ontario's broad definition of the term, all facilities that operate pursuant to exemptions under ss. 56.1 and 56(1) of the *CDSA* and are 200m from a school or childcare centre will be forced to close, regardless of the actual services that they provide to their clients/patients.

138. Ontario may seek to rely on their creation of HART Hubs to argue that the law is minimally impairing. This is a red herring. First, HART Hubs appear nowhere in the *CCRA* itself and are therefore irrelevant to the s. 1 analysis as no government (present or future) is required by law to establish them in connection with mandated SCS closures under the *CCRA*. Secondly, Ontario presents a false dichotomy between SCSs and HART Hubs. As Dr. Day, Dr. Wyman, Dr. Bayoumi, and Dr. Hyshka all explain, there is no basis to treat the availability of SCSs as an *alternative* to other forms of treatment for people with SUD; indeed, the provision of a combination of different treatment options – including harm reduction and SCSs – is likely highly effective.[184] Removing one form of treatment that assists one group of people and simultaneously establishing

[183] Dr. Bayoumi Affidavit, Ex A, para 46, AR, Tab 11, p 677.
[184] Dr. Werb Reply Affidavit, Ex A, para 7, 10, 43, 45, RAR, Tab 24, pp 292, 295, 311-312; Dr. Wyman Affidavit, para 6, 22, RAR. Tab 25, pp 328, 333; Dr. Bayoumi Reply Affidavit, Ex A, para 15, RAR, Tab 26, p 369; Dr. Hyshka Affidavit, para 72, RAR, Tab 27, p 416.

a different form of treatment for a different group with different needs does not render Ontario's legislation minimally impairing. Third, beyond high-level statements in press releases, there is no actual evidence of what the HART Hubs will consist of.

(iii) Deleterious effects

139. Finally, any expected benefits from the *CCRA* are vastly outweighed by the devastating harms it occasions on the rights of Ontarians.

140. The final question under the *Oakes* test is whether there is proportionality between the effects of the measure that limits the right and the law's objective. This inquiry focuses on the practical impact of the law.[185] It calls for a broader assessment of whether the benefits of the impugned law are worth the cost of the rights limitation, as measured by the values underlying the *Charter*.[186] Benefits that are speculative and marginal – such as those claimed here – carry less weight when balanced against the *CCRA*'s significant and tangible deleterious effects.[187]

141. On one side of the balance, the deleterious effects of the *CCRA* are incredibly serious. By depriving some of society's most vulnerable individuals access to the SCSs on which they have been relying, the legislation will lead to serious mental and physical harms, including from unsafe injection practices (leading to the spread of infectious diseases, abscesses, and "cotton fever") and lasting brain damage (if oxygen is not readily provided for non-fatal overdoses). Finally, in the face of the opioid crisis and the toxic drug supply in Ontario, by increasing the probability of overdoses that are not reversed, the *CCRA* will likely lead to more overdose deaths.

---

[185] *Canada (Attorney General) v. JTI-Macdonald Corp.*, 2007 SCC 30, para 45.
[186] *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37, para 77.
[187] *Thomson Newspapers Co. v. Canada (Attorney General)*, [1998] 1 SCR 877, para 125, 129-130; *R. v. K.R.J.*, 2016 SCC 31, para 92.

142. Against those serious harms, this Court must weigh Ontario's speculative and uncertain public safety benefits. As discussed above, Ontario has not presented evidence that the *CCRA* will actually lead to a decrease in the anti-social behaviour that it points to, or children's exposure to that behaviour. Indeed, the *CCRA* may actually *increase* children's exposure to this behaviour.

143. The real underlying problem that is driving Ontario's public safety concerns – including children's exposure to disorderly behaviour associated with drug use – is the severe opioid crisis in our cities. Removing one of the responses to that crisis – and replacing it with a less effective option that can serve less people with different needs – will not make it better.

144. Even if this Court accepts that there is a chance that the *CCRA* may have some salutary effects, these uncertain benefits are hardly sufficient to exact such a heavy constitutional toll. Ontario's unproven hope that the *CCRA* will somehow make communities safer is not worth the pain and lives that the law will cost on our most vulnerable neighbours.

E. The *CCRA* Is *Ultra Vires* the Province

145. In pith and substance, the *CCRA* is criminal law, aimed at denouncing and suppressing conduct which, in Ontario's view, is harmful to public safety and social order. The provisions are thus *ultra vires* Ontario, and constitutionally invalid under the division of powers.

146. The division of powers analysis proceeds in two stages.[188] First, the court characterizes the law or provision in issue, and second, based on that characterization, the court classifies the law by reference to the heads of power enumerated in ss. 91 and 92 of the *Constitution Act*, *1867*.[189]

147. The objective at the characterization stage is to determine the law's "pith and substance".

---

[188] *Murray-Hall v. Quebec (Attorney General)*, 2023 SCC 10, para 22.
[189] *Reference re An Act respecting First Nations, Inuit, and Métis children, youth and families*, 2024 SCC 5, para 37.

This exercise identifies the "dominant purpose" or the "main thrust" of the law. At the classification stage, the court's goal is to assign the law "to one of the 'classes of subjects' in respect to which the federal and provincial governments have legislative authority under ss. 91 and 92 of the *Constitution Act, 1867*" to determine whether it is *ultra vires* the enacting legislature.[190]

(i) Characterization of the CCRA

148. To discern the pith and substance of the law, a court considers its purpose and effects. The pith and substance must be described as precisely as possible.[191] While this analysis starts with the text of the provisions, the court can also consider extrinsic evidence to illuminate the underlying purpose.[192] Extrinsic evidence is particularly salient where the legislation is alleged to be colourable, to show that "its effects diverge substantially from its stated aim."[193]

a. Purpose of the CCRA

149. As set out above at Part III.B(iii)(a), the purpose of the *CCRA* is the promotion of public safety by protecting the public from exposure to anti-social behaviours associated with drug use.

150. The *CCRA* is concerned exclusively with activity that would constitute a criminal offence under the *CDSA*, but for the granting of an exemption. Both ss. 2 and 3 of the *CCRA* (the only operative provisions) are expressly tied to the *CDSA*'s exemption regime through the *CCRA*'s definition of a "supervised consumption site" and the express references in s. 3.

---

[190] *Murray-Hall v. Quebec (Attorney General)*, 2023 SCC 10, para 23
[191] *Reference re Assisted Human Reproduction Act*, 2010 SCC 61, para 190.
[192] *Kitkatla Band v. British Columbia (Minister of Small Business, Tourism and Culture)*, 2002 SCC 31, para 53; *Canadian Western Bank v. Alberta*, 2007 SCC 22, para 27; *Reference re Genetic Non-Discrimination Act*, 2020 SCC 17, para 34.
[193] *Murray-Hall v. Quebec (Attorney General)*, 2023 SCC 10, paras 50, 62.

151. Although the regulation of drugs can also have a health purpose,[194] the *CCRA* has no healthcare objective. Nothing in the legislation promotes public or individual health. Indeed, the legislative record indicates that Ontario does not regard the SCSs targeted by the *CCRA* as constituting "healthcare" at all. The Hansard debates show government MPPs repeatedly casting SCSs as sources of crime and social disorder that must be suppressed or eliminated:[195]

- In introducing the *CCRA,* Minister Jones referred to "reported concerns expressed about community safety" and "disruptive behaviour and increased crime around drug consumption sites", and repudiated this "approach that accepts and promotes the use of illegal drugs over treatment and recovery". Minister Jones asserted there have been "numerous stories of altercations, stabbings, shootings and unfortunately even a homicide" and claimed that "hydromorphone distributed at consumption sites is in fact being diverted and trafficked, increasing the supply of dangerous and illegal drugs in communities where these sites operate."[196]

- One government MPP asserted that the legislation would give parents "a sense of relief" and allow them to "feel safer about their child going to school" without having to "worry about what happens in these sites."[197]

- Another government MPP argued that "these places are magnets for crime" like theft, drug trafficking, assaults, and homicide.[198]

152. Other public statements made by representatives of Ontario further support the conclusion that the *CCRA*'s purpose is suppressing activities that Ontario views as contributing to criminality and disorder. Shortly after the legislation was announced, Premier Doug Ford stated at a press conference that "it's the worst thing that could ever happen to a community to have one of these safe injection sites in their neighbourhood".[199] The Parliamentary Assistant to the Minister of

---

[194] *Murray-Hall v. Quebec (Attorney General)*, 2023 SCC 10, para 74.
[195] Costoff Affidavit, Ex A, Ontario Hansard November 20, 2024, p 10466, AR, Tab 10, p 487.
[196] Costoff Affidavit, Ex A, Ontario Hansard November 19, 2024, p 10394, AR, Tab 10, p 450.
[197] Costoff Affidavit, Ex A, Ontario Hansard November 20, 2024, pp 10454-10455, AR, Tab 10, pp 474-475, see also pp 10459, 1041 (AR pp 480, 482).
[199] Costoff Affidavit, Ex A, Ontario Hansard November 20, 2024, p 10466, AR, Tab 10, p 487.
[199] Costoff Affidavit, para 8, Ex F, AR, Tab 10, pp 430, 622.

Health, Anthony Leardi, stated "we don't need more drug injection sites, we need less. I am opposed to providing free needles and free supervision for people to consume illegal drugs".[200]

153. Minister Jones similarly expressed during a press conference: "I do not call watching someone inject an illicit drug to be healthcare in the province of Ontario".[201] Minister Jones explained that, under the law, municipalities and public health boards will have to come to the Province for permission to apply for an exemption, concluding that "there will be no further safe injection sites in the province of Ontario under our government".[202] These comments reveal that Ontario's impetus for enacting the *CCRA* was not a principal concern over improving healthcare services. It was fundamental opposition to supervised consumption services themselves.

154. This case resembles *Morgentaler*, where the Supreme Court held that the true objective behind Nova Scotia's prohibition of abortions outside of hospitals was to restrict abortions themselves as socially undesirable conduct, and not protecting the health and safety of pregnant women, or maintaining the quality of the public health care system by preventing privatization.[203] Like the *CCRA*, the impugned regulations in *Morgentaler* did not prohibit the activity itself, but restricted *where* it could be conducted; that the regulations permitted abortion to continue did not prevent the Court from concluding that their real aim was suppressing it. Like in *Morgentaler,* the extrinsic evidence strongly points to the *CCRA* being animated by opposition to supervised consumption services as themselves a form of "public evil"—in the words of the Premier, "the worst thing that could ever happen to a community"—that needs to be eliminated from society.

---

[200] Costoff Affidavit, Ex E, AR, Tab 10, p 613 [emphasis added].
[201] Costoff Affidavit, para 6, Ex D, 10:30, AR, Tab 10, p 611.
[202] Costoff Affidavit, para 9, Ex G, 22:25, AR, Tab 10, p 624.
[203] *R. v. Morgentaler,* 1993 CanLII 74 (SCC), [1993] 3 S.C.R. 463, pp 494, 513.

b. Effects of the CCRA

155. The effect of legislation can be a good indicator of its true purpose.[204] In this exercise, the court can consider both the legal effects that flow directly from the provisions of the statute itself, and the practical effects, which represent the actual or predicted "side" effects that flow from the operation of the law, including its ultimate long-term effects.[205]

156. As noted above, the immediate legal effect of the *CCRA* will be the closure of at least ten SCSs as of April 1, 2025, and even more are likely to be affected over time as new private schools and childcare centres are established. As existing exemptions come up for renewal, s. 3(2)1 is likely to block even more SCSs (those operated by municipalities or local boards) from relocating, continuing to operate, or being established.

157. That the *CCRA* will have a drastic and immediate adverse impact on the availability of supervised consumption services in Ontario points to the true object of the legislation being the suppression of the activity as morally and socially undesirable.

(ii) Classification of the CCRA

158. In classifying the impugned law, the question is whether the *CCRA*, considering its pith and substance, should be classified within the federal criminal law power under s. 91(27) of the *Constitution Act, 1867* or whether it falls under provincial jurisdiction over property and civil rights and matters of a merely local or private nature under ss. 92(13) and (16), respectively.[206] The focus of the classification analysis remains on the law's dominant characteristic, as identified

---

[204] *R. v. Morgentaler,* 1993 CanLII 74 (SCC), [1993] 3 S.C.R. 463, pp 482-3, 495.
[205] *Kitkatla Band v. British Columbia (Minister of Small Business, Tourism and Culture)*, 2002 SCC 31, para 54; *R. v. Morgentaler,* 1993 CanLII 74 (SCC), [1993] 3 S.C.R. 463, p 483.
[206] *Murray-Hall v. Quebec*, 2023 SCC 10, paras 71-73.

at the first stage of the analysis, and not on its "secondary" or "incidental" effects.[207]

159. In general, legislation will fall within the criminal law power under s. 91(27) where it has a criminal law purpose backed by a prohibition and a penalty, though these three criteria are not determinative.[208] The *CCRA* has both a criminal law purpose and a prohibition.

160. As described in greater detail above, by prohibiting certain SCSs from operating, the *CCRA* subjects SCS clients to increased risk of criminal liability—particularly those with SUD who will continue to feel compelled to use drugs even when they cannot do so legally. The *CCRA*'s prohibitions do not need to be backed by their own direct penalties because the same conduct, once it no longer takes place under the auspices of a legal SCS, is already criminalized and will subject those involved to the fines and imprisonment available under s. 4 of the *CDSA*.

161. Further, the Supreme Court held in *Quebec (Attorney General) v. Canada (Attorney General)*, that a prohibition backed by a penalty is not strictly necessary for the criminal law power under s. 91(27). In that case, Quebec challenged as a federal statute repealing the long gun registry. The Court acknowledged that the provision was not a prohibition backed by a penalty, but nevertheless held that it constituted valid criminal law. The Court observed that as concerns legislation that undoes an existing legislative scheme, "due regard must be paid to the proper classification *of that scheme*"; in that case, the "matter" of the impugned law came within the same criminal law subject as the provision it sought to repeal.[209]

162. Here, the *CCRA* is provincial legislation that effectively seeks to undo the s. 56(1) and 56.1 *CDSA* exemptions that have been issued by the federal government under its criminal law power.

---

[207] *Reference re Impact Assessment Act*, 2023 SCC 23, para 113.
[208] *Reference re Firearms Act (Can.)*, 2000 SCC 31, para 27; *Murray-Hall v. Quebec*, 2023 SCC 10, paras 66-67.
[209] *Quebec (Attorney General) v. Canada (Attorney General),* 2015 SCC 14, para 33.

The "matter" dealt with under the *CCRA* is the same as that dealt with under the *CDSA*'s exemption regime: whether there should be exceptions to the prohibition on the possession of controlled substances at these specific sites. In other words, the *CCRA* seeks to recriminalize what the federal government has decriminalized. As such, it is criminal law and constitutionally invalid.

F. Federal Paramountcy Renders the *CCRA* Constitutionally Inoperative

163. Even if this Court holds that the *CCRA* is *intra vires* Ontario, the *CCRA* frustrates the purpose of the *CDSA* and its exemption regime and is constitutionally inoperative under the doctrine of federal paramountcy. The doctrine of federal paramountcy dictates that where inconsistency or conflict arises between the two overlapping but independently valid laws, the federal law prevails, and the provincial law is inoperable.[210] The inconsistency can manifest as an operational conflict or a frustration in purpose between the laws. Operational conflict arises where compliance with both a valid federal law and a valid provincial law is impossible.[211] A frustration of purpose arises where it is technically possible to comply with both laws, but the operation of the provincial law frustrates the purpose of the federal law.[212]

(i) Purpose of the CDSA *exemptions framework*

164. The *CCRA* frustrates the purpose behind ss. 56(1) and 56.1 of the *CDSA:* the promotion of public health and safety.[213] Sections 56(1) and 56.1 relieve against the *CDSA*'s criminal prohibitions in circumstances where those prohibitions would produce results contrary to the legislation's health and safety goals. In particular, s 56.1 allows for SCSs, in order to reduce the

---

[210] *Canadian Western Bank v. Alberta*, 2007 SCC 22, para 69; *Alberta (Attorney General) v. Moloney*, 2015 SCC 51, para 17.
[211] *Saskatchewan (Attorney General) v. Lemare Lake Logging Ltd.*, 2015 SCC 53, para 18; *Orphan Well Association v. Grant Thornton Ltd.*, 2019 SCC 5, para 65.
[212] *Orphan Well Association v. Grant Thornton Ltd.*, 2019 SCC 5, at para 65; *Law Society of British Columbia v Mangat*, 2001 SCC 67, at paras 70-72.
[213] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, at paras 41, 110, 152.

risk of death and disease for people who use drugs. Section 56.1 was originally introduced in 2015 in response to the Supreme Court's decision in *PHS.* The first iteration of s. 56.1 set out 26 prescribed conditions which had to be met, imposing a "formidable barrier" to obtaining a s. 56.1 exemption. In 2017, against the backdrop of the worsening opioid crisis, parliament amended s. 56.1 to make it easier to obtain an exemption to operate an SCS, bringing the prescribed conditions down from 26 to five. Those five conditions mirror the factors identified in *PHS*.[214]

165. The Parliamentary debates, including statements of the federal Health Minister at the bill's second reading, leave no doubt that the impetus behind the amendments was the worsening opioid crisis claiming the lives of Canadians and the desire to "simplify and streamline the application process for communities that want and need to establish supervised consumption sites".[215]

(ii) Operation of the CCRA *is incompatible with the* CDSA*'s purpose*

166. The *CCRA* introduces significant barriers to accessing SCSs without regard for the public health impact, frustrating the *CDSA*'s public health purpose. The *CDSA*'s exemption regime ensures the dual public health and safety objectives can be advanced in harmony. The operation of the *CCRA* is incompatible with that goal. It frustrates the balancing the *CDSA* seeks to achieve by placing its thumb on the scale, ensuring public safety will always trump public health—no matter how marginal the risk to public safety, and no matter how devastating the risk to public health.

167. Here, Parliament enacted and amended s. 56.1 of the *CDSA* to expand and expedite the availability of supervised consumption services amidst the ongoing opioid crisis. Issuing a s. 56.1 exemption reflects the federal Minister's determination that doing so strikes the appropriate

---

[214] *Chinatown & Area Business Association v. Canada (Attorney General),* 2019 FC 236, paras 23-28.
[215] Costoff Affidavit, Ex C, Canada Hansard January 31, 2017, February 15, 2017, pp 8201, 8203-8204, 8261, 8987, AR, Tab 10, pp 543, 545-546, 587, 604.

balance between public health and public safety. The *CCRA* effects the opposite result from what the *CDSA* exemption regime seeks to achieve: it prohibits the operation of SCSs in certain locations, despite the federal Minister's determination that allowing them to operate in those same locations is necessary to advance the *CDSA*'s dual public health and safety goals.

168. The Court in *PHS* rejected the argument that the s. 56 regime should no longer apply to SCSs once a province legislates in that area: "the wording of s. 56 of the *CDSA* makes clear that the federal government did not grant any leeway to the provinces … The federal Minister alone has the power to determine if an activity should be exempt from the prohibitions in the *CDSA.* Action by the provincial authorities is neither contemplated nor authorized by the *CDSA.*"[216]

169. The *CCRA* directly contradicts this statement from the Supreme Court and stands in the way of the federal legislation achieving its objective. It should be declared inoperative.

G. An Interlocutory Injunction Should Be Granted Pending this Court's Decision

170. Section 2 of the *CCRA* comes into force on April 1, 2025. The Applicants respectfully request that the Court issue an interlocutory injunction restraining the application of s. 2 of the *CCRA* pending the release of this Court's decision. Such an injunction is necessary to maintain the *status quo* until such time as this Court is prepared to rule on the Application.

171. The test for injunctive relief in constitutional cases is the well-established three-part *RJR-MacDonald* test: (i) there is a serious constitutional issue to be tried; (ii) the claimants would suffer irreparable harm if no injunction was granted and they are ultimately successful; and (iii) the balance of convenience favours the granting of an injunction.[217]

---

[216] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, para 56.
[217] *Harper v. Canada (Attorney General)*, 2000 SCC 57, para 4; *RJR-MacDonald Inc v Canada (Attorney General)*, [1994] 1 S.C.R. 311, pp 332-333.

172. The three stages are not "water-tight compartments"; they take colour from the circumstances of the individual case such that the relative strength of the applicant's claim and the nature of the harm they will suffer are relevant considerations in the overall assessment.[218]

173. The first branch is a low threshold. A prolonged examination of the merits is unnecessary; as long as the case is neither frivolous nor vexatious, the court should proceed to the next steps.[219] By their very nature, challenges to the constitutionality of legislation tend to raise serious issues.[220] Exceptions to this low threshold exists when the interlocutory injunction would effectively amount to a final determination of the action or when the constitutional question is a simple question of law alone.[221] Neither exception is present in this case.

174. The Applicants have certainly cleared the first branch of a serious issue to be tried. Above, the Applicants have set out a strong case that the *CCRA* violates *Charter* rights and is *ultra vires* the provincial legislature. The claim is neither frivolous nor vexatious.

175. In this case, the Applicants – and other Ontarians who rely on SCSs – will face irreparable harm if an injunction is not granted. Irreparable harm is harm that cannot be quantified in monetary terms or cured by damages.[222] The impact of the *CCRA*, and the required closures of SCSs pursuant to s. 2, creates a serious risk of harm to the health and lives of people who use drugs through the spread of infectious diseases, unsafe injection practices, and fatal overdoses (as well as non-fatal overdoses that leave the person with lasting brain damage and other harms). These are harms that cannot be quantified or cured in monetary terms. If this Court ultimately rules that the *CCRA* is

---

[218] *AC and JF v Alberta*, 2021 ABCA 24, para 27.
[219] *RJR-MacDonald Inc v Canada (Attorney General)*, [1994] 1 S.C.R. 311, pp 337-338.
[220] *Trang v. Edmonton Remand Centre (Alberta)*, 2001 ABQB 659, para 16.
[221] *RJR-MacDonald Inc v Canada (Attorney General)*, [1994] 1 S.C.R. 311, pp 338-339.
[222] *RJR-MacDonald Inc v Canada (Attorney General)*, [1994] 1 S.C.R. 311, p 341.

unconstitutional, no amount of monetary damages can reverse the spread of Hepatitis C and HIV, cure the brain damage of someone who was not provided oxygen in time during an overdose, or bring back the life of a person who died from a preventable overdose.

176. Finally, the balance of convenience favours an interlocutory injunction in this case. In challenges to validly enacted legislation, there is a presumption under the balance of convenience stage that the impugned law is directed to the public good such that only in "clear cases" will it favour the injunction.[223] However, while the law requires the court to assume the existence of harm to the public interest, it does not require the court to assume that such harm is of any gravity.[224]

177. In order to prove that the balance of convenience favours an interlocutory injunction, the applicant must demonstrate that the suspension of the legislation would itself provide a public benefit.[225] Both the concerns of society generally and the particular interests of identifiable groups are relevant to the assessment.[226] The government does not have a monopoly on the public interest. As the Alberta Court of Appeal explained: "Granting the interim relief risks offending the public interest in the enforcement of legislation. Failing to grant the relief risks a continuing breach of the plaintiff's asserted constitutional rights, which itself is contrary to the public interest."[227]

178. Here, the presumed public interest for s. 2 of the *CCRA* to come into force on April 1, 2025 is attenuated by the evidence that the *CCRA* – by forcing the closure of 10 SCSs next month – will not actually achieve Ontario's public safety objectives of decreasing social disorder, including

---

[223] *Harper v. Canada (Attorney General)*, 2000 SCC 57, para 9; *Black v. Alberta*, 2023 ABKB 123, para 63.
[224] *Black v. Alberta,* 2023 ABKB 123, para142.
[225] *Harper v. Canada (Attorney General)*, 2000 SCC 57, para 9; *RJR-MacDonald Inc v Canada (Attorney General)*, [1994] 1 S.C.R. 311, pp 348-349.
[226] *AC and JF v Alberta*, 2021 ABCA 24, para 34.
[227] *AC and JF v Alberta*, 2021 ABCA 24, para 19.

children's exposure to such disorderly conduct. Instead, the evidence is that the *CCRA* will be counter-productive and will actually *increase* the very disorder that Ontario is hoping to reduce.

179. Ontario does not have a monopoly on the protection of the public interest. The Applicants are also seeking to protect the public interest through this challenge: by protecting the lives and health of a particularly vulnerable and marginalized population.

180. In *Black*, the Alberta Court of King's Bench recently granted an interim injunction to a woman with OUD against new government restrictions against certain opioid treatments, holding that the law would force her to return to dangerous street-sourced opioids:

> Ms. Black's interest in avoiding death or serious harm is not just self-interest. Canadian society has a public interest in the well-being of its members. Indeed, the inviolability of life is a fundamental value in Canadian society … and legislation or state action that has the effect of jeopardizing the right to life is not easily justified …. The public interest favours preventing Ms. Black and anyone similarly situated from being exposed to the real risk of death that would result from the operation of the [impugned law].[228]

181. The Applicants have presented a very strong case against the constitutionality of the *CCRA*. The harm faced by the Applicants and other Ontarians with SUD should s. 2 of the *CCRA* come into force will be devastating and life threatening. It is in the public interest to protect their lives.

182. A key difference between this case and others concerning interlocutory injunctions in *Charter* challenges is that the Applicants have presented a complete record of the *CCRA*'s *Charter* breaches.[229] The Applicants will have presented their full evidence and argument to the Court before s. 2 of the *CCRA* takes effect; they seek only a narrow injunction to maintain the *status quo*

---

[228] *Black v. Alberta,* 2023 ABKB 123, para 146.
[229] See, by contrast, *AC and JF v. Alberta*, 2021 ABCA 24, para 19.

while providing this Court the time it needs to fully consider and rule on the Application. The brief amount of time for the injunction further tips the balance of convenience in the Applicants' favour.

183. Given the strength of the Application, the devastating and irreparable harms that people in Ontario who use drugs will face if the law comes into effect, and the evidence that the *CCRA* will actually undermine its public safety objectives, this is one of the clear cases where an interlocutory injunction restraining legislation coming into force is appropriate.

184. In the alternative, if this Court concludes that the balance of convenience favours Ontario, the Applicants seek an interlocutory injunction only with respect to the law's application to KMOPS and the Kitchener CTS: the two SCSs used by the individual Applicants. The Supreme Court has recognized that the public interest is much less likely to be detrimentally affected when a discrete and limited number of applicants are exempted from the application of certain provisions of a law.[230] In the context of a more limited interlocutory exemption for KMOPS and the Kitchener CTS, the balance of convenience favours the Applicants even more.

PART IV - ORDER REQUESTED

185. The Applicants respectfully request an order:

(a) declaring that ss. 2 and 3(2)1 of the *CCRA* violate ss. 7 and 15 of the *Charter* in a manner that cannot be justified under s. 1 of the *Charter*;

(b) declaring that ss. 2 and 3(2)1 of the *CCRA* are invalid and of no force or effect pursuant to s. 52(1) of the *Constitution Act, 1982*;

[230] *RJR-MacDonald Inc v Canada (Attorney General)*, [1994] 1 S.C.R. 311, p 341.

(c) declaring that the *CCRA* is *ultra vires* the Ontario Government because it encroaches upon the federal government's exclusive jurisdiction over the criminal law under s. 91(27) of the *Constitution Act, 1867*;

(d) in the alternative to (c), an order declaring that the *CCRA* is constitutionally inoperative because its frustrate the purpose of the *CDSA*; and

(e) to the extent necessary, granting an interlocutory injunction restraining the application and effect of s. 2 and 3(2)1 of the *CCRA* until the final determination of this Application;

(f) granting the Applicants their costs of this Application on a full indemnity basis, plus taxes; and

(g) granting such further and other relief as counsel may advise and as this Honourable Court may deem just.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 5th day of March, 2025.

Carlo Di Carlo / Spencer Bass / Olivia Eng

STOCKWOODS LLP
Barristers

Lawyers for the Applicants
The Neighbourhood Group Community Services, Katherine Resendes and Jean-Pierre Aubry Forgues

SCHEDULE "A" - LIST OF AUTHORITIES

1. *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44
2. *Canadian Council of Refugees v. Canada (Citizenship and Immigration)*, 2023 SCC 17
3. *Canada (Attorney General) v. Bedford*, 2013 SCC 72
4. *Carter v. Canada (Attorney General)*, 2015 SCC 5
5. *R. v. Monney*, [1999] 1 SCR 652
6. *R. v. Malmo-Levine*, 2003 SCC 74
7. *R. v. Safarzadeh-Markhali*, 2016 SCC 14
8. *R. v. Moriarity*, 2015 SCC 55
9. *R. v. Sharma*, 2022 SCC 39
10. *R v Moreira*, 2023 ONCA 807
11. *R. v. Graat*, [1982] 2 SCR 819
12. *Canada (Attorney General) v. Bedford*, 2010 ONSC 4264
13. *Quebec (Attorney General) v. A*, 2013 SCC 5
14. *Kahkewistahaw First Nation v. Taypotat*, 2015 SCC 30
15. *Fraser v. Canada (Attorney General),* 2020 SCC 28
16. *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 SCR 625
17. *Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux*, 2018 SCC 17
18. *Ontario (Attorney General) v. G*, 2020 SCC 38
19. *Simons et al v. Minister of Public Safety et al*, 2020 ONSC 1431
20. *Black v. Alberta,* 2023 ABKB 123
21. *Selkirk et. al. v. Trillium Gift of Life Network et. al.*, 2021 ONSC 2355
22. *Ontario (Disability Support Program) v. Tranchemontagne*, 2010 ONCA 593

23. *Entrop v. Imperial Oil Limited*, 2000 CanLII 16800 (ONCA)

24. *Withler v. Canada (Attorney General)*, 2011 SCC 12

25. *Corbiere v. Canada (Minister of Indian and Northern Affairs)*, [1999] 2 SCR 203

26. *R. v. Oakes*, [1986] 1 SCR 103

27. *R. v. Ndhlovu*, 2022 SCC 38

28. *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37

29. *Canada (Attorney General) v. JTI-Macdonald Corp.*, 2007 SCC 30

30. *R. v. Heywood*, [1994] 3 SCR 761

31. *Little Sisters Book and Art Emporium v. Canada (Minister of Justice),* 2000 SCC 69

32. *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 SCR 199

33. *Sauvé v. Canada (Chief Electoral Officer),* 2002 SCC 68

34. *Health Services and Support - Facilities Subsector Bargaining Assn. v. British Columbia,* 2007 SCC 27, [2007] 2 SCR 391

35. *Thomson Newspapers Co. v. Canada (Attorney General)*, [1998] 1 SCR 877

36. *R. v. K.R.J.*, 2016 SCC 31

37. *Murray-Hall v. Quebec (Attorney General)*, 2023 SCC 10

38. *Reference re An Act respecting First Nations, Inuit, and Métis children, youth and families*, 2024 SCC 5

39. *Reference re Assisted Human Reproduction Act*, 2010 SCC 61

40. *Kitkatla Band v. British Columbia (Minister of Small Business, Tourism and Culture)*, 2002 SCC 31

41. *Canadian Western Bank v. Alberta*, 2007 SCC 22

42. *Reference re Genetic Non-Discrimination Act*, 2020 SCC 17

43. *R. v. Morgentaler,* 1993 CanLII 74 (SCC), [1993] 3 SCR 463

44. *Reference re Impact Assessment Act*, 2023 SCC 23

45. *Reference re Firearms Act (Can.)*, 2000 SCC 31

46. *Quebec (Attorney General) v. Canada (Attorney General),* 2015 SCC 14

47. *Alberta (Attorney General) v. Moloney*, 2015 SCC 51

48. *Saskatchewan (Attorney General) v. Lemare Lake Logging Ltd.*, 2015 SCC 53

49. *Orphan Well Association v. Grant Thornton Ltd.*, 2019 SCC 5

50. *Law Society of British Columbia v Mangat*, 2001 SCC 67

51. *Chinatown & Area Business Association v. Canada (Attorney General),* 2019 FC 236

52. *Harper v. Canada (Attorney General)*, 2000 SCC 57

53. *RJR-MacDonald Inc v. Canada (Attorney General)*, [1994] 1 SCR 311

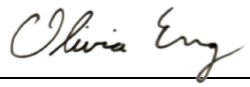
54. *AC and JF v. Alberta*, 2021 ABCA 24

55. *Trang v. Edmonton Remand Centre (Alberta)*, 2001 ABQB 659

I certify that I am satisfied as to the authenticity of every authority.

Note: Under the Rules of Civil Procedure, an authority or other document or record that is published on a government website or otherwise by a government printer, in a scholarly journal or by a commercial publisher of research on the subject of the report is presumed to be authentic, absent evidence to the contrary (rule 4.06.1(2.2)).

Date March 5, 2025



Signature

SCHEDULE "B" - TEXT OF STATUTES, REGULATIONS & BY - LAWS

Controlled Drugs and Substances Act
S.C. 1996, c. 19
Assented to 1996-06-20

An Act respecting the control of certain drugs, their precursors and other substances and to amend certain other Acts and repeal the Narcotic Control Act in consequence thereof

Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

…

PART I

Offences and Punishment

Particular Offences

Possession of substance

4 (1) Except as authorized under the regulations, no person shall possess a substance included in Schedule I, II or III.

Obtaining substance

(2) No person shall seek or obtain

(a) a substance included in Schedule I, II, III or IV, or

(b) an authorization to obtain a substance included in Schedule I, II, III or IV

from a practitioner, unless the person discloses to the practitioner particulars relating to the acquisition by the person of every substance in those Schedules, and of every authorization to obtain such substances, from any other practitioner within the preceding thirty days.

Punishment

(3) Every person who contravenes subsection (1) where the subject-matter of the offence is a substance included in Schedule I

(a) is guilty of an indictable offence and liable to imprisonment for a term not exceeding seven years; or

(b) is guilty of an offence punishable on summary conviction and liable

(i) for a first offence, to a fine not exceeding one thousand dollars or to imprisonment for a term not exceeding six months, or to both, and

(ii) for a subsequent offence, to a fine not exceeding two thousand dollars or to imprisonment for a term not exceeding one year, or to both.

Punishment

(4) Subject to subsection (5), every person who contravenes subsection (1) where the subject-matter of the offence is a substance included in Schedule II

(a) is guilty of an indictable offence and liable to imprisonment for a term not exceeding five years less a day; or

(b) is guilty of an offence punishable on summary conviction and liable

(i) for a first offence, to a fine not exceeding one thousand dollars or to imprisonment for a term not exceeding six months, or to both, and

(ii) for a subsequent offence, to a fine not exceeding two thousand dollars or to imprisonment for a term not exceeding one year, or to both.

(5) [Repealed, 2018, c. 16, s. 195]

Punishment

(6) Every person who contravenes subsection (1) where the subject-matter of the offence is a substance included in Schedule III

(a) is guilty of an indictable offence and liable to imprisonment for a term not exceeding three years; or

(b) is guilty of an offence punishable on summary conviction and liable

(i) for a first offence, to a fine not exceeding one thousand dollars or to imprisonment for a term not exceeding six months, or to both, and

(ii) for a subsequent offence, to a fine not exceeding two thousand dollars or to imprisonment for a term not exceeding one year, or to both.

Punishment

(7) Every person who contravenes subsection (2)

(a) is guilty of an indictable offence and liable

(i) to imprisonment for a term not exceeding seven years, where the subject-matter of the offence is a substance included in Schedule I,

(ii) to imprisonment for a term not exceeding five years less a day, where the subject-matter of the offence is a substance included in Schedule II,

(iii) to imprisonment for a term not exceeding three years, where the subject-matter of the offence is a substance included in Schedule III, or

(iv) to imprisonment for a term not exceeding eighteen months, where the subject-matter of the offence is a substance included in Schedule IV; or

(b) is guilty of an offence punishable on summary conviction and liable

(i) for a first offence, to a fine not exceeding one thousand dollars or to imprisonment for a term not exceeding six months, or to both, and

(ii) for a subsequent offence, to a fine not exceeding two thousand dollars or to imprisonment for a term not exceeding one year, or to both.

(8) [Repealed, 2018, c. 16, s. 195]

1996, c. 19, s. 4; 2018, c. 16, s. 195

Definition of medical emergency

4.1 (1) For the purposes of this section, **medical emergency** means a physiological event induced by the introduction of a psychoactive substance into the body of a person that results in a life-threatening situation and in respect of which there are reasonable grounds to believe that the person requires emergency medical or law enforcement assistance.

Exemption — medical emergency

(2) No person who seeks emergency medical or law enforcement assistance because that person, or another person, is suffering from a medical emergency is to be charged or convicted of an offence under subsection 4(1) if the evidence in support of that offence was obtained or discovered as a result of that person having sought assistance or having remained at the scene.

Exemption — persons at the scene

(3) The exemption under subsection (2) also applies to any person, including the person suffering from the medical emergency, who is at the scene on the arrival of the emergency medical or law enforcement assistance.

Exemption — evidence

(4) No person who seeks emergency medical or law enforcement assistance because that person, or another person, is suffering from a medical emergency, or who is at the scene on the arrival of the assistance, is to be charged with an offence concerning a violation of any condition of a pre-trial release or probation order relating to an offence under subsection 4(1) if the evidence in support of that offence was obtained or discovered as a result of that person having sought assistance or having remained at the scene.

…

PART VI

General

Regulations and Exemptions

Exemption by Minister

56 (1) The Minister may, on any terms and conditions that the Minister considers necessary, exempt from the application of all or any of the provisions of this Act or the regulations any person or class of persons or any controlled substance or precursor or any class of either of them if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.

Exception

(2) The Minister is not authorized under subsection (1) to grant an exemption for a medical purpose that would allow activities in relation to a controlled substance or precursor that is obtained in a manner not authorized under this Act to take place at a supervised consumption site.

1996, c. 19, s. 56; 2015, c. 22, s. 5; 2017, c. 7, s. 41

Exemption for medical purpose — supervised consumption site

56.1 (1) For the purpose of allowing certain activities to take place at a supervised consumption site, the Minister may, on any terms and conditions that the Minister considers necessary, exempt the following from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical purpose:

(a) any person or class of persons in relation to a controlled substance or precursor that is obtained in a manner not authorized under this Act; or

(b) any controlled substance or precursor or any class of either of them that is obtained in a manner not authorized under this Act.

Application

(2) An application for an exemption under subsection (1) shall include information, submitted in the form and manner determined by the Minister, regarding the intended public health benefits of the site and information, if any, related to

(a) the impact of the site on crime rates;

(b) the local conditions indicating a need for the site;

(c) the administrative structure in place to support the site;

(d) the resources available to support the maintenance of the site; and

(e) expressions of community support or opposition.

Subsequent application

(3) An application for an exemption under subsection (1) that would allow certain activities to continue to take place at a supervised consumption site shall include any update to the information provided to the Minister since the previous exemption was granted, including any information related to the public health impacts of the activities at the site.

Notice

(4) The Minister may give notice, in the form and manner determined by the Minister, of any application for an exemption under subsection (1). The notice shall indicate the period of time — not less than 45 days or more than 90 days — in which members of the public may provide the Minister with comments.

Public decision

(5) After making a decision under subsection (1), the Minister shall, in writing, make the decision public and, if the decision is a refusal, include the reasons for it.

2015, c. 22, s. 5; 2017, c. 7, s. 42

56.2 A person who is responsible for the direct supervision, at a supervised consumption site, of the consumption of controlled substances, may offer a person using the site alternative pharmaceutical therapy before that person consumes a controlled substance that is obtained in a manner not authorized under this Act.

2017, c. 7, s. 42

Safer Streets, Stronger Communities Act, 2024, SO 2024, c 27

An Act to enact two Acts and to amend various Acts with respect to public safety and the justice system

Assented to December 4, 2024

Preamble

The Government of Ontario:

Believes in keeping Ontario communities safe through supported and accountable policing and an efficient and effective justice system.

Is taking action to protect children, families and people struggling with addiction by restricting supervised consumption sites, in line with its belief that addictions treatment is the best way to achieve lasting recovery.

Is committed to fighting auto theft and careless driving in Ontario with enhanced oversight of commercial motor vehicles and stronger penalties.

Is working to give police the tools that will assist them in keeping our communities safe from sex offenders.

Therefore, His Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

Contents of this Act

1 This Act consists of this section, sections 2 and 3 and the Schedules to this Act.

…

SCHEDULE 4
COMMUNITY CARE AND RECOVERY ACT, 2024

Definitions

1 In this Act,

"child care centre" means a child care centre within the meaning of the *Child Care and Early Years Act, 2014*; ("centre de garde")

"controlled substance" means a controlled substance within the meaning of the *Controlled Drugs and Substances Act* (Canada); ("substance désignée")

"designated premises" means,

(a) a school, other than a school at which the only programs provided are adult education programs,

(b) a private school, other than,

(i) a private school located on a reserve, or

(ii) a private school that only offers classes through the internet,

(c) a child care centre, other than a child care centre located on a reserve,

(d) an EarlyON child and family centre, other than an EarlyON child and family centre located on a reserve, or

(e) a prescribed premises; ("lieu désigné")

"EarlyON child and family centre" means a centre of that name, administered by a service system manager within the meaning of the *Child Care and Early Years Act, 2014*, offering programs for families and children; ("centre pour l'enfant et la famille ON y va")

"Health Canada" means the federal Minister of Health and the Department over which that Minister presides; ("Santé Canada")

"local board" means a local board within the meaning of section 1 of the *Municipal Affairs Act*; ("conseil local")

"Minister" means the Minister of Health or any other member of the Executive Council to whom responsibility for the administration of this Act is assigned or transferred under the *Executive Council Act*; ("ministre")

"precursor" means a precursor within the meaning of the *Controlled Drugs and Substances Act* (Canada); ("précurseur")

"prescribed" means prescribed by the regulations; ("prescrit")

"private school" means a private school within the meaning of the *Education Act*; ("école privée")

"regulations" means the regulations made under this Act; ("règlements")

"reserve" means a reserve as defined in subsection 2 (1) of the *Indian Act* (Canada) or an Indian settlement located on Crown land, the Indian inhabitants of which are treated by Indigenous and Northern Affairs Canada in the same manner as Indians residing on a reserve; ("réserve")

"safer supply services" means the prescribing of medications by a legally qualified medical practitioner as an alternative to a controlled substance or precursor; ("services d'approvisionnement plus sécuritaire")

"school" means a school within the meaning of the *Education Act*; ("école")

"supervised consumption site" means a site in respect of which the federal Minister of Health has granted an exemption to allow activities at the site in relation to a controlled substance or precursor that is obtained in a manner not authorized under the *Controlled Drugs and Substances Act* (Canada),

(a) under section 56.1 of the *Controlled Drugs and Substances Act* (Canada), in circumstances where the federal Minister of Health is of the opinion that the exemption is necessary for a medical purpose, or

(b) under subsection 56 (1) of the *Controlled Drugs and Substances Act* (Canada), in circumstances where the federal Minister of Health is of the opinion that the exemption is necessary for a scientific purpose or is otherwise in the public interest. ("site de consommation supervisée")

Note: Section 2 comes into force on April 1, 2025.

Prohibition re location of supervised consumption site

2 (1) Subject to subsection (4), no person shall establish or operate a supervised consumption site at a location that is less than 200 metres, measured in accordance with subsection (2), from a designated premises.

Measurement

(2) Subject to the regulations, the distance mentioned in subsection (1) shall be measured in accordance with the following rules:

1. The distance shall be measured from the geometric centre of the building in which a supervised consumption site is located.
2. In the case of a school, the distance shall be measured to the door primarily used by the public to enter the building in which the school is located for the purpose of accessing the area where the school operates.
3. In the case of a private school, the distance shall be measured from,
    i. the centre of the building in which the school is located, as determined by the private school and made available on a Government of Ontario website, or
    ii. if the private school is located only in a portion of a building, the centre of the portion of the building in which the school is located, as determined by the private school and made available on a Government of Ontario website.
4. In the case of a child care centre or EarlyON child and family centre, the distance shall be measured to the geographic coordinates of the street address of the child care centre or EarlyON child and family centre, determined through the use of software or a web service that implements an address geocoding process.
5. In the case of a premises prescribed for the purposes of clause (e) of the definition of "designated premises" in section 1, the distance shall be measured to the point specified in the regulations.
6. If the measurement results in a number of metres that is not a whole number, the number shall be rounded up to the nearest whole number.

Geocoding

(3) If the regulations provide for a specific software or web service for the purposes of paragraph 4 of subsection (2), the distance to a child care centre or EarlyON child and family centre shall be measured using the prescribed software or web service.

Exception

(4) If a private school began providing instruction or a child care centre began operating after the day the *Safer Streets, Stronger Communities Act, 2024* received Royal Assent, subsection (1) does not apply to a supervised consumption site with respect to the private school or child care centre, as the case may be, until the day that is 30 days after the day the private school began providing instruction or the child care centre began operating.

Same

(5) Despite subsection (4), if the Minister specifies a day on which subsection (1) applies to a supervised consumption site, subsection (1) applies to the supervised consumption site as of that day.

Limit on power of municipalities, local boards

Application for exemption to decriminalize

3 (1) Subject to such exceptions as may be prescribed, despite sections 7 and 8 of the *City of Toronto Act, 2006* and sections 9, 10 and 11 of the *Municipal Act, 2001*, a municipality or local board does not have the power to apply to Health Canada for an exemption under subsection 56 (1) of the *Controlled Drugs and Substances Act* (Canada) from any provision of that Act for the purpose of decriminalizing the personal possession of a controlled substance or precursor.

Applications related to supervised consumption sites, safer supply services

(2) Subject to such exceptions as may be prescribed, despite sections 7 and 8 of the *City of Toronto Act, 2006* and sections 9, 10 and 11 of the *Municipal Act, 2001*, a municipality or local board does not have the power, without the approval of the Minister, to do any of the following:

1. Apply to Health Canada for an exemption or a renewal of an exemption to the *Controlled Drugs and Substances Act* (Canada) for the purpose of operating a supervised consumption site.
2. Apply to Health Canada for funding under Health Canada's Substance Use and Addictions Program or any other Health Canada program in respect of safer supply services, or enter into an agreement with the Government of Canada with respect to funding under such a program in respect of safer supply services.
3. Support, including by passing a by-law or making a resolution, an application made to Health Canada by any other person in respect of any matter described in paragraph 1 or 2.

Regulations

4 The Lieutenant Governor in Council may make regulations,

(a) prescribing anything that is referred to in this Act as prescribed or as otherwise dealt with in the regulations;

(b) defining or clarifying the meaning of any word or expression used in this Act that is not otherwise defined in this Act.

Note: On April 1, 2025, section 4 of the Act is amended by adding the following clause: (See: 2024, c. 7, Sched. 4, s. 5)

(c) varying, for specified circumstances, how the distance mentioned in subsection 2 (1) shall be measured under subsection 2 (2).

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES et al.	and	HIS MAJESTY THE KING IN RIGHT OF ONTARIO	Court File No. CV-24-00732861-0000
Applicants		Respondent	

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceeding commenced at TORONTO

FACTUM OF THE APPLICANTS

LAX O'SULLIVAN LISUS GOTTLIEB LLP
Suite 2750, 145 King Street West
Toronto, ON M5H 1J8

Rahool P. Agarwal LSO#: 54528I
ragarwal@lolg.ca

STOCKWOODS LLP
Suite 4130, 77 King Street West
Toronto, ON M5K 1H1

Carlo Di Carlo LSO #: 62159L
carlodc@stockwoods.ca
Spencer Bass LSO#: 75881S
spencerb@stockwoods.ca
Olivia Eng LSO #: 84895P
oliviae@stockwoods.ca

NANDA & COMPANY
10007 80 Avenue NW
Edmonton, AB T6E 1T4

Avnish Nanda LSA #: 18732
avnish@nandalaw.ca

Lawyers for the Applicants