Federal Court  Cour fédérale

Date: 20160224

Docket: T-2030-13

Citation: 2016 FC 236

BETWEEN:

**NEIL ALLARD, TANYA BEEMISH,
DAVID HEBERT AND SHAWN DAVEY**

Plaintiffs

and

**HER MAJESTY THE QUEEN IN RIGHT OF
CANADA**

Defendant

REASONS FOR JUDGMENT

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PHELAN J.

I. Introduction

[1] This is a *Charter* challenge to the current medical marihuana regime under the *Marihuana for Medical Purposes Regulations*, SOR/2013-119 [MMPR] brought by four individuals. It is important to bear in mind what this litigation is about, and equally, what it is not about.

[2] This case is not about the legalization of marihuana generally or the liberalization of its recreational or life-style use. Nor is it about the commercialization of marihuana for such purposes.

This case is about the access to marihuana for medical purposes by persons who are ill, including those suffering severe pain, and/or life-threatening neurological conditions. Such persons also encompass those in the very last stages of their life.

[3] This is another decision in a line of cases starting with *R v Parker*, (2000) 49 OR (3d) 481, 188 DLR (4th) 385 (ONCA) [*Parker*], and culminating in *R v Smith*, 2015 SCC 34, [2015] 2 SCR 602 [*Smith*], that have examined, often with a critical eye, the efforts of government to

regulate the use of marihuana for medical purposes and the various barriers and impediments to accessing this necessary drug.

[4] Like other cases, this most recent attempt at restricting access founders on the shoals of the *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [the *Charter*], particularly s 7, and is not saved by s 1.

1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.	**1.** La *Charte canadienne des droits et libertés* garantit les droits et libertés qui y sont énoncés. Ils ne peuvent être restreints que par une règle de droit, dans des limites qui soient raisonnables et dont la justification puisse se démontrer dans le cadre d'une société libre et démocratique.
…	…
7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.	**7.** Chacun a droit à la vie, à la liberté et à la sécurité de sa personne; il ne peut être porté atteinte à ce droit qu'en conformité avec les principes de justice fondamentale.

[5] The Court has concluded that the Plaintiffs' liberty and security interest are engaged by the access restrictions imposed by the MMPR and that the access restrictions have not been proven to be in accordance with the principles of fundamental justice.

II. Summary/Overview

[6] The Plaintiffs are four individuals, who have a medical requirement for marihuana to deal with certain physical conditions from which they suffer. Their lives have been adversely impacted by the imposition of the relatively new regime to control the use of marihuana for medical purposes.

[7] The focus of this litigation is the most recent response of the federal government to the teachings of *Parker* that effectively mandated a regime to make marihuana available for medical purposes to persons in need. The Court in *Parker* held that the criminal prohibition against the possession of marihuana in s 4 of the *Controlled Drugs and Substances Act*, SC 1996 c 19 [CDSA], was of no legal effect absent a constitutionally acceptable medical exemption from that prohibition.

[8] The federal government previously put in place the *Marihuana Medical Access Regulations*, SOR/2001-227 [MMAR] in 2001, repealed the MMAR on March 31, 2014, and put in place a substantially different regime under the MMPR.

For purposes of this case, the terms “cannabis” and “marihuana” (marijuana) are used interchangeably.

[9] The fact finding process in this case was challenging due to volume and relevancy. The case, on consent, proceeded as a summary trial where affidavit evidence was taken as “read” into the record and only those witnesses whom a party wished to cross-examine appeared in Court.

There was a large volume of evidence, not subject to cross-examination, which nevertheless had to be assessed with a critical focus on relevancy and weight. A list of the witnesses for the parties, both lay and expert, is attached as Schedule A.

[10] The previous jurisprudence on marihuana for medical purposes under the MMAR was extremely helpful in establishing the relationship between s 7 interests and the consumption of marihuana for medical purposes. After the trial concluded, the Supreme Court rendered its decision in *Smith* (discussed more fully later). That decision held that the former medical access regime's limitation to the use of only dried marihuana unjustifiably violated the guarantees in s 7. This trial was reopened to permit the parties to make submissions on the effect of the *Smith* decision on the present case.

[11] That decision reaffirms the connection between s 7 rights and the restrictions on the use of marihuana and disposes of the question of the methods of consumption issue raised as one of the numerous issues in this trial. The restriction to dried marihuana under the MMPR is void for the same reasons it was held to be void under the MMAR in *Smith*.

[12] On the issue of the proper dosages and the alleged therapeutic effects of different strains of marihuana, there remains significant scientific debate on this topic. A clear theme running through the evidence of this trial is that despite the lengthy period for which marihuana for medical purposes has been available, there is a paucity of evidence, particularly from government, in respect of its use and effects. Marihuana is not treated as a "medicine" by statute, regulation or policy, and the information gap posed a significant problem. In addition to methods

of consumption, the evidence adduced during the course of the litigation focused on the Plaintiffs' access to marihuana considering dosages, strains, cultivation, cost economics and the administration of the drug in other jurisdictions.

[13] The anecdotal evidence of the Plaintiffs on the impact of different strains is accepted but its weight is not significant. The Court is not in any position to prescribe or condone different medical treatments. The Defendant asks the Court to conclude that, given the high level of use of medical marihuana (significantly more than some other countries), Canadian medical practitioners are, in effect, overprescribing medical marihuana. There is insufficient evidence for the Court to reach that conclusion much less ground a s 1 finding on that basis.

[14] To the extent that affordability was advanced as a ground of s 7 violation, it has not been made out. More importantly, it is not necessary to make such a finding. Affordability can be a barrier to access, particularly where it is a choice made to expend funds on medical treatment to the detriment of other basic needs. However, this case does not turn on a right to "cheap drugs", nor a right "to grow one's own", nor do the Plaintiffs seek to establish such a positive right from government.

[15] The evidence does establish that under the single source system of a Licensed Producer [LP] there is no guarantee that the necessary quality, strain and quantity will be available when needed at some acceptable level of pricing (through such mechanisms as flexible pricing or discount pricing) – due to the structure of the regulations and the characteristics of the market.

[16] Ultimately, considering that liberty and security interests are engaged, the Court has found that the evidence of each Plaintiff's individual circumstances was sufficient to demonstrate that the regulatory restrictions in the MMPR upon the individuals (including but not limited to the prohibitions against certain methods of consumption and plant growth by a patient or his or her delegate) does not bear a connection to the objective of the legislation and is therefore arbitrary. The access restrictions did not prove to reduce risk to health and safety or to improve access to marihuana – the purported objectives of the regulation. In the alternative, even if some connection is found, the restriction is still overbroad and does not minimally impair s 7 rights.

III. Background

A. *Regulatory Scheme*

[17] Drugs and controlled substances are primarily regulated by the CDSA, the *Food and Drugs Act*, RSC 1985 c F-27 [FDA] and their related regulations.

Cannabis (marihuana) is a controlled substance scheduled under the CDSA and a narcotic subject to the *Narcotic Control Regulations*, CRC c 1041 [NCR].

[18] Subsequent to the Ontario Court of Appeal's decision in *Parker* referred to earlier, which in practical terms mandated a constitutionally acceptable medical exemption for the use of marihuana, the federal government [Canada] enacted the MMAR. These regulations have been amended numerous times in response to decisions from various courts.

B. *MMAR*

[19] The MMAR, prior to its repeal and replacement with the MMPR, permitted individuals who had the support of a medical practitioner to obtain an Authorization to Possess [ATP] marihuana for medical purposes from Health Canada.

[20] The MMAR did not set any limit on the daily dosage a doctor could authorize – however, it did impose a cap on the amount of marihuana that an ATP holder could possess at 30 times (30x) one's daily dosage.

[21] Under the MMAR, ATP license holders could obtain lawful access to marihuana in one of three ways:

1. through a Personal-Use Production Licence [PUPL], which permitted the individual ATP license holder to grow a certain quantity of marihuana for his or her own use;
2. through a Designated Person Production Licence [DPPL] that permitted a person designated by an ATP license holder to produce marihuana for up to two (2) ATP licence holders; or
3. through purchasing dried marihuana directly from Health Canada which had contracted with a private company to produce and distribute medical marihuana.

[22] The production of marihuana under a PUPL or DPPL could only be conducted at the site designated on that licence.

Cultivation could be indoors or outdoors, although not both at the same time.

[23] There were no restrictions as to the location of the production facility beyond the fact that if outdoors, it could not be adjacent to a school, public playground, day care facility or other public place frequented mainly by persons less than 18 years of age.

There were mandatory compliance requirements that licence holders had to meet including compliance with all local by-laws.

[24] The number of plants that could be grown by a person with a production licence was calculated using a formula set out in the MMAR based primarily on the ATP licence holder's authorized daily dose. The MMAR permitted up to four production licences to be issued in respect of the same site.

[25] There was significant growth in ATPs between 2002 and the end of 2013 from 455 to 37,151, and in PUPLs from 326 to 28,228. Growth was expected to continue.

[26] As of December 31, 2013, the average daily dosage was 18.22 grams per day, which permitted an individual to grow 89 plants. This level of daily dosage was significantly higher than in Israel or the Netherlands – two countries used in this case by Canada as comparators to suggest that daily dosage is a problem in this country.

[27] The MMAR provided for an inspection system under which Health Canada inspectors were required to either obtain consent to enter a dwelling or secure a warrant. As part of the Defendant's justification for the new system, Health Canada estimated that the inspection of all residential growing operations in existence in 2013 would cost $55 million. The number has little relevance in the absence of evidence to show that the inspection of all sites annually is reasonably justified. Health Canada produced no evidence of the amount of inspections necessary to ensure compliance with the regulations.

[28] As evident in the justification for the new MMPR, program costs were a significant, if not dominant, priority. The administrative cost of operating the MMAR program and supplying dried marihuana became significant as demand increased.

[29] In 2005-06 the cost of that program was $5 million per year. By 2012 that cost was projected to increase to over $15 million per year. As Health Canada subsidized the cost of the marihuana it sold to the extent of 50% of product cost, the annual $15 million cost included this subsidy.

C. *MMPR*

[30] The Defendant, through the evidence of the then Director of the Bureau of Medical Cannabis/Director of Medical Marihuana Regulatory Reform [Director] contended that concerns about the MMAR led to government reform. She was the Defendant's key witness on the rationale for changes in the medical marihuana regime as incorporated in the MMPR.

A series of decisions including *Hitzig v Canada (Attorney General)* (2003), 231 DLR (4th) 104 (ONCA) [*Hitzig*], *Sfetkopoulos v Canada (Attorney General)*, 2008 FC 33, [2008] 3 FCR 399 [*Sfetkopoulos*], *R v Beren*, 2009 BCSC 429, 192 CRR (2d) 79 [*Beren*], had required changes to the regulatory regime to lessen the restrictions on cultivation and facilitate access to marihuana for medical purposes.

[31] The Director contended that the concerns arising from the MMAR included: the rapid increase in the number of individuals authorized to possess and produce increasing amounts of marihuana; the fact that the majority of medical marihuana was grown in dwelling houses, which were not constructed to support large scale production; and the unintended negative impacts on public health, safety and security (which covered such matters as mould, fires, thefts, harms from fertilizers, odours and diversion to the black market).

She further contended that some MMAR program participants had expressed dissatisfaction due to regulatory wait times.

Finally, she stated that the program was becoming an administrative and financial burden for the federal government.

[32] While the Director asserted that Health Canada had received complaint letters from certain BC and Ontario districts, fire officials and neighbours of PUPL holders, these references were vague and not extensive. The reference to municipality feedback consisted of eight instances: a BC fire chief, a BC mayor, a BC municipality, an Ontario municipal fire authority, an administrative officer in a BC district, a large BC community, a BC district and an Ontario Police Services official.

[33] Against this background, the Director acknowledged in cross-examination that:

- Health Canada, despite having data for the kilograms of marihuana produced by MMAR licensees, had no data with respect to public safety issues including fires, thefts, harms arising from fertilizers or other chemicals used in gardens and no effort had been made to collect such data;
- Health Canada had no statistics relating to incidents in which people who produced their own marihuana became sick from it;
- the federal government was and would continue to be the major beneficiary of the move to the MMPR in terms of cost savings, and the persons who were and would continue to be most impacted were the patients due to the increase in cost;
- Health Canada had no information that the Plaintiffs or a substantial number of licensees ever over-produced their licences, diverted marihuana to the black market, produced unsafely, caused smells, had any fires, produced any mouldy marihuana or suffered any negative health consequences from consuming their medicine.

[34] Despite this lack of data and information, Health Canada began the process to develop a new medical marihuana regime by 2010. The key principles of this new regime included:

- treat marihuana as much as possible like any other medication (but not as a pharmaceutical drug);
- restore Health Canada's role as a regulator and eliminate the government role in supplying and distributing marihuana for medical purposes;

- create a new supply and distribution system using fully regulated, inspected and audited LPs;
- phase out personal and designated production and institute mechanisms for compliance and enforcement;
- reduce the risk of abuse and exploitation of the regulatory regime and improve access to marihuana for medical purposes;
- address the public health and safety risks that police, fire authorities and municipalities had expressed to Health Canada; and
- provide physicians with up-to-date information on the use of marihuana for medical purposes.

[35] Health Canada examined different possibilities and issues. It also engaged in a consultation process that included online consultation, meetings with stakeholders and consultations following a draft publication in the Canada Gazette. However, the particulars of the policy process are not particularly relevant to the Court's consideration of the impact of the MMPR on the Plaintiffs' *Charter* rights.

[36] The Court's role is only to determine if the policy or regulations comply with the *Charter*, not if their development was adequate. Even a bad policy may be *Charter* compliant. The Supreme Court of Canada in *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44 at para 105, [2011] 3 SCR 134 [*PHS*], stated the following on the role of the court:

> … It is for the relevant governments, not the Court, to make criminal and health policy. However, when a policy is translated

> into law or state action, those laws and actions are subject to scrutiny under the *Charter*: *Chaoulli*, at para. 89, *per* Deschamps J., at para. 107, *per* McLachlin C.J. and Major J., and at para. 183, *per* Binnie and LeBel JJ.; *Rodriguez*, at pp. 589-90, *per* Sopinka J. The issue before the Court at this point is not whether harm reduction or abstinence-based programmes are the best approach to resolving illegal drug use. It is simply whether Canada has limited the rights of the claimants in a manner that does not comply with the *Charter*.

[37] Similarly, the issue before the Court is not whether the LP regime (MMPR) or the personal cultivation regime (MMAR) is the best approach for access to medical cannabis. It is simply whether Canada has limited the rights of the Plaintiffs in a manner that does not comply with the *Charter*.

[38] In the end, the MMPR completely reformed the medical marihuana access regime, most substantially invalidating all PUPLs and DPPLs and the amount an individual is authorized to possess. It dispossessed licensees of the ability to control the medical marihuana they consumed.

[39] Justice Manson in his March 21, 2014 Order [the Manson Order] (in which he kept the MMAR largely in place for qualified persons) (*Allard v Canada*, 2014 FC 280, 451 FTR 45) summarized the situation as follows:

> [15] The MMPR mandates that dried marihuana be produced by a Licensed Producer [LP], pursuant to section 12 of the MMPR. Individuals who formerly were or could be issued an ATP must register the prescription of a medical practitioner with an LP to obtain dried marihuana. If they do so, section 3 authorizes them to obtain and possess marihuana produced by that LP. The amount authorized for possession under section 5 is lower than under the MMAR: either 150 grams or 30 times the amount prescribed for daily consumption by the individual's medical practitioner, whichever is less.

> [16] An LP is required to meet various quality and security measures as per sections 12-101. This includes provisions in sections 13 and 14 which state that the production site may not be outdoors or in a dwelling-place.

IV. Judicial Context

[40] As of 1999, it was only possible for individuals in Canada to possess marihuana for medical purposes by way of s 56 of the CDSA which allows the Minister of Health to exempt any person or class of persons from the application of the CDSA or its regulations if necessary for a medical or scientific purpose or if it is otherwise in the public interest.

[41] In 2000, the Ontario Court of Appeal, in *Parker*, dealt with an accused charged with cultivation of marihuana under the former *Narcotic Control Act*, RSC 1985 c N-1, and with possession of marihuana under the CDSA. He needed the marihuana to control his epilepsy. As there was no legal source of the type of marihuana he required, Parker grew his own.

[42] The Ontario Court of Appeal upheld the trial finding that the prohibition against marihuana in s 4 of the CDSA infringed Parker's s 7 *Charter* rights. The Court of Appeal declared the prohibition on the possession of marihuana in the CDSA to be of no force and effect, but suspended the declaration for one year.

Based on the principles established by the Supreme Court of Canada in *R v Morgentaler*, [1988] 1 SCR 30 [*Morgentaler*] and *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519, the Court concluded that forcing Parker to choose between his health and imprisonment violated his right to liberty and security of the person. This violation did not

accord with the principles of fundamental justice nor was the unfettered discretion of the Minister to provide an exemption under s 56 of the CDSA consistent with the principles of fundamental justice.

[43] Following upon *Parker*, the federal government promulgated the MMAR, outlined earlier in these Reasons.

[44] In *Hitzig*, the Ontario Court of Appeal dealt with three civil applications challenging the constitutionality of the MMAR. By the time the government brought in the MMAR in 2001, it had decided that government-supplied marihuana from its Prairie Plant Systems (the only authorized grower of marihuana), which typically supplied marihuana to those who could not grow their own or have a designate, would be available only for research purposes.

[45] The Court, in declaring certain provisions of the MMAR invalid, allowed all DPPL holders to be compensated to grow for more than one ATP holder and to combine their growing with more than two other DPPL holders. The Court also acknowledged that the government could choose to address the constitutional difficulty of marihuana supply by an approach fundamentally different from that contemplated by the MMAR.

[46] This Court in *Sfetkopoulos* heard a judicial review application to declare invalid s 41(b.1) of the MMAR, which restricted a designated licensee to producing medical marihuana for only one user. The substantive issue was whether the remedial steps taken by Canada had brought the MMAR into conformity with the *Charter* requirements identified in *Parker* and *Hitzig*.

[47] As those cases held, the *Charter* requires that government not hinder access to marihuana for no good reason for those with a demonstrated need to obtain and use this substance.

Justice Strayer, following the reasoning in those two decisions, concluded that s 41(b.1) constituted an impermissible restriction on s 7 liberty and security rights of the applicants. The comments of Justice Strayer are prescient to this case.

[48] The "liberty interest" identified by Justice Strayer would include:

- the right to choose, on medical advice, to use marihuana for the treatment of serious conditions (which right implies a right of access to marihuana); and
- the right not to have one's physical liberty endangered by the risk of imprisonment from having to access marihuana illegally.

The "security interest" included similar rights for those with a medical need to have access to medication without undue interference (this Court's emphasis).

[49] With respect to the "principles of fundamental justice", Justice Strayer held that the limitation on DPPLs and therefore the limitation on access did little or nothing to enhance the state's interest. As such, it was arbitrary.

[50] The Court critically examined the limitations on DPPLs and found them lacking justification. The government's justification - to some extent similar to the Regulatory Impact Analysis Statement [RIAS] in the present case - included: the need to control distribution of an unapproved drug; the desire to minimize risk of diversion to non-authorized use; consistency

with international obligations; and movement toward a supply model where there would be product standards and regulated production with the advice of physicians.

[51] The government's concern about the risk of diversion had to be justified, and it was found not to be.

[52] On the issue of the movement to a supply model, the Court stated that:

> [18] … That may well be a laudable goal and if ever reached would make unnecessary litigation such as the present case. But we do not know when this new age will dawn and in the meantime the courts, in their wisdom, have concluded that persons with serious conditions for which marihuana provides some therapy should have reasonable access to it. It is no answer to say that someday there may be a better system. Nor does the hope for the future explain why a designated producer must be restricted to one customer.

In the present case, one of the issues is why a customer must be restricted to a single supply.

[53] The restraint on access was not in accordance with the principles of fundamental justice because it did not respond to the concerns motivating the *Hitzig* decision and left ATP holders, who are unable to grow for themselves and who cannot engage a designated producer due to MMAR restrictions, to seek marihuana in the black market.

[54] In Justice Strayer's view (one which could with slight adaption be replicated here):

> [19] … it is not tenable for the government, consistently with the right established in other courts for qualified medical users to have reasonable access to marihuana, to force them either to buy from the government contractor, grow their own or be limited to the unnecessarily restrictive system of designated producers. At the moment, their only alternative is to acquire marihuana illicitly and

> that, according to *Hitzig*, is inconsistent with the rule of law and therefore with the principles of fundamental justice.

As seen earlier, the MMPR limits a patient to a single government-approved contractor and eliminates the ability to grow one's own marihuana or to engage one's own designated producer. That system is likewise not tenable.

[55] The Court found s 41(b.1) to be arbitrary, contrary to the principles of fundamental justice, not rationally connected to its objectives and a disproportional restraint to any state interests promoted.

The decision was upheld on appeal. The Federal Court of Appeal agreed in law and fact with the Federal Court's decision.

[56] In 2009, the BCSC rendered its decision in *Beren*, dealing with a challenge to s 5 and 7 of the CDSA. It focused on the failure of the MMAR to provide practical access to medical marihuana for those whose medical conditions would appear to fall within the exemption provided, despite the amendments following *Hitzig* and a change in policy with respect to the availability of medical marihuana for qualified patients through government supply.

[57] The Court in *Beren* largely adopted the Court's reasoning in *Hitzig* in respect of "fundamental justice" and Justice Strayer's reasoning in *Sfetkopoulos* in respect of impediments to supply.

Following *Sfetkopoulos* and *Beren*, the MMAR was amended to further facilitate access to medical marihuana.

[58] In the context of the MMAR at the time of its replacement by the MMPR, the judicial teachings were that access for approved medical patients was mandated by the *Charter* and that restrictions on access, use and supply were to be strictly limited. It is evident that Canada struggled with these two conflicting notions of access and control, as well as the direction toward greater access.

As seen in its structure and evident from a review of its operation, the MMPR moved in the opposite direction.

[59] Even after the MMPR had been enacted, significant developments affecting the MMAR moved through the Court system. In *Smith,* first decided by the British Columbia Supreme Court, the accused argued that the CDSA and MMAR could not constitutionally prohibit rendering dried cannabis into oils and other substances. The case was an attack on the MMAR provision (also found in the MMPR) that only dried cannabis can be used. The trial judge found against the limitation to dried marihuana.

[60] The matter moved through to the Supreme Court in *Smith*. The appeal required the Court to decide whether a medical access regime that only permits access to dried marihuana unjustifiably violates the guarantee of life, liberty and security of the person contrary to s 7 of the *Charter*.

[61] The Supreme Court reaffirmed the lower court decision that the medical marihuana regime engaged s 7 rights. More specifically, the legislative scheme's restriction of medical marihuana to dried marihuana limited s 7 rights in several ways:

- the prohibition on possession of cannabis derivatives infringed Smith's liberty interest by exposing him to the threat of imprisonment on convictions under the CDSA;
- the prohibition engages the liberty interests of medical marihuana users as they could face criminal sanctions if they produce or possess cannabis products other than dried marihuana;
- the prohibition on possession of active cannabis compounds for medical purposes limits liberty by foreclosing reasonable medical choices through the threat of criminal prosecution. Specifically, the state prevents people who have already established a legitimate need for marihuana – a need the legislative scheme purports to accommodate – from choosing the method of administration;
- the right to security of the person is infringed by forcing a person to choose between a legal but inadequate treatment and an illegal but more effective choice of administration of marihuana; and
- the prohibitions on non-dried medical marihuana were also arbitrary because they undermined the health and safety of medical marihuana users by diminishing the quality of their medical care. The effect of the prohibition, which in reality limited usage to smoking marihuana, contradicted the objective of the medical marihuana regime.

[62] Germane to the present case, the Supreme Court accepted the trial court's conclusion that the evidence did not establish a connection between the restriction and the promotion of health and safety. A general proposition of the Defendant is that the MMPR is justified on health and

safety grounds and addresses such concerns as diversion of medical marihuana into the illegal market – a fact not supported by the evidentiary record in *Smith*.

[63] On the matter of s 1 justification, the Supreme Court in *Smith* stated:

> [29] The remaining question is whether the Crown has shown this violation of s. 7 to be reasonable and demonstrably justified under s. 1 of the *Charter*. As explained in *Bedford*, the s. 1 analysis focuses on the furtherance of the public interest and thus differs from the s. 7 analysis, which is focused on the infringement of the individual rights: para. 125. However, in this case, the objective of the prohibition is the same in both analyses: the protection of health and safety. It follows that the same disconnect between the prohibition and its object that renders it arbitrary under s. 7 frustrates the requirement under s. 1 that the limit on the right be rationally connected to a pressing objective (*R. v. Oakes*, [1986] 1 S.C.R. 103). Like the courts below, we conclude that the infringement of s. 7 is not justified under s. 1 of the *Charter*.

[64] The *Smith* decision confirmed the teachings of the prior jurisprudence in respect of improving access to medical marihuana but dealt specifically with one aspect of the challenge to the MMPR – the restriction to dried marihuana.

The current challenge to the MMPR is more broadly based and attacks the very foundation and operation of the MMPR as an integrated regulatory scheme.

V. Factual Background

[65] In the context of the earlier background, the medical marihuana regime under the MMPR and the trial evidence must be assessed.

A. *Medical Marihuana Use*

[66] The medical benefits of marihuana were largely undisputed at trial and have been recognized in previous cases. It is therefore not necessary to exhaust all the medical evidence that was adduced in the course of this litigation. It is important to note, however, that aspects of the therapeutic benefit and dosage remain disputed for particular illnesses and individuals. The following is a brief overview of some of the medical findings:

- Marihuana has medicinal value for certain individuals, particularly in terms of pain relief, reducing nausea and stimulating appetite;
- Conditions that allow for medical marihuana use, *inter alia*, include: chronic neuropathic pain, HIV, multiple sclerosis, Parkinson's disease, Tourette syndrome and Fibromyalgia. It is also used in the context of palliative care for end-of-life patients;
- There is limited research and scientific knowledge on marihuana as a medicine; and
- Although disputed, there are risks with consuming marihuana. Accordingly, there is a need for studies of adverse effects in long-term users of marihuana for medical purposes.

(1) Dosage

[67] It was agreed by the experts that there is no possibility of overdose death from cannabis consumption by humans, whether the consumption is oral, inhaled or topical. Conversely, medically appropriate dosages of cannabis were an issue of significant debate. The Defendant

suggested that overdosing pursuant to over-prescription was a serious problem. Dosages were also relevant when determining methods of consumption. The position of the experts regarding dosage more generally is summarized below.

[68] Dr. Pate - Plaintiffs' expert on botany and pharmacology - stated that there is little scientific research on the efficacy of marihuana products or the medically appropriate dosages. He agreed that marihuana overdoses can produce side effects that are "extremely unpleasant" and postulated that orally ingesting "cannabis-based medicines" may require "lesser dosages" - one reason why oral ingestion results in the amelioration of unwanted side effects. Pate further admitted that this was difficult to confirm because it would depend on the case at hand including the route of administration, the effect desired and the individual patient tolerance.

[69] Dr. Baruch - Defendant's expert on cannabis use in Israel - gave evidence based on his research and experience in Israel. He stated that physicians in Israel may recommend medical marihuana starting at 20 grams per month and the dose can be increased, with the support of another physician, up to a maximum dose of 100 grams per month. Medically appropriate maximum dosage should not exceed five grams per day. Dosages beyond this amount do not provide any additional therapeutic benefit and may result in adverse effects. Consumption amounts to 1 gram per day in Israel and only 86 permits for an amount of marihuana exceeding 100 grams have been issued, which represents less than 0.5 percent of authorized patients. Of these 86 exemptions, none exceed 200 grams per month.

[70] Dr. Baruch noted that "there is cumulating evidence that the response to escalating doses of cannabis has an inverted U shape […] as the dose increases above a certain point the effectiveness of cannabis decrease and risk side effects increase […] This is one more reason why physicians prescribing cannabis should be extra cautious when using escalating doses especially when reaching high doses (above 2 g per day)" [as written].

Finally, Dr. Baruch commented on the growing literature concerning the development of tolerance, dependence and withdrawal from cannabis use, especially among heavy cannabis users.

[71] Dr. Daenick – Defendant's expert on cannabis use and dosage - stated that in his experience, most of his patients generally use 3-5 grams a day, only when necessary, with some patients using much less. He noted that there are no medical indications for the use of amounts in excess of 5 grams a day. The College of Family Physicians of Canada agrees that 1-3 grams per day is a medically appropriate dosage. In his expert report, Dr. Daenick states that despite the fact that there is no medical reason for dosages over 5 grams per day, only a quarter of patients under the MMAR were approved for 1-5 grams per day. The majority were approved for over 10 grams per day.

[72] Dr. Daenick opined on several reasons for these high dosages, these reasons were not factually supported.

[73] Dr. Ferris – Plaintiffs' rebuttal expert on use and dosage - generally agrees that doses of 3-5 grams of cannabis per day are adequate for most patients. However, the dose for oral

consumption is 2.5 times the inhaled consumption dose, thus the prescribed range for patients consuming marihuana via edibles can easily be 10-12.5 grams per day. Tolerance, genetics and access to low or high-potency strains, also needs to be considered to determine dosage. Dosage is determined through doctor patient interactions and dialogues that result in a dosage that works for the particular patient's medical issues.

[74] Dr. Kalant – Defendant's expert on medical marihuana use - opined that dosages beyond 5 grams per day do not provide any additional therapeutic benefit and may result in adverse effects. Specifically, he testified that a number of studies of medical marihuana have found that progressive increases in dosage at first increase the therapeutic effect, but further increases lead to loss of therapeutic effect and replacement by adverse effects. He accepted and elaborated on the inverted U-shape phenomenon described by Dr. Baruch.

[75] Dr. Kalant touched upon a problem that has run throughout this case – that despite the government having exerted control over medical marihuana, there is a surprising lack of research to justify many of the assumptions relied on by government. He acknowledged that there is insufficient evidence on which to base scientifically reasoned dosage ranges for different medical uses and acknowledged that patients can develop significant levels of tolerance to the effects of particular dosages.

[76] Dr. Clarke – Plaintiffs' rebuttal expert on cannabis use - commented that high potency of cannabis in the medical context means that a patient needs to consume less to achieve medical

efficacy, lowering the chances of adverse side effects. Medical users do not want to overconsume and they want to avoid side effects.

[77] Finally, the Bureau of Medical Cannabis in the Netherlands estimates that the average daily dosage of medical marihuana in that country is about 0.68 grams per patient. However, this data must be approached with caution considering the particulars of that regime including the access to coffee shops selling marihuana. The availability of marihuana in that generally unenforced environment calls into question the weight given to some of the evidence from that Bureau.

[78] In my view, the weight of the evidence presented in this Court is that:

- the medically appropriate dose may depend on individual tolerance, particular potency of strains (e.g. the CBD and THC rations), the route of administration and the content of the edibles;
- Canada has an exceedingly high dosage and the reasons suggested for this were vastly speculative;
- many of the experts agree that there is a U-shape effect, where after a certain amount, the medicinal effect of the cannabis is limited;
- the recommended amount is largely agreed upon as 1-5 grams per day; and
- there is insufficient evidence to determine why dosages in Canada are so high and what the effect on patients would be if they were to consume less than currently prescribed.

(2) Methods of Consumption

[79] Much of the debate regarding methods of consumption and the legal prohibition against non-dried marihuana has been dealt with in *Smith*. The finding that the dry marihuana restriction was more dangerous to one's health than other forms of consumption undermines the Defendant's position that the MMPR - which maintained the dried marihuana restriction - were focused on public health and safety.

[80] It is useful to touch on some of the evidence on this issue presented in this case.

Dr. Pate provided evidence explaining how the cannabis plant is harvested for its medicinal resin compounds inside the glandular trichomes of the plant. The glandular trichomes containing the therapeutically active chemical compounds can be isolated from the plant matter in different ways thus eliminating most of the plant matter in the final product, resulting in resin ("hash", "kit" or "pollen") or extracts (oil, butter).

[81] There are multiple ways to ingest the active compounds of cannabis, which have different risks and benefits: inhalation (rapid onset with short-term relief), oral ingestion (gradual onset with longer-term relief), topical (assists skin conditions and joint pain with no psychoactive effects), and trans-mucosal (rapid onset with short-term relief, without smoking). Ingesting the resin can be more effective than other forms of administration. As mentioned earlier, Dr. Pate also stated that an individual may consume less cannabis if in edible form depending on a number of factors, including intended benefit and tolerance.

[82] Dr. Baruch stated that in Israel, licenced individuals may purchase marihuana in the form of cannabis buds or cannabis oil (extract), and children who require marihuana for medical purposes are provided with cannabis cookies made using dried cannabis. Cannabis oil was introduced for religious reasons. There is little to no difference between the quantities of marihuana a patient must consume through inhalation compared to oral ingestion to obtain the same effect.

[83] Dr. Kalant states that there is no scientific evidence that a particular method of consumption is required to treat a particular medical condition, or that certain forms of consumption are more efficacious than others. Dr. Kalant was unable to find a single scientific study comparing the therapeutic effects of undried versus dried cannabis.

[84] According to Dr. Kalant, the restriction to dried marihuana could not be justified. In like manner, there was insufficient evidence that other forms of consumption are particularly effective. Any such evidence was anecdotal. However, it was the Defendant's burden to justify restrictions to particular forms of consumption.

(3) Strains

[85] In much the same vein as the issue of consumption, there is a lack of scientific research relating to medicinal uses of different strains. Thus, much of the evidence relied upon was anecdotal including the conclusions by the experts.

[86] The Ontario Court of Appeal in *R v Mernagh*, 2013 ONCA 67, at paras 63-65, stated the following on anecdotal evidence when commenting on a trial judge's findings not being supported by evidence:

> **63** Mr. Mernagh, both on the application and on this appeal, fundamentally misconceived the nature of the evidentiary foundation required in a case of this kind. He relies on the passage at para. 9 of *Hitzig*, which states: "[T]he courts, relying on evidence of individuals' personal experiences and anecdotal evidence have determined that some seriously ill persons derive substantial medical benefit from the use of marihuana." He wrongly takes this to mean that anecdotal evidence of serious illness, and the relief of symptoms through marihuana use, is sufficient to establish a person's own medical need to use marihuana. This interpretation misunderstands the scope for anecdotal evidence in *Charter* analysis and over-reads the passage in *Hitzig*.
>
> **64** The reference to anecdotal evidence in *Hitzig* recognizes nothing more than that for the purposes of judicial fact-finding, anecdotal evidence has been used to establish the general proposition that marihuana can have some medical benefit for some people. Anecdotal evidence, in a sense, compensates for scientific evidence that might otherwise have been used for that purpose. In the absence of more and better studies about the therapeutic value of marihuana, anecdotal evidence may be a reasonable substitute.
>
> **65** Mr. Mernagh's lay evidence was sufficient to show that he was not a recreational user and that his s. 7 right to security of the person was engaged. However, it was not sufficient to show that he fit the medical criteria in the *MMAR*, and was therefore entitled to a physician's declaration in support of an application for an exemption. [footnotes omitted]

[87] In light of the above comments and in the absence of more and better studies about the therapeutic value of strain efficacy, anecdotal evidence is a reasonable substitute in this case. This is because there is a concordance between the anecdotal evidence and objective scientific

evidence that different strains have a greater percentage of the active ingredient THC. The issue is not without controversy.

[88] Dr. Pate, on behalf of the Plaintiffs, stated that cannabis has a number of phenotypes (strains) that are created by breeding different varieties of the plant with each other. Different strains produce differing effects and levels of efficacy on the patient, depending on the individual and the medical condition. The differing effects and levels of efficacy are probably caused by varying amounts, ratios and synergistic effects of the therapeutically active compounds.

[89] I accept Dr. Baruch's statement that Israel is recognized as perhaps the leading country in the world in terms of cannabis research. Dr. Baruch has had great success in managing to create strains of cannabis that are significantly potent (24% THC). The medicine is stable, which means that if the strain is said to have certain levels of CBD or THC, it in fact does. The average supply in Israel affects a high quality product.

[90] However, according to the evidence of Catherine Sandvos, legal counsel and the Deputy Manager of the Bureau of Medicinal Cannabis [BMC], part of the Netherlands Department of Health Division, it is the understanding of the BMC that patient preference for a particular variety is a matter of taste that is unrelated to efficacy. There are currently five varieties of dried marihuana with differing levels of THC and CBD available for medical use for patients in the Netherlands.

[91] The Defendant's witness, Dr. Kalant, agrees that different strains may have different chemical compositions, but is of the view that there is a lack of scientific research as to whether different strains have different effects for particular patients and illnesses. Dr. Kalant states that "it is not at all clear that the large number of so-called strains advertised on the internet are in fact distinct strains as defined botanically". These advertisements are not accompanied by any evidence that they meet the criteria or that they have been analysed chemically for their contents of various cannabinoids. The alleged medical efficacy of particular strains is not the result of clinical testing or scientific research but is instead "based either on subjective anecdotal reports or promotional advertising by producers".

Dr. Kalant states that there is no scientific evidence to support the anecdotal claims that certain strains are useful for certain medical conditions. All that is known is that THC to CBD ratios result in different levels of psychoactivity.

[92] Zachary Walsh - the Plaintiffs' expert on affordability and access - also commented on strains based on the result of his survey, stating:

- A large proportion of the respondents reported that access to specific strains of cannabis was very important to their symptom relief;
- Whether or not the empirical work will correspond with the patient reports remains to be seen, but patients consistently, across samples, report that a diversity of strains is important. There is basic science showing different cannabinoid levels across different strains;

- There is a scientific reason to believe that different strains would have different physiological effects and there are also “entourage effects”, referring to the concurrent effects of these diverse cannabinoids that vary across strains.

The treatment of survey evidence is discussed later.

[93] The evidence is that the use of medical marihuana has both physical and psychological effects on patients. The relief given is influenced in part by the patient’s perspective and cannot be callously dismissed as something akin to a placebo. The lack of access to different strains does appear to have an adverse effect on some patients including some of the Plaintiffs in this matter.

B. *Marihuana Cultivation*

[94] Remo Colasanti was the Plaintiffs’ expert witness in cannabis cultivation. He opined on how to produce cannabis indoors in various ways in a residential area without interfering with neighbours’ rights in relation to odour, public safety, fire and electrical safety and mould, and without risks to the producer and those around them. His evidence is given less weight than might otherwise be the case because he, like a number of “expert witnesses”, was so committed to one side of the debate, that the objectivity which this Court needed was undermined. However, his evidence assisted the Court in relation to the details of how the cannabis plant is cultivated and provided context for some of the concerns asserted by the Defendant to justify the MMPR’s provisions. It also touched upon the prohibition against “growing one’s own” marihuana.

[95] Cannabis needs light, water and nutrients to survive and grow. It can be grown outdoors or indoors. Lighting and physical space are the primary determinants for overall yield in indoor cannabis production, not the number of plants. Small amounts of cannabis can be produced in small spaces such as closets, grow tents and growth chambers.

[96] There are two primary stages in the plant's life cycle: vegetative growth and flowering. Each stage is characterized by differing amount of light. The sun provides the light needed to grow outdoors and in greenhouses. For indoor production, different types of lights are used including a) fluorescent, b) LED, and c) high intensity lights designed for indoor plant cultivation.

[97] Colasanti testified that larger plants are less work and can produce the necessary amount of cannabis. He also opined that with the right lighting and physical space, an individual could obtain the same yield from 6 plants as from 600.

[98] He also gave evidence regarding the infamous (at least in this litigation) "Bloom Box". The Bloom Box is an example of a self-contained hydroponic grow box that can be used to safely and inexpensively grow cannabis without odour and does not use excessive amounts of power. It costs $3,300 plus tax. I find the purpose of this evidence was to illustrate that marihuana can be cultivated effectively, safely and cheaply without massive investment or the measures necessary to address the hazards associated with large growing operations.

[99] Dr. Thomas Baumann - the Plaintiffs' expert witness on horticulture - is a horticulturist and Professor of Agriculture at the University of the Fraser Valley. He provided an expert opinion with respect to general and specific issues or concerns involved in the production or cultivation of plants for food, enjoyment, health purposes, personal use or family use, and limitations thereon.

[100] On cultivation, Dr. Baumann states that the technology and equipment that exists today enables a person to grow any plant either outside (in soil or in greenhouses) or indoors, safely with respect to themselves and others, and without damage to the building or structure in which production takes place. Use of proper electrical connections, water management, environmental controls (humidity and temperature) and compliance with all laws and regulations is required no matter the kind of plant being produced. (The cost of cultivation is discussed below in affordability and access.)

C. *Risk of Cultivation*

[101] The risk of cultivation of marihuana was a major plank in the Defendant's case that any interference with s 7 rights was in accordance with principles of fundamental justice or otherwise justified in a free and democratic society (s 1).

The Defendant canvassed the risks of cultivation through "expert" witnesses. By way of overview, it is necessary for the Court to provide some context for its consideration of social science and other "non-hard" science expert witnesses. Many "expert" witnesses were so imbued with a belief for or against marihuana - almost a religious fervour - that the Court had to approach such evidence with a significant degree of caution and scepticism.

[102] It is important to recognize the standard necessary for admission of expert opinion evidence:

> 50 Courts must be vigilant to guard against such impermissible evidence. It is trite law that expert witnesses should not give opinion evidence on matters for which they possess no special skill, knowledge or training, nor on matters that are commonplace, for which no special skill, knowledge or training is required.
>
> (*Johnson v Milton (Town)*, 2008 ONCA 440)

[103] In the leading case, *R v Mohan*, [1994] 2 SCR 9 [*Mohan*], the Supreme Court provided criteria on the admission of expert evidence that advances a novel scientific theory. Although the experts in the present trial did not advance a novel scientific theory, and the expert qualifications were not objected to during the course of the trial, it is still necessary to evaluate their probative value. Since *Mohan*, the courts have provided guidance on this evaluation.

[104] An expert witness should provide independent assistance to the court and should not assume the role of an advocate (*Carmen Alfano Family Trust (Trustee of) v Piersanti*, [2012] OJ No 2042 at paras 96-120 (ONCA)). An expert should state the facts or assumptions upon which his or her opinion is based and should not omit to consider material facts which weaken his or her opinion. In *R v Abbey*, 2009 ONCA 624 [*Abbey*], the Ontario Court of Appeal provided the following guidance when assessing the opinion of an expert witness in this context:

> **119** As with scientifically based opinion evidence, there is no closed list of the factors relevant to the reliability of an opinion like that offered by Dr. Totten. I would suggest, however, that the following are some questions that may be relevant to the reliability inquiry where an opinion like that offered by Dr. Totten is put forward:

* To what extent is the field in which the opinion is offered a recognized discipline, profession or area of specialized training?

* To what extent is the work within that field subject to quality assurance measures and appropriate independent review by others in the field?

* What are the particular expert's qualifications within that discipline, profession or area of specialized training?

* To the extent that the opinion rests on data accumulated through various means such as interviews, is the data accurately recorded, stored and available?

* To what extent are the reasoning processes underlying the opinion and the methods used to gather the relevant information clearly explained by the witness and susceptible to critical examination by a jury?

* To what extent has the expert arrived at his or her opinion using methodologies accepted by those working in the particular field in which the opinion is advanced?

* To what extent do the accepted methodologies promote and enhance the reliability of the information gathered and relied on by the expert?

* To what extent has the witness, in advancing the opinion, honoured the boundaries and limits of the discipline from which his or her expertise arises?

* To what extent is the proffered opinion based on data and other information gathered independently of the specific case or, more broadly, the litigation process?

120 The significance of testing the expert's methodologies against those accepted in the field was highlighted in *Kumho Tire Co.* at p. 152:

> The objective of that requirement [the gatekeeper function] is to ensure the reliability and relevancy of expert testimony. *It is to make certain that an expert, whether basing testimony upon professional studies or personal experience, employs in the courtroom the same level of intellectual rigour that characterizes the practice of an expert in the relevant field.* [Emphasis added.]

[105] The Supreme Court most recently applied the *Abbey* framework and extensively commented on expert opinion evidence in *White Burgess Langille Inman v Abbott and Haliburton Co*, 2015 SCC 23, [2015] 2 SCR 182:

> [22] *Abbey* (ONCA) introduced helpful analytical clarity by dividing the inquiry into two steps. With minor adjustments, I would adopt that approach.
>
> [23] At the first step, the proponent of the evidence must establish the threshold requirements of admissibility. These are the four *Mohan* factors (relevance, necessity, absence of an exclusionary rule and a properly qualified expert) and in addition, in the case of an opinion based on novel or contested science or science used for a novel purpose, the reliability of the underlying science for that purpose: *J.-L.J.*, at paras. 33, 35-36 and 47; *Trochym*, at para. 27; Lederman, Bryant and Fuerst, at pp. 788-89 and 800-801. Relevance at this threshold stage refers to logical relevance: *Abbey* (ONCA), at para. 82; *J.-L.J.*, at para. 47. Evidence that does not meet these threshold requirements should be excluded. Note that I would retain necessity as a threshold requirement: *D.D.*, at para. 57; see D. M. Paciocco and L. Stuesser, *The Law of Evidence* (7th ed. 2015), at pp. 209-10; *R. v. Boswell*, 2011 ONCA 283, 85 C.R. (6th) 290, at para. 13; *R. v. C. (M.)*, 2014 ONCA 611, 13 C.R. (7th) 396, at para. 72.
>
> [24] At the second discretionary gatekeeping step, the judge balances the potential risks and benefits of admitting the evidence in order to decide whether the potential benefits justify the risks. The required balancing exercise has been described in various ways. In *Mohan*, Sopinka J. spoke of the "reliability versus effect factor" (p. 21), while in *J.-L.J.*, Binnie J. spoke about "relevance, reliability and necessity" being "measured against the counterweights of consumption of time, prejudice and confusion": para. 47. Doherty J.A. summed it up well in *Abbey*, stating that the "trial judge must decide whether expert evidence that meets the preconditions to admissibility is sufficiently beneficial to the trial process to warrant its admission despite the potential harm to the trial process that may flow from the admission of the expert evidence": para. 76.

[106] The Court went on to discuss the nature of an expert's duty to the court and where it fits into the framework:

> [27] One influential statement of the elements of this duty are found in the English case *National Justice Compania Naviera S.A. v. Prudential Assurance Co.*, [1993] 2 Lloyd's Rep. 68 (Q.B.). Following an 87-day trial, Cresswell J. believed that a misunderstanding of the duties and responsibilities of expert witnesses contributed to the length of the trial. He listed in *obiter dictum* duties and responsibilities of experts, the first two of which have particularly influenced the development of Canadian law:
>
> > 1. Expert evidence presented to the Court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of litigation ….
> >
> > 2. An expert witness should provide independent assistance to the Court by way of objective unbiased opinion in relation to matters within his [or her] expertise . . . . An expert witness in the High Court should never assume the role of an advocate. [Emphasis added; citation omitted; p. 81.]
>
> (These duties were endorsed on appeal: [1995] 1 Lloyd's Rep. 455 (C.A.), at p. 496.)
>
> …
>
> [32] Underlying the various formulations of the duty are three related concepts: impartiality, independence and absence of bias. The expert's opinion must be impartial in the sense that it reflects an objective assessment of the questions at hand. It must be independent in the sense that it is the product of the expert's independent judgment, uninfluenced by who has retained him or her or the outcome of the litigation. It must be unbiased in the sense that it does not unfairly favour one party's position over another. The acid test is whether the expert's opinion would not change regardless of which party retained him or her: P. Michell and R. Mandhane, "The Uncertain Duty of the Expert Witness" (2005), 42 *Alta. L. Rev.* 635, at pp. 638-39. These concepts, of course, must be applied to the realities of adversary litigation. Experts are generally retained, instructed and paid by one of the adversaries. These facts alone do not undermine the expert's independence, impartiality and freedom from bias.

As to admissibility or weight, the following comments were provided:

> [45] Following what I take to be the dominant view in the Canadian cases, I would hold that an expert's lack of independence

> and impartiality goes to the admissibility of the evidence in addition to being considered in relation to the weight to be given to the evidence if admitted. That approach seems to me to be more in line with the basic structure of our law relating to expert evidence and with the importance our jurisprudence has attached to the gatekeeping role of trial judges. Binnie J. summed up the Canadian approach well in *J.-L.J.*: "The admissibility of the expert evidence should be scrutinized at the time it is proffered, and not allowed too easy an entry on the basis that all of the frailties could go at the end of the day to weight rather than admissibility" (para. 28).
>
> …
>
> [54] Finding that expert evidence meets the basic threshold does not end the inquiry. Consistent with the structure of the analysis developed following *Mohan* which I have discussed earlier, the judge must still take concerns about the expert's independence and impartiality into account in weighing the evidence at the gatekeeping stage. At this point, relevance, necessity, reliability and absence of bias can helpfully be seen as part of a sliding scale where a basic level must first be achieved in order to meet the admissibility threshold and thereafter continue to play a role in weighing the overall competing considerations in admitting the evidence. At the end of the day, the judge must be satisfied that the potential helpfulness of the evidence is not outweighed by the risk of the dangers materializing that are associated with expert evidence.

[107] Finally, I note that opinion evidence is worthless and arguably irrelevant if there is an absence of factual foundation for the opinion (*R v J.-L.J.*, 2000 SCC 51 at para 59, [2000] 2 SCR 600).

[108] Bearing in mind these principles, the evidence of some of the "experts" on both sides will be given little or no weight. Some had their evidence shredded in cross-examination; this was particularly true of some of the Defendant's non-technical "experts".

[109] The risks of cannabis production presented during the course of the litigation can appropriately be assessed in four separate categories: mould and other contamination; fire; home invasion, violence and diversion; and community impacts.

D. *Mould and Other Contamination*

[110] Dr. Miller was the Defendant's expert witness on mould. He is an expert on fungal physiology. He stated that marihuana plants release a significantly larger amount of moisture than most houseplants – in particular, one marihuana plant adds as much moisture as approximately seven to ten house plants. He outlined that the average residential dwelling in Canada was not constructed to deal with the humidity produced by hundreds of marihuana plants. If cultivation occurred in a multiunit residential building, in addition to mould damage, the chance of contaminants and odour transfer would be common.

[111] Dr. Miller stated that mould damage in houses can cause negative health impacts and that plants are only one possible source of moisture (along with showers, cooking and other common domestic activities). Moisture problems can be addressed by "adding point source ventilation to remove excess moisture from growing plants" and by an "engineered solution".

[112] Dr. Miller's evidence establishes that mould, while an issue, is one which can be handled without undue difficulty or complexity.

[113] Mr. Schut - a rebuttal witness of the Plaintiffs on mould remediation - was adduced as an expert in mould prevention techniques and technologies, and remediation of mould infested

buildings. He is the manager of Enviromold, a company that specializes in preventing and controlling mould and remediating premises that have suffered from mould damage. He has inspected and been in charge of cleaning up and remediating over 50 marihuana grow operations in his 10 year career. In his view, there is no difference between growing 20 marihuana plants and 20 tomato plants in an indoor garden. A properly built indoor garden will address the humidity and ventilation issues that exist in a facility and in particular, in the room in which the production occurs. Such improvements upon the condition of a building or residence can be made by fixing any prior existing ventilation problems that might result in mould damage. In many respects, his evidence was consistent with Dr. Miller on the use of ventilation for remediation.

[114] Several other witnesses also addressed mould as an issue. It was acknowledged that different areas of the country, such as the Lower Mainland of British Columbia including the Fraser Valley, present greater mould issues than other regions given the prevalence of natural dampness.

It is a problem throughout the evidence that the evidence about the Lower Mainland predominated often to the near exclusion of the rest of the country. However, the MMPR and its justification operates across the country.

[115] The evidence establishes that mould issues are often local in nature but more importantly are remediable – a matter which is more amenable to local regulation. It hardly justifies the type of regulation at issue.

E. *Fire*

[116] The Defendant relied heavily on both the risk of fire and crime (home invasion and diversion) as its justification for the MMPR. On both these topics the Defendant's experts exhibited a significant degree of bias against marihuana generally. There was a lack of objectivity both in data and analysis. If there was any "expertise", it was overshadowed by the lack of credibility of those witnesses.

[117] The Defendant relied on the evidence of the Fire Chief for Surrey, British Columbia, Mr. Garis, to advance its position regarding fire risk in marihuana cultivation. He testified that inspections of MMAR residential growing operations in Surrey revealed widespread problems with respect to improper wiring and electrical panels, unpermitted structural modifications and the visible presence of mould. His Report set out data compiled from inspections carried out at illicit and MMAR residential growing operations in Surrey.

[118] His evidence was seriously undermined in cross-examination and in the rebuttal expert evidence of the Plaintiffs. Moreover, the evidence was not credible and was biased. As explained later, this Court cannot put any significant weight on his Report.

[119] Mr. Moen, Fire Captain and Acting Battalion Chief of the City of Fort McMurray, was a rebuttal witness of the Plaintiffs. He is of the view that Chief Garis ignored alternative evidence or explanations for the cause of fires at illegal grow operations. The numbers of fires at all grow sites, which includes illegal sites, has stayed the same or gone down since the number of MMAR

licenced growers has increased exponentially. According to Garis' own fire statistics, Moen was of the view there is no difference between the estimated fire risk of houses that have a licenced grow site and other houses in British Columbia.

[120] A theme that ran through some of the evidence of the Defendant was that there was little or no difference between the risks from an illegal grow op and that of a properly licenced and code-compliant MMAR site. The statistical evidence does not support the conclusion that an illegal, covert operation would present the same risk as an open, legal operation.

[121] Mr. Boileau, a certified Red Seal journeyman electrician, was also a rebuttal witness of the Plaintiffs. His expert opinion is that electrical contractors are able to (and do) perform electrical installations at indoor marihuana grow facilities under permit for holders of MMAR licences, and those installations are inspected in compliance with the *Safety Standards Act*, [SBC 2003] Chapter 39.

[122] The Defendant's fire risk evidence was weak and inconsistent. I prefer the evidence of the Plaintiffs.

F. *Home Invasion/Violence/Diversion*

[123] Corporal Shane Holmquist, a member of the RCMP's Coordinated Marijuana Enforcement Team, was the key so-called "expert" witness for the Defendant. He provided evidence on mould and contamination, fire, home invasion and violence, diversion and community impacts.

[124] On home invasion and violence, what he described as his most “qualified” expertise, Holmquist stated that residential marihuana growing operations, whether legal or illicit, are at risk of home invasions and theft because of the monetary value of marihuana. There have been instances where “grow rips” have resulted in serious injuries to the occupants of the residence.

[125] On diversion, he stated that under the MMAR it was difficult for law enforcement to detect diversion because of the “cover” provided by the individuals’ authorizations to produce and possess.

[126] Holmquist was the most egregious example of the so-called expert discussed earlier in paragraph 101. He was shown, in cross-examination, to be so philosophically against marihuana in any form or use that his Report lacked balance and objectivity. He possessed none of the qualifications of the usual expert witness. His assumptions and analysis were shown to be flawed. His methodologies were not shown to be accepted by those working in his field. The factual basis of his various opinions was uncovered as inaccurate. I can give this evidence little or no weight. It does not establish that there was a sound basis for the new regulatory scheme.

G. *Community Impacts*

[127] The Defendant relied on Larry Dybvig’s evidence (an expert on property values) to provide findings relating to the community impacts of personal cultivation. He is a professional appraiser. Specifically, Dybvig provided evidence on property values testifying that marihuana growing sites usually require by-law compliance, inspection and remediation to deal with various problems caused by cultivating marihuana in homes not designed for that purpose. It is noted that

his evidence only relates to illicit marihuana grow operations and therefore is irrelevant to this case.

[128] Mr. Wilkins, an insurance broker with LMG Insurance Brokers (the insurance company is Lloyds of London), was a rebuttal expert for the Plaintiffs. He stated that in the course of his work between 2010 to the present, he has arranged for building insurance for approximately 300 MMAR cannabis growers who grow inside their residences, in outbuildings and at commercial properties. He provided expert evidence on the issue of insurability of legal MMAR sites, including risks of fire and theft at MMAR grow sites. He stated that the cannabis garden facilities he insures are properly and safely installed according to applicable by-laws and codes.

His evidence speaks to the workability of the MMAR in terms of community impacts. It also demonstrates that the MMAR sites did not pose the same problems as the illicit sites discussed by Dybvig.

H. *Other Witnesses*

[129] Eric Nash was both a fact witness and a rebuttal expert witness for the Plaintiffs. His fact evidence included his personal cultivation history. In rebuttal, Nash provided opinions with respect to reports tendered from Corporal Holmquist, Chief Garis, John Miller and Larry Dybvig. Specifically, he commented on the 17 MMAR sites that he has visited and the 400 MMAR growers that he has communicated with. All these sites had professionally installed ventilation and electrical equipment, were clean and well maintained and had been inspected by municipal by-law officers. None of the sites had issues with mould, fire, security or otherwise. In his opinion, with professional advice and proper ventilation, installation and monitoring, indoor

cannabis production can and does take place safely and securely in residential homes and properties under the MMAR. Based on his experience visiting illegal sites for criminal cases to provide an expert opinion, there is no comparison between illegal and legal grows. That evidence is consistent with other expert evidence accepted by the Court.

[130] Professor Susan Boyd provided an expert rebuttal report to the opinions given by Holmquist and Garis. She is a Distinguished Professor at the University of Victoria, where she teaches and conducts research within the Faculty of Human and Social Development. She is the co-author of the book *Killer Weed: Marijuana Grow Ops, Media and Justice*, in which she systematically studies and compares media and justice portrayals of cannabis use and production in Canada. In her Report, Professor Boyd comprehensively details what proper research should entail. She stated that Mr. Garis and Corporal Holmquist did not have evidence for their conclusions.

Her conclusion is the same as this Court's, as seen earlier.

VI. The Plaintiffs

[131] While the justification for the MMPR system is a vital part of this case, the evidence of the individual Plaintiffs is important in comparing the rights infringement caused by the MMPR with its objective.

A. *Neil Allard*

[132] Mr. Allard, a 60 year old man, was declared permanently retired in 1999 after working with Veterans Affairs Canada. He is diagnosed with “Myalgic Encephalomylitis”, a neuro-immune disorder, and clinical depression. He has used cannabis since 1998; it alleviates his pain and assists with his symptoms, such as headaches.

In 2004, Mr. Allard received his first ATP and its limits were based on a dosage level of 5 grams a day. Currently, he is prescribed a dosage of 20 grams of cannabis per day. He requires about 600 grams per month. He holds a PUPL and cultivates marihuana in his residence.

[133] At trial, he testified that his current daily use varies between 10 to 20 grams. His methods of consumption largely include vaporizing; however, he also juices and uses edibles and oils to meet his medical needs. Particularly, he finds that consuming cannabis juice (non-psychoactive) relieves his nausea, cramping and other gastro-intestinal symptoms and improves his energy and cognitive abilities. He uses cannabis oil topically to treat skin, back and body pain and itchiness.

[134] Mr. Allard grows approximately a dozen different strains. His evidence is that the number and type of strains changes over time due to him developing a tolerance. He also states that some of the strains that he has tried are ineffective in relieving symptoms and some strains make him feel worse. Further, knowing he has a continuous safe supply of cannabis reduces his stress and anxiety levels – he derives therapeutic benefit from cultivating including stress reduction and meditative benefit.

B. *Shawn Davey and Brian Alexander*

[135] Mr. Davey is 38 years old. In 2000, he was involved in a serious accident resulting in permanent brain injury that reduced his cognitive abilities. He experiences constant major pain, numbness and memory and balance problems. He has used cannabis since 2002; it relieves his pain without the side effects of prescription drugs.

[136] Together Mr. Davey and Brian Alexander, also an MMAR patient, cultivate cannabis in an outbuilding located on a leased agricultural land reserve. They are both PUPL holders.

[137] Since 2013, Mr. Davey's prescription for cannabis has been 25 grams per day. His initial dosage was 1 or 2 grams but that has increased through the years. He states that his dosage is high on the recommendation of his doctor, as he needs large quantities to make cannabis butter for his edibles. His evidence underscores that the amount of cannabis used bears a relationship to the method of consumption.

[138] Mr. Davey estimates that 90% of his cannabis intake is through edibles - cookies made from cannabis butter - because they relieve pain for longer periods of time and allow him to sleep through the night. He estimates that he uses his vaporizer or smokes approximately every half hour through the day and it provides rapid onset pain relief. He also uses the cannabis oil for topical applications for body pain and consumes cannabis tea on occasion. His evidence is consistent with that in *Smith*.

[139] Mr. Davey has used a variety of different strains and through trial and error, has found that one particular strain is especially effective for him. He did not find that ineffective strains worsen his condition. Davey derives therapeutic benefit from his involvement in the cultivation. His anxiety is reduced knowing what goes into his body.

C. *Tanya Beemish and Dave Hebert*

[140] Tanya Beemish is 27 years old. David Hebert, her common law spouse, is 32 years old. Ms. Beemish, who intended to appear at trial, was so ill that even alternatives to attendance in court, were not feasible. Her evidence, on consent, was presented by her common law spouse.

[141] Ms. Beemish has Type 1 Diabetes and a related complication of gastroparesis. Her symptoms include extreme nausea, continuous vomiting, pain, lack of appetite and sleeplessness. She states cannabis effectively treats her nausea and discomfort, stimulates her appetite, helps with her anxiety and depression and reduces the unpleasant negative effects of her other medications.

[142] Ms. Beemish is no longer able to work and since November 2013, she has spent most of her time hospitalized. She is not permitted to use medical marihuana in the hospital, which aggravates her suffering. The Manson Order did not cover Ms. Beemish or Mr. Hebert, as they needed to relocate residences due to financial issues and could not meet the residency requirements of the MMAR.

[143] Prior to their relocation, Mr. Hebert held a DPPL and cultivated cannabis for Ms. Beemish. Ms. Beemish is authorized to use up to 5 grams a day. Her use depends on the severity of her symptoms and ranges from 2-15 grams.

[144] She consumes cannabis primarily by smoking and vaporizing, partly because eating is difficult in her condition. She also drinks cannabis juice. Mr. Hebert occasionally bakes Ms. Beemish brownies with cannabis butter; however, this is rare as solid foods are difficult for Ms. Beemish to consume.

[145] Mr. Hebert grew six strains for Ms. Beemish and documented their effectiveness. Her most effective strain is “whiteberry” along with “blueberry”. The other strains were not ineffective. Whiteberry is a difficult strain to purchase on the black market and is the most expensive.

[146] The Court accepts each of the Plaintiffs’ evidence as true. They established their need for medical marihuana and the benefits from its use in different forms of consumption. They confirm, if only anecdotally, the benefits of different strains. They also establish the importance of easy access to their own medical marihuana, assurance of its supply, control over their health care and therapeutic benefit from cultivation.

[147] They also establish that many of these benefits under the MMAR are lost to them under the MMPR, and the adverse effects they feel from the MMPR. These adverse effects such as access, include as well matters of affordability and availability.

D. *Affordability*

[148] The expert evidence of Professor Grootendorst and Professor Walsh provided context for the application of cost in the access to medical marihuana analysis. The parties had extremely divergent analyses of the costs. In sum, the Defendant, considering the medically agreed upon dosages, concluded that affordability was not an issue for the Plaintiffs; the Plaintiffs provided a detailed chart illustrating the cost for each Plaintiff based on varying dosages and prices concluding that even at 5 grams a day at $5 per gram, two of the three Plaintiffs would be significantly adversely impacted.

[149] Dr. Zachary Walsh, PhD., R. Psych is an Assistant Professor at the Department of Psychology of the University of British Columbia, Okanagan Campus. In his evidence, he references a study he conducted entitled: *Cannabis Access for Medical Purposes: Patient Characteristics, Patterns of Use and Barriers to Access* [CAMPS survey], which involved drafting a detailed survey and collecting the results from 628 medical cannabis patients. It was not a clinical trial. He also refers to two articles he co-authored and published.

[150] While the study was designed to characterize medical cannabis users and their experience accessing medical cannabis, it is the largest study of medical users in Canada to date. The rationale for the study rested in part on the observation that rates of registration in the MMAR were well below estimates of medical cannabis use. The researchers felt that this discrepancy reflected factors that warranted further examination and highlighted potential barriers to access.

Overall, those with the worst health had greater levels of barriers related to affordability. Financial saving was among the most widely noted motives for self-production.

[151] Importantly, Dr. Walsh assessed affordability in the CAMPS survey in two categories: (1) the patient's ability to pay for the amount of cannabis that he or she needed to address his or her medical needs; and, (2) the extent to which people had to choose between their medicine and the other necessities of life. During examination, Dr. Walsh stated that affordability is not an absolute ability to afford based on the amount of money one has – it would be the type of choices and lifestyle constraints that would be implied by the cost.

[152] Amongst other conclusions, the CAMPS survey indicated that the lowest income groups have the most difficulty affording medicine. A large number of those people choose between obtaining their medicine and other necessities. The people with the poorest health have the greatest difficulty affording their medicine and are the most likely to choose between their medicine and other necessities.

[153] This would make those with the poorest health the most vulnerable to the unregulated pricing regime under the MMPR.

[154] With regards to access and the source of cannabis, almost 1/3 of the respondents in the CAMPS survey reported to be self-producing, of whom 50% were licensed to produce for personal use. Among self-producers, the most important reason for self-producing was quality (39%), followed by price (36%), avoiding the black market (29%), selection of specific strain of

cannabis (24%) and safety (12%). It was noted that most medical cannabis users continue to obtain their cannabis from an illicit source.

[155] Professor Grootendorst is an associate professor at the University of Toronto, Faculty of Pharmacy. His research and teaching focus on health economics. He expects the price of commercially sourced medical marihuana to decline over time. This expectation is conditional on the size of the market for medical marihuana supplied by LPs growing sufficiently large over time. He discussed several possible scenarios depending on the fraction of users who do not procure their medical marihuana from LPs. Although Professor Grootendorst had limited knowledge of cannabis supply, access, cultivation and the legislative regime, his evidence is useful when considering affordability and access generally.

[156] Professor Grootendorst's evidence considered the different costs to the user of cultivation, including private costs (comprised of money costs and opportunity costs) and external costs. With respect to LPs, he stated that the average production costs over time will lower because of learning by doing, lower prices for skilled labour, economies of scale and technological innovation. He cautions that this cost reduction could be affected if patients are exempted from the MMAR and continue to cultivate on their own. It is noted that he is not aware of the percentage of users who cultivate versus purchase and did not have specific knowledge of the industry or its nuances.

[157] Professor Grootendorst's evidence is somewhat speculative. The lowering of costs of medical marihuana essentially assumes an open and competitive market. Grootendorst's

assumptions of competitive behaviour are suspect in the MMPR structure which limits suppliers through a licence system. Absent some form of price controls, the limited number of licensed suppliers can set the price of medical marihuana with few competitive restraints – an aspect of access.

E. *Access/Availability*

[158] Mike King, a fact witness of the Plaintiffs, contacted 15 LPs and recorded the number of strains they produce, the price range in dollars per gram, the availability of new client accounts and the requirements to qualify for compassionate pricing for each LP.

[159] The Plaintiffs state that a fair summary of his findings is that availability of medical marihuana from LPs is sporadic, with many either out of stock or not accepting new customers. He found that while some offered discounted pricing, the availability of such pricing varied widely and was limited by various criteria. This evidence is accepted as of the time Mr. King conducted his survey. Other evidence suggests that these issues were moving targets with no certainty as to pricing for medical marihuana.

[160] Mr. Jason Wilcoz and Ms. Danielle Lukiv were plaintiff witnesses who provided affidavit evidence on the correspondence they received from MMAR patients. I would give their evidence little weight and find that the issues around the MMPR are more adequately addressed by the other evidence.

[161] Jamie Shaw, the president and CEO of the Canadian Association of Medical Cannabis Dispensaries [CAMCD], a non-profit society registered in Ontario, and the Communications Coordinator for the BC Compassion Club Society [BCCCS], a non-profit society in British Columbia, provided evidence on dispensaries.

[162] Although dispensaries were not a focus of the parties' submissions, I find Ms. Shaw's evidence to be extremely important as dispensaries are at the heart of cannabis access. Particularly, she states that with the pronouncement of the proposed regulation, consultation was denied and a number of dispensaries closed in 2012 and 2013 due to the potential that the new system would not serve their membership. However, in March 2014, the number of dispensaries was estimated at 36. Over the last year, this number has increased exponentially and is now estimated at around 103 across Canada.

[163] Although not legal under any past or previous medical marihuana regulations, current trends in dispensary growth suggest a connection between the restrictions to access under the MMPR and the need for patients to obtain their medical marihuana from illicit sources.

F. *Cost of Cultivation*

[164] It is not disputed that cultivation is also a cost that impedes access. The Plaintiffs gave evidence on their personal financial ability to cultivate and purchase their consumption requirements.

[165] Cultivation of cannabis involves a calculation of the yield expected from the plant and the growing stage of each plant. One may have numerous plants with a small yield or few plants with a large yield. Mr. Allard is currently authorized to produce 98 plants. His method of cultivation yields approximately 28 grams per plant. He is currently growing 23 plants and has grown up to 75 plants at one time, 20-30 of which were clones (all at different stages of growth).

[166] Mr. Allard estimates that his total financial cost for all the equipment and construction at his three different cultivation sites totaled $35,000. His expenses to cultivate his cannabis are $230 per month. He can currently finance his cultivation with some financial freedom; however, his income will decrease when he turns 65 and it is accepted that this financial freedom will no longer exist. Considering his daily dosage of 20 grams per day, at a hypothetical price of $5 a gram, the cost under the MMPR would exceed his current total tax pension income.

[167] Mr. Davey and Mr. Alexander estimate that the production costs amount to between $1 and $2 dollars per gram. The initial setup cost was $27,040 and Mr. Davey spends $750 month. Mr. Alexander estimates that the outbuilding would likely have cost between $50,000 and $60,000 to build.

[168] These Plaintiffs argue that to purchase this current dosage from an LP at $5 per gram would cost Mr. Davey $3,750 a month. A high quality strain would cost him $7,500 a month. His current monthly income is approximately $5,100 and his current monthly expenses including cultivation total $3,747.

[169] Mr. Hebert stated his monthly production cost was about $110 and his set up cost was $4,225.97. He produced on average 130 grams per month. Currently, Mr. Hebert buys a specific strain from the black market at a discounted rate of $4-5 per gram and this is adequate because Ms. Beemish's consumption is restricted due to her hospital stay. It is accepted that at this rate and consumption amount, they would be able to access a LP; however, the desired strain is not available at that price.

[170] Other witnesses commented on the cost of setting up a small, efficient, safe cannabis garden in a dwelling and concluded that it could be done for about $2,000.

[171] Overall, with respect to affordability, I find that it is a barrier to access. The scope of this barrier is not easily qualified as the definition of affordability reflects the individualized nature of such determination. On access, the evidence adduced was similar to affordability, where a detailed factual finding cannot be made. It can be concluded, however, that there is no guarantee that quality and strain availability at price flexibility (discount pricing) will be accessible when needed.

VII. Analysis

A. *Section 7 Rights and Interests*

[172] Any interpretation of s 7 is to be generous and liberal. The Supreme Court has stated that a "rights enhancing" approach is to be conducted when assessing these rights. It should also be noted that to trigger *Charter* protections, the effects on the interests under section 7 must be

more than trivial - they must be serious (*Chaoulli v Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 SCR 791 at para 123 [*Chaoulli*]).

[173] The Plaintiffs argue that the MMPR takes away the ability of the patient to produce cannabis for themselves compelling them to purchase from a LP, whether or not the LP has adequate supply or the required strains, and whether the patient can afford it. This places patients in the position of having to choose between their liberty and their health in order to have access to an adequate supply of medicine.

[174] A critical restriction under the MMPR (in addition to the usage restriction to dried marihuana) is that medical marihuana patients must purchase their marihuana from LPs and that is the only legal access option.

[175] Additionally, the Plaintiffs submit that section 7 permits the government to regulate commercial behaviour in this area but does not permit the government to criminalize individual non-commercial patient conduct such as personal production of cannabis-based products.

(1) Liberty Interest

(a) *Law*

[176] In *Blencoe v British Columbia (Human Rights Commission)*, 2000 SCC 44, [2000] 2 SCR 307 [*Blencoe*], the majority of the Supreme Court interpreted the scope of this right, broadly stating that although an individual has the right to make fundamental personal choices free from

state interference, such personal autonomy is not synonymous with unconstrained freedom (para 54). In that case, freedom from the type of anxiety, stress and stigma suffered by the respondent in a thirty month delay in the processing of a human rights complaint was not elevated to the stature of a constitutionally protected section 7 right.

[177] One of the most cogent statements on the right to liberty is found in *Morgentaler* where Wilson J at page 166 held that the right to liberty, "properly construed, grants the individual a degree of autonomy in making decisions of fundamental personal importance." It also guarantees to every individual a degree of personal autonomy over important decisions intimately affecting their private lives.

[178] The jurisprudence in respect of medical marihuana has established that the prohibition against marihuana engages s 7 liberty interests. The scheme of regulating access to medical marihuana must properly address that liberty interest.

[179] In *Parker*, the Court considered the liberty interest in two ways: first, the threat of criminal prosecution and possible imprisonment; and second, the right to make a decision of fundamental importance, including the choice of medication to alleviate the effects of an illness with life-threatening consequences.

[180] Expanding on *Parker*, the Court in *Hitzig* held that a liberty interest was at risk in the context of this medical exemption due to the threat of criminal prosecution and imprisonment arising from the need to possess and use. The risk manifested itself in several ways, including

barriers to access and eligibility hurdles, as well as the consequences of straying outside the conditions set for possession for those who had an ATP. In other words, the scheme itself stood between individuals and their right to make fundamentally important personal decisions, unimpeded by state action interfering with the right to liberty.

> **91** As *R. v. Parker*, *supra* points out, the liberty interest of these individuals can be considered in two ways. First, viewed more narrowly, their right to liberty is at risk in the context of this medical exemption due to the threat of criminal prosecution and imprisonment arising from their need to possess and use marihuana for medial purposes. This risk manifests itself in several ways. The risk clearly exists for those who do not have an ATP because they cannot clear the eligibility hurdles set up by the MMAR. It also exists for those with medical need who do not have an ATP for any other reason (although in each case that other reason may be a factor in assessing compliance with the principles of fundamental justice). Further, even for those with an ATP, this aspect of the liberty interest is at risk should they stray outside the conditions set for their possession by the MMAR. For example, the MMAR authorize an ATP holder to possess marihuana, but only in a strictly limited quantity, beyond which there is no exemption.
>
> (*Hitzig*, para 91)

(b) *Positions - Summary*

[181] The Plaintiffs submit that criminalizing personal production of medical cannabis is a severe infringement on autonomy that deprives them of control over their bodily integrity “free from” state interference. Further, the removal of personal production as a supply option will inevitably leave patients unable to afford sufficient quantities of medicine, constituting “state action that causes physical and psychological suffering”. The Plaintiffs submit that for some patients, this may either hasten or lead to their death.

[182] Specifically, the Plaintiffs submit that the personal production of medical cannabis involves individual autonomy, dignity and the right to make fundamental personal choices free from state interference, thereby impacting or engaging liberty.

[183] They go on to state that the consumption of cannabis for medical purposes implicates the section 7 right to security of the person because imposing criminal consequences on medical marihuana consumers creates serious state-induced psychological stress. (This is more appropriately a security interest argument).

[184] The constitutionally viable exemption to provide reasonable access to medically approved patients was determined by the courts to include the right to produce for oneself, and this led to the MMAR enabling personal production in order to achieve that reasonable access.

[185] The Defendant denies that the MMAR engages the Plaintiffs' personal decision liberty interest because the issues of lack of affordability or access to suitable strains under the LP regime does not engage the liberty interest. The Defendant denies that matters of individual autonomy, dignity and the right to make fundamental choices are engaged by the MMPR.

[186] Canada acknowledges only that the MMPR engages the Plaintiffs' liberty interest in the limited sense that they do face the possibility of being sanctioned with imprisonment if they choose to cultivate their own marihuana or buy it from the black market as opposed to availing themselves of the lawful option to purchase from LPs. These activities are criminal offences under the CDSA.

(c) *Analysis*

[187] In my view, the liberty interest is engaged in two distinct ways – the right not to have one's physical liberty endangered by the risk of imprisonment and the right to make decisions of fundamental personal importance. Previous jurisprudence has established that choice of medication including cannabis to alleviate the effects of an illness with life-threatening consequences is a decision of fundamental personal importance. In relation to this particular state action, the MMPR, I find that the analysis can be conducted in three different ways.

[188] Firstly, following the *Hitzig* analysis, liberty is at risk for those who cannot access the LP regime if they cultivate or purchase outside the regime for any reason, including affordability, dosage and strain preference, as they risk conviction and imprisonment. The risk is also manifested if they stray outside the conditions set for their possession by the MMPR – possessing more than 150 grams.

[189] Secondly, the scheme stands between the Plaintiffs and their right to make this decision of fundamental importance unimpeded by state action. Decisions of fundamental importance, particularly in the medical context, were most recently canvased in *Carter v Canada*, 2015 SCC 5, [2015] 1 SCR 331:

> [67] The law has long protected patient autonomy in medical decision-making. In *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181, a majority of this Court, per Abella J. (the dissent not disagreeing on this point), endorsed the "tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity" (para. 39). This right to "decide one's own fate" entitles adults to direct the course

> of their own medical care (para. 40): it is this principle that underlies the concept of "informed consent" and is protected by s. 7's guarantee of liberty and security of the person (para. 100; see also *R. v. Parker* (2000), 49 O.R. (3d) 481 (C.A.)). As noted in *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.), the right of medical self-determination is not vitiated by the fact that serious risks or consequences, including death, may flow from the patient's decision. It is this same principle that is at work in the cases dealing with the right to refuse consent to medical treatment, or to demand that treatment be withdrawn or discontinued: see, e.g., *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119; *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.); and *Nancy B. v. Hôtel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. Sup. Ct.). [Emphasis added]

[190] The case law decided under the MMAR applies to the analysis of the MMPR's constitutionality as the case law addressed the limitations and prohibitions imposed on medical marihuana including the cultivation, distribution and use, finding such limitations to engage section 7 rights. The limitations in the MMPR are more impeding than the MMAR in prohibiting home growth, invalidating PUPL and DPPLs and limiting the amount an individual is authorized to possess.

[191] While the patient is presented with a means of access, the simple interference with making a decision about bodily integrity and medical care has been held to trench on liberty. As held in *Hitzig* at para 93:

> **93** Here, as in *Parker*, there is no doubt that the decision by those with the medical need to do so to take marihuana to treat the symptoms of their serious medical conditions is one of fundamental personal importance. While this scheme of medical exemption accords them a medical exemption, it does so only if they undertake an onerous application process and can comply with its stringent conditions. Thus, the scheme itself stands between these individuals and their right to make this fundamentally important personal decision unimpeded by state

> action. Hence the right to liberty in this broader sense is also implicated by the MMAR. [Emphasis added]

[192] The Plaintiffs argue that there is a right to direct the course of one's medical treatment and not have it imposed by the government, either directly or by way of delegation. It is accepted that those taking medical marihuana to treat symptoms of their serious medical condition are making a decision of fundamental importance. Although this decision is not prohibited, it is restricted by the MMPR and it is that restriction that engages the liberty interest. The reason the restriction is not trivial is due to the underlying context of medical decision making.

[193] It is important to acknowledge that the decision of fundamental importance, the subject decision, is about the access to marihuana for medical purposes, and that access, while not prohibited, is restricted. The issue is the scope of the restrictions to access. The analysis does not concern the decision to cultivate or to access cannabis for medical purposes illicitly.

[194] Justice Strayer stated in *Sfetkopoulos* at para 10, that "liberty" comprehends the right to make decisions of fundamental personal importance including the right to choose on medical advice to use marihuana for treatment of serious conditions, and that right implies a right of access to such marihuana. It would also include the right not to have one's physical liberty endangered by the risk of imprisonment from having such access illicitly. At the time of both *Sfekopoulos* and *Hitzig*, there was a regime in place to access marihuana legally, and similar to the case at hand, that regime had limitations. The limitations were assessed at the second stage of the section 7 analysis.

[195] Third and most convincingly, the individuals are restricted under the MMPR to purchasing from a LP. The decision to cultivate cannabis for medical purposes or purchase cannabis from the black market, such as a store front dispensary, could result in criminal prosecution. Any offence that includes incarceration in the range of possible sanctions engages liberty (*Re BC Motor Vehicle Act*, [1985] 2 SCR 486 at p 515). Both parties are in agreement that, at the least, the liberty interest is engaged due to the threat of criminal prosecution and incarceration if the Plaintiffs or approved patients decide to access their marihuana outside the regulatory regime.

The maximum penalty for producing cannabis is 14 years in prison.

[196] The above analysis of the MMPR's engagement of the liberty interest is consistent with the Supreme Court's recent decision in *Smith* – although that case dealt with the MMAR and more narrowly focused on the prohibitions on the means of consumption. The Court held that:

a) the prohibition on possession of cannabis derivatives infringes Smith's liberty interest by exposing him to the threat of imprisonment on conviction under s 4(1) or 5(2) of the CDSA; and

b) the prohibition limits liberty by foreclosing reasonable medical choices through the threat of criminal prosecution.

The Plaintiffs have made their case that their liberty interests are engaged by the MMPR regime.

(2) Security Interest

(a) *Law*

[197] The security of the person will only be violated where the state interferes in profoundly intimate and personal choices (*Blencoe* at paras 83 and 86). This interest is comprised of both physical integrity and psychological integrity.

[198] On physical integrity, the Supreme Court's statement in *Morgentaler* is often referenced - the security of the person will be engaged by deprivation by means of a criminal sanction of access to medication reasonably required for the treatment of a medical condition that threatens life or health. In *Parker*, the Court specifically stated that the choice of medication to alleviate the effects of an illness with life-threatening consequences is a decision of fundamental personal importance.

[199] The security of the person interest is engaged, even independently of criminal sanction, by the establishment of a regulatory regime which restricts access to marihuana. This was true of the MMAR and is true of the MMPR. The Ontario Court of Appeal in *Hitzig* articulated this principle as follows:

> **95** In this case, the MMAR, with their strict conditions for eligibility and their restrictive provisions relating to a source of supply, clearly present an impediment to access to marihuana by those who need it for their serious medical conditions. By putting these regulatory constraints on that access, the MMAR can be said to implicate the right to security of the person even without considering the criminal sanctions which support the regulatory structure. Those sanctions apply not only to those who need to take marihuana but do not have an ATP or who cannot comply with its

> conditions. They also apply to anyone who would supply marihuana to them unless that person has met the limiting terms required to obtain a DPL. As seen in *Rodriguez v. British Columbia (A.G.)*, [1993] 3 S.C.R. 519, a criminal sanction applied to another who would assist an individual in a fundamental choice affecting his or her personal autonomy can constitute an interference with that individual's security of the person. Thus, we conclude that the MMAR implicate the right of security of the person of those with the medical need to take marihuana.
>
> …
>
> **104** Even apart from these criminal sanctions for non-compliance, the MMAR constitute significant state interference with the human dignity of those who need marihuana for medical purposes. To take the medication they require they must apply for an ATP, comply with the detailed requirements of that process, and then attempt to acquire their medication in the very limited ways contemplated by the MMAR. These constraints are imposed by the state as part of the justice system's control of access to marihuana. As such, they are state actions sufficient to constitute a deprivation of the security of the person of those who must take marihuana for medical purposes. They are state actions within the administration of justice that stand between those in medical need and the marihuana they require.
>
> [Court underlining]

(b) *Positions - Summary*

[200] The Plaintiffs submit that security of the person is engaged because it encompasses personal autonomy involving control over one's bodily integrity, free from state interference, such as interference with an individual's physical or psychological integrity, causing physical or serious psychological suffering.

[201] With respect to the security interest, the Defendant states that the MMPR does not engage this interest for the same reasons it does not engage fundamental decision making – it is the

Plaintiffs' attitude toward LPs rather than their ability to access the cannabis under the MMPR that is at the heart of this challenge, not their lack of affordability or suitable strains under the regime.

(c) *Analysis*

[202] The *Hitzig* analysis applies to this case, albeit the regime in *Hitzig* – the MMAR – is distinguishable from the MMPR. The common and significant factor is that constraints are imposed in both regimes. In *Hitzig*, in addition to the patients having no legal source of supply, many long term users of medical marihuana were unable to produce their own and could not obtain a designate to produce it for them.

[203] In the present case, one cannot cultivate for oneself or purchase the marihuana from a supplier that is not registered as a LP. As a result of these restrictions, if one cannot access a LP for any reason, that person's security is engaged as there would be no access to their medication resulting in physical or psychological suffering.

The Defendant's specific concerns about choice in relation to access considering dosage and strain and affordability are dealt with below.

(3) Affordability and Access Discussion

[204] Affordability as a barrier to accessing cannabis for medical purposes was a major issue in this case raised by the Plaintiffs, rebutted by the Defendant and therefore must be addressed. As the litigation developed, its importance plateaued. The cost of purchasing from LPs and the cost

of personal cultivation have very little to do with the engagement of liberty and security interests except as it relates to the economic dimensions of access. This case is about the restriction on access imposed by the MMPR regime. Costs are a consequence of the regime; not an independent grounds.

[205] This is not a case about economic interests. Specifically, the Plaintiffs are not requesting to place a positive obligation on the government to subsidize the cost of accessing cannabis for medical purposes. As stated earlier, this is not a case about the entitlement to inexpensive medication.

[206] However, the interests have an economic dimension due to restriction of access caused by affordability. Although affordability (as defined by both Dr. Walsh and Dr. Grootendorst) encompasses a choice, this choice is only necessary due to state action, which must be *Charter* compliant. It is not a lifestyle choice or a preference choice as argued by the Defendant.

[207] A choice argument was put forward by the government in *PHS*, where it argued that any negative health risks drug users may suffer if Insite is unable to provide them with health services, are not caused by the CDSA's prohibition on possession of illegal drugs, but rather are the consequences of the drug users' decision to use illegal drugs (para 97). The relevant portion of the Supreme Court's response is found at paras 103 to 105:

> [103] The third way to view Canada's choice argument is as a matter of government policy. Canada argues that the decision to allow supervised injection is a policy question, and thus immune from *Charter* review.
>
> [104] The answer, once again, is that policy is not relevant at the stage of determining whether a law or state action limits a *Charter*

> right. The place for such arguments is when considering the principles of fundamental justice or at the s. 1 stage of justification if a *Charter* breach has been established.
>
> [105] The issue of illegal drug use and addiction is a complex one which attracts a variety of social, political, scientific and moral reactions. There is room for disagreement between reasonable people concerning how addiction should be treated. It is for the relevant governments, not the Court, to make criminal and health policy. However, when a policy is translated into law or state action, those laws and actions are subject to scrutiny under the *Charter*: *Chaoulli*, at para. 89, *per* Deschamps J., at para. 107, *per* McLachlin C.J. and Major J., and at para. 183, *per* Binnie and LeBel JJ.; *Rodriguez*, at pp. 589-90, *per* Sopinka J. The issue before the Court at this point is not whether harm reduction or abstinence-based programmes are the best approach to resolving illegal drug use. It is simply whether Canada has limited the rights of the claimants in a manner that does not comply with the *Charter*.
>
> [Court underlining]

[208] Similar to *PHS*, the issue before this Court is not whether the MMPR is the best policy; it is whether the restrictions imposed by the MMPR limit the Plaintiffs in a manner that is *Charter* compliant. The Defendant argues that the Plaintiffs are able to afford the cannabis with the LP regime. Their strain preference is not supported medically and therefore the LP regime adequately facilitates this access. As a result, the MMPR does not engage liberty or security interests except by the concession mentioned earlier.

[209] The Court does not find the Defendant's arguments to be sound. It is argued that the evidence does not establish that purchasing marihuana in medically appropriate amounts is prohibitively expensive for anyone. This is a skewed assumption for two reasons. First, the Court is not to determine what is expensive and what is not. It is to determine whether affordability is a barrier to access and whether affordability is inherently about a choice. If this choice involves

access to medicine, the case law establishes that the choice is of fundamental personal importance.

[210] Secondly, this assumption implies that the average MMAR patient, who is currently authorized to consume approximately 18 grams a day, will suffice on 1 to 5 grams a day. This conclusion cannot be made by the Court because such a conclusion ignores the evidence on tolerance, method of consumption and other personal characteristics and needs of the individual. The Court is in no position to establish the maximum dosages which should be made available.

[211] It is unnecessary to debate whether the Plaintiffs' preference of one strain versus another is medically established. There is enough anecdotal evidence that the type of strain affects the patients' choice in treating their illnesses. Additionally, there is enough evidence that currently, the LP regime may not have an adequate supply of a patient's dose amount in their preference of strain.

[212] The Plaintiffs have established that the MMPR has undermined the health and safety of medical marihuana users by diminishing the quality of their health care through severe restrictions on access to medical marihuana. It is the restriction that engages s 7 interests.

[213] Overall, the question is whether these limitations are in accordance with the principles of fundamental justice. It is clear that section 7 liberty and security of the person rights are both engaged.

B. *Principles of Fundamental Justice*

[214] As stated in *Carter* at para 71, section 7 does not promise that the state will never interfere with a person's life, liberty or security of the person; rather, the state will not do so in a way that violates the principles of fundamental justice.

(1) Objective of the Legislation

[215] All three principles of fundamental justice compare the rights infringement caused by the law with the objective of the law, not with the law's effectiveness (*Canada (Attorney General) v Bedford*, 2013 SCC 72, [2013] 3 SCR 1101 [*Bedford*] at para 123). The Supreme Court has cautioned against defining the objective too broadly as it becomes difficult to say that means used to further it are overbroad or disproportionate. In *Bedford*, the Court held that the object of the prohibition should be confined to measures directly targeted by the law.

[216] The objective of the CDSA was defined in *PHS* at para 129, adopting *R v Malmo-Levine*, 2003 SCC 74, [2003] 3 SCR 571 [*Malmo-Levine*], as the protection of health and public safety. This objective was also adopted by the Supreme Court in *Smith*. In *Smith*, the object of the restriction to dried marihuana was defined as simply "the protection of health and safety" (para 24).

[217] The Defendant submitted that the objective of the MMPR is the protection of health and safety of patients who are medically qualified to consume cannabis for medical purposes.

[218] The Defendant submits that the MMPR's RIAS states that the overall objective of the regulation is "to reduce the risks to public health, security and safety of Canadians, while significantly improving the way in which individuals access marihuana for medical purposes" (Court underlining). More specifically, by treating marihuana like other prescription medications in Canada, the MMPR is intended to address many, if not all, of the significant negative consequences that resulted from the MMAR. It attempts to provide access to dried marihuana for medical purposes in a way that minimizes the health and safety risks associated with its production and consumption.

[219] Although the Supreme Court recently stated that the objective of the CDSA is the protection of health and safety, the objective of the MMPR is more specific and I agree with the definition provided by the Defendant. This definition does not alter the objective of the CDSA; the MMPR supports the application of the Act.

[220] In sum, the objective has two parts, as discussed in closing submissions; one is the reduction of the risk to public health and safety, and the other is to improve the way in which a person who needs marihuana gains access to cannabis.

[221] It is important to note that the second part of the objective can be viewed as a direct comparison to the old regime. The MMPR was said by the Defendant to address many, if not all, of the significant negative consequences that resulted from the MMAR.

(2) Section 1 v Section 7

[222] The objective of the prohibition is the same in both section 1 and 7 analyses and therefore, similar to *Smith* and the other marihuana cases, the evidence should be considered at the section 7 stage:

> [29] The remaining question is whether the Crown has shown this violation of s. 7 to be reasonable and demonstrably justified under s. 1 of the *Charter*. As explained in *Bedford*, the s. 1 analysis focuses on the furtherance of the public interest and thus differs from the s. 7 analysis, which is focused on the infringement of the individual rights: para. 125. However, in this case, the objective of the prohibition is the same in both analyses: the protection of health and safety. It follows that the same disconnect between the prohibition and its object that renders it arbitrary under s. 7 frustrates the requirement under s. 1 that the limit on the right be rationally connected to a pressing objective (*R. v. Oakes*, [1986] 1 S.C.R. 103). Like the courts below, we conclude that the infringement of s. 7 is not justified under s. 1 of the *Charter*.
>
> [*Smith* at para 29]

[223] This issue was fully canvassed in *Bedford*:

> [124] This Court has previously identified parallels between the rules against arbitrariness, overbreadth, and gross disproportionality under s. 7 and elements of the s. 1 analysis for justification of laws that violate *Charter* rights. These parallels should not be allowed to obscure the crucial differences between the two sections.
>
> [125] Section 7 and s. 1 ask different questions. The question under s. 7 is whether the law's negative effect on life, liberty, or security of the person is in accordance with the principles of fundamental justice. With respect to the principles of arbitrariness, overbreadth, and gross disproportionality, the specific questions are whether the law's purpose, taken at face value, is connected to its effects and whether the negative effect is grossly disproportionate to the law's purpose. Under s. 1, the question is different — whether the negative impact of a law on the rights of individuals is proportionate to the pressing and substantial goal of

the law in furthering the public interest. The question of justification on the basis of an overarching public goal is at the heart of s. 1, but it plays no part in the s. 7 analysis, which is concerned with the narrower question of whether the impugned law infringes individual rights.

[126] As a consequence of the different questions they address, s. 7 and s. 1 work in different ways. Under s. 1, the government bears the burden of showing that a law that breaches an individual's rights can be justified having regard to the government's goal. Because the question is whether the broader public interest justifies the infringement of individual rights, the law's goal must be pressing and substantial. The "rational connection" branch of the s. 1 analysis asks whether the law was a rational means for the legislature to pursue its objective. "Minimal impairment" asks whether the legislature could have designed a law that infringes rights to a lesser extent; it considers the legislature's reasonable alternatives. At the final stage of the s. 1 analysis, the court is required to weigh the negative impact of the law on people's rights against the beneficial impact of the law in terms of achieving its goal for the greater public good. The impacts are judged both qualitatively and quantitatively. Unlike individual claimants, the Crown is well placed to call the social science and expert evidence required to justify the law's impact in terms of society as a whole.

[127] By contrast, under s. 7, the claimant bears the burden of establishing that the law deprives her of life, liberty or security of the person, in a manner that is not connected to the law's object or in a manner that is grossly disproportionate to the law's object. The inquiry into the purpose of the law focuses on the nature of the object, not on its efficacy. The inquiry into the impact on life, liberty or security of the person is not quantitative — for example, how many people are negatively impacted — but qualitative. An arbitrary, overbroad, or grossly disproportionate impact on one person suffices to establish a breach of s. 7. To require s. 7 claimants to establish the efficacy of the law versus its deleterious consequences on members of society as a whole, would impose the government's s. 1 burden on claimants under s. 7. That cannot be right.

[128] In brief, although the concepts under s. 7 and s. 1 are rooted in similar concerns, they are analytically distinct.

[129] It has been said that a law that violates s. 7 is unlikely to be justified under s. 1 of the *Charter* (*Motor Vehicle Reference*, at p. 518). The significance of the fundamental rights protected by s. 7

> supports this observation. Nevertheless, the jurisprudence has also recognized that there may be some cases where s. 1 has a role to play (see, e.g., *Malmo-Levine*, at paras. 96-98). Depending on the importance of the legislative goal and the nature of the s. 7 infringement in a particular case, the possibility that the government could establish that a s. 7 violation is justified under s. 1 of the *Charter* cannot be discounted.

[224] Considering the commentary in *Bedford*, it is necessary to evaluate the evidence at the second stage of section 7 due to the manner in which evidence was adduced in this trial. If the Court was to consider the evidence in section 1, the section 7 analyses would be incomplete as the health and safety issues as they pertain to the public are relevant to the objective of the MMPR. This complicates the burden of proof issue; however, the result is the same either way, as the evidence is the same applied in either section.

(3) Arbitrariness

(a) *Law*

[225] The most recent statement of the Court on this principle is in *Carter* at para 83:

> [83] The principle of fundamental justice that forbids arbitrariness targets the situation where there is no rational connection between the object of the law and the limit it imposes on life, liberty or security of the person: *Bedford*, at para. 111. An arbitrary law is one that is not capable of fulfilling its objectives. It exacts a constitutional price in terms of rights, without furthering the public good that is said to be the object of the law.

[226] In *Morgentaler*, the effect of the law actually contravened the objective of the law. In *Chaoulli*, the four-judge majority found that the prohibition was arbitrary because there was no

real connection on the facts between the effect and the objective of the law. In *PHS*, the Minister's decision was contrary to the objectives of the drug possession laws.

[227] Arbitrariness was elaborated on in *Bedford* at para 111:

> [111] Arbitrariness asks whether there is a direct connection between the purpose of the law and the impugned effect on the individual, in the sense that the effect on the individual bears some relation to the law's purpose. There must be a rational connection between the object of the measure that causes the s. 7 deprivation, and the limits it imposes on life, liberty, or security of the person (Stewart, at p. 136). A law that imposes limits on these interests in a way that bears *no connection* to its objective arbitrarily impinges on those interests. Thus, in *Chaoulli*, the law was arbitrary because the prohibition of private health insurance was held to be unrelated to the objective of protecting the public health system.

(b) *Positions – Summary*

[228] The Plaintiffs submit that the impugned restrictions compel patients, under the threat of criminal sanction to (a) purchase from LPs irrespective of their individual ability to do so; (b) possess artificially limited quantities of medicine thus denying them the ability to travel for work or pleasure, or requiring them to make multiple orders per month from LPs; and (c) ingest the medicinal compounds in unnecessarily restrictive, less effective and more harmful ways.

[229] The Plaintiffs argue that the restrictions are arbitrary because they will cause, not prevent, harm to health and safety. The evidence at trial failed to show that public safety will be advanced in any significant way by the removal of the ability to lawfully and safely continue to personally produce medical cannabis. Further, the evidence demonstrated that in so doing, the Defendant

will put the health and safety of some patients at risk because the exemption proposed by the MMPR will not allow Plaintiffs access to adequate supplies of medicine.

[230] Specifically, patient health and safety will be harmed because (a) patients will either go without sufficient medicine or be impoverished or break the law to produce it; (b) patients, fearful of criminal charges, will no longer have their production sites inspected for safety and will go back underground as they did in the period before being able to obtain licensing, causing risks of harm to public health and safety; (c) patients are forced under the threat of criminal sanction to consume medicine in less effective and more harmful ways; and (d) as patients will be criminalised for possessing reasonable quantities of medicinal cannabis, they must either go without or continually order/replenish their supply, leading to gaps in supply.

[231] The Defendant states that the restriction on personal cultivation is not arbitrary because it is a rational response to the genuine health and safety concerns associated with the residential cultivation of marihuana for medical purposes. Extensive evidence before the Court is of the real risks associated with the personal cultivation of medical marihuana. Several of the Plaintiffs' witnesses concede that unless properly constructed and inspected, the cultivation of medical marihuana in residential dwellings can be a risky, unsafe endeavour. Others concede that some medical cannabis growers abused their personal and designated production licences by diverting their cannabis to the illicit market.

[232] Several of the Defendant's experts address these various risks and abuses in their reports and provide cogent examples of the problems that may arise in home cultivation sites. Further,

the evidence from international medical marihuana regimes suggest a trend away from home cultivation in favour of commercial production because of the risks and abuses associated with the personal production of medical marihuana.

(c) *Analysis*

[233] Both parties' submissions on the issue of arbitrariness do not hit the mark. The Defendant has mischaracterized the evidence and disregarded the admissions on cross-examination. Although the Plaintiffs have not proved their statements or directed the Court to any evidence on their assertions, I find the restriction in the MMPR to bear no connection to the objective of the law.

[234] First, considering how the MMPR impacts each Plaintiff, the effects of the restrictions are contrary to the objective of the MMPR to improve access.

[235] Second, there is no real connection between restricting access to cannabis for medical purposes to purchasing from LPs and the objectives of reducing risks to health and safety and improving access. The health and safety concerns that the law purports to disparage were not established and there was inadequate evidence to conclude that access was overall improved. In fact, access was further restricted.

(d) *Impact on the Plaintiffs*

[236] Access to cannabis for medical purposes is not improved for the Plaintiffs under the MMPR. By limiting their access to purchasing from LPs, the health and safety of the Plaintiffs is also diminished. Although I find that the Plaintiffs might not be forced to resort to the black market and break the law, the MMPR force them to choose between their medication and other basic necessities without a rational connection to the objective.

[237] At his current consumption under the MMPR, Mr. Allard would be spending his entire income on cannabis for medical purposes, which would impact his health and safety. Without the restricted access of the MMPR, he is able to access his medication without impacting his health and safety. This is one example of the consequences which flow from the restricted access under the MMPR.

The same analysis applies to Mr. Davey, who would be spending over seventy percent of his income (at $5 a gram, $3,750 a month and his monthly income is $5,100) on purchasing cannabis, negatively impacting his health and safety and also reducing his capacity to provide for his other health needs.

[238] At five grams a day, her prescribed amount, if Ms. Beemish purchased from an LP at $5 a gram, it would exceed her monthly income. It is likely, however, that Ms. Beemish might qualify for one of the discounts for low income or disabled individuals. Such discounts are not guaranteed nor imposed by regulation. Further, Ms. Beemish finds that a particular strain is more effective for treatment and this positively impacts her health. The MMPR regime does not

guarantee this strain even if she consistently qualified for some subsidized form of LP programs. Consuming a less-effective strain would negatively affect her health and safety. Without the restriction, she was able to access the most beneficial medication for her health.

(e) *Response to Defendant's Position*

[239] With respect to health and safety risks, the Defendant submits that the witnesses provided cogent evidence to illustrate the risks associated with cannabis growing operations.

[240] I find that the evidence was insufficient and largely did not distinguish between legal cannabis growing operations under the MMAR and illegal growing operations. Additionally, there was limited, if any, expert evidence that convincingly asserted that these risks exist across the country and to a magnitude that mandates state interference.

[241] For fire risk as noted earlier, the Defendant relies on the expert evidence of Len Garis, the Fire Chief of Surrey, British Columbia. This evidence is unreliable for many reasons. Most importantly, this witness was not credible and was biased. He was an active public advocate against cannabis cultivation. His Report provided no analysis or context for the Court to accurately judge the purported fire risks. Instead, it was painfully obvious that his entire study was motivated to support a cause – his own personal view against residential growing operations.

[242] During Mr. Garis' testimony, it was acknowledged that the risk of kitchen fires is higher than the risk of fires caused by residential cannabis cultivation (the Fire Commissioner Office fire statistics did not include a single fire at a legal medical cannabis production site between

2001 and 2012). He provided very little information on legal cultivation operations and focused his entire evidence on Surrey, British Columbia. Finally, he admitted that if a certified electrician carried out the modifications necessary at a production site, the alleged risk can be addressed.

[243] Although the Defendant relies on Ms. Ritchot's evidence of other cities, who conducted similar but vastly smaller studies, no context is provided for the Court to adequately assess the studies and thus little weight is given to this evidence.

[244] The Plaintiffs' rebuttal witness, Mr. Boileau, provided useful evidence that contextualized this risk under the MMAR regime. If in compliance with the *Safety Standards Act*, electrical installations at legal indoor marihuana grow facilities by MMAR license holders are just as safe as any other electrical installation at any other type of facility.

[245] For the specific health issue of toxic mould, the Defendant relied on the expert evidence of Dr. Miller. Dr. Miller noted that each marihuana plant added as much moisture to a house as approximately seven to ten houseplants. He specifically expressed concern with growing in a multi-unit residential building. The Plaintiffs' witnesses, Mr. Schut, Mr. Colasanti and Mr. Nash, stated that proper steps must be taken to remove the excess moisture. I find that although mould appears to be a valid concern, the evidence demonstrates that the concern is extinguished with a proper ventilation system.

[246] On risk arising from the monetary value of marihuana, there was no evidence of actual theft or related risk. The Defendant's argument was speculative at best, relying on the street value of marihuana at $5-$10 per gram.

[247] Regarding the potential criminal abuses of MMAR license holders, the evidence did not establish that this was a warranted risk. Importantly, I do not rely on any evidence by Corporal Holmquist as his examples were exposed under cross-examination as incomplete. The limited incidents listed in his Report cannot support his conclusions as they are not fully researched, lack important details and are not contextually analyzed. His conclusions are result-oriented and exhibit a biased analysis.

[248] The Defendant also argues that the restriction is consistent with international medical marihuana regimes. Concerns about diversion to the illegal market led to the development of the specific regimes in different countries. I note that the evidence at trial confirmed that each country was continuously changing their structures and administration to address the needs of patients requiring medical marihuana while the drug remains a banned substance federally.

[249] Canada, like some of the countries referred to in evidence, is a signatory to a number of international drug control conventions (see *Hitzig*, at paras 32 and 33). However it is not particularly helpful for this Court to focus on the systems in place in other countries as the policies and legal structures in place are vastly different region by region. Importantly, there was limited evidence of the concerns of non-commercial publicly regulated cannabis cultivation. The issues in this case are governed by *Charter* obligations, not international ones.

[250] I do not find the treatment of cannabis consistent with other plant-based medicines. Although the *Natural Health Products Regulations*, SOR/2003-196 [NHPR], state that natural health products cannot contain a controlled substance, it is beneficial to recognize that the NHPR regulate the sale of these products to the public, not the personal cultivation and subsequent consumption of them.

[251] Additionally, despite the stated objective of treating medical marihuana as a medicine, the MMPR does not treat marihuana for medical purposes in the same way as other psychoactive drugs. It is not regulated through the FDA drug approval process and is not subject to the controls on safety and efficacy. The Defendant conceded that there are no "lethal doses" associated with the drug unlike other drugs.

[252] Taking the evidence in comparison to the objective of the MMPR outlined in the RIAS, the only consequence of the MMPR remaining largely unchallenged is that of government cost savings. The regulatory cost burden has significantly been transferred to the LPs. Cost savings, while a legitimate policy goal, cannot, in this case, trump the Plaintiffs' *Charter* rights and form a *Charter*-compliant justification for the MMPR.

[253] Overall, viewed from the different perspectives, the law is arbitrary as the limits it imposes on section 7 interests bear no rational connection to its objective. Considering the Plaintiffs' situations, the MMPR does not reduce risk to their health and safety, nor does it improve their access to cannabis. In response to the Defendant's primary defense that health and safety risks of cultivation are reduced by the MMPR, the evidence does not qualify this risk.

Many of the risks purported to be significant were not proved to exist, including fire, home invasion/violence/diversion and community impacts.

[254] The law is therefore arbitrary.

(4) Overbreadth

(a) *Law*

[255] *Carter* states the following on overbreadth:

> [85] The overbreadth inquiry asks whether a law that takes away rights in a way that generally supports the object of the law, goes too far by denying the rights of some individuals in a way that bears no relation to the object: *Bedford*, at paras. 101 and 112-13. Like the other principles of fundamental justice under s. 7, overbreadth is not concerned with competing social interests or ancillary benefits to the general population. A law that is drawn broadly to target conduct that bears no relation to its purpose "in order to make enforcement more practical" may therefore be overbroad (see *Bedford*, at para. 113). The question is not whether Parliament has chosen the least restrictive means, but whether the chosen means infringe life, liberty or security of the person in a way that has no connection with the mischief contemplated by the legislature. The focus is not on broad social impacts, but on the impact of the measure on the individuals whose life, liberty or security of the person is trammelled.
>
> (Court underlining)

[256] The Supreme Court in *Bedford* provided helpful guidance on this principle:

> [112] Overbreadth deals with a law that is so broad in scope that it includes *some* conduct that bears no relation to its purpose. In this sense, the law is arbitrary *in part*. At its core, overbreadth addresses the situation where there is no rational connection between the purposes of the law and *some*, but not all, of its impacts. For instance, the law at issue in *Demers* required unfit

accused to attend repeated review board hearings. The law was only disconnected from its purpose insofar as it applied to permanently unfit accused; for temporarily unfit accused, the effects were related to the purpose.

[113] Overbreadth allows courts to recognize that the law is rational in some cases, but that it overreaches in its effect in others. Despite this recognition of the scope of the law as a whole, the focus remains on the individual and whether the effect on the individual is rationally connected to the law's purpose. For example, where a law is drawn broadly and targets some conduct that bears no relation to its purpose in order to make enforcement more practical, there is still no connection between the purpose of the law and its effect on the *specific individual*. Enforcement practicality may be a justification for an overbroad law, to be analyzed under s. 1 of the *Charter*.

…

[118] An ancillary question, which applies to both arbitrariness and overbreadth, concerns how significant the lack of correspondence between the objective of the infringing provision and its effects must be. Questions have arisen as to whether a law is arbitrary or overbroad when its effects are *inconsistent* with its objective, or whether, more broadly, a law is arbitrary or overbroad whenever its effects are *unnecessary* for its objective (see, e.g., *Chaoulli*, at paras. 233-34).

[119] As noted above, the root question is whether the law is inherently bad because there is *no connection*, in whole or in part, between its effects and its purpose. This standard is not easily met. The evidence may, as in *Morgentaler*, show that the effect actually undermines the objective and is therefore "inconsistent" with the objective. Or the evidence may, as in *Chaoulli*, show that there is simply no connection on the facts between the effect and the objective, and the effect is therefore "unnecessary". Regardless of how the judge describes this lack of connection, the ultimate question remains whether the evidence establishes that the law violates basic norms because there is *no connection* between its effect and its purpose. This is a matter to be determined on a case-by-case basis, in light of the evidence.

[Court underlining]

[257] In sum, the law goes too far and interferes with some conduct that bears no connection to its objectives.

(b) *Positions - Summary*

[258] The Plaintiffs submit that in this case, the Defendant conceded at trial that the impugned restrictions apply to persons whose conduct did not implicate the objectives of protecting health and safety. None of the patient witnesses engage in diversion, and there was no evidence that any had suffered any harm to either their health or safety, or caused any harm to public health or safety, as a result of their cannabis cultivation and consumption. Health Canada was unable to produce any significant records of any such problems generally throughout the history of the MMAR.

The Plaintiffs' factual argument is accurate.

[259] If the evidence of possible harms associated with personal production of cannabis and cannabis-based medicines is accepted, the blanket prohibition catches people outside of the class of persons who are suffering and/or causing such harms and is, therefore, overbroad. The blanket prohibition on production, possessing more than 150 grams and consuming forms other than dried marihuana is not proven to be connected to the objective of protecting health and safety.

[260] The evidence establishes that the great majority of patients were able to produce their own cannabis as medicine without any threat to their own health and safety or that of the public. It follows that the limitation on their rights is not connected to the objective of protecting public safety and health. The law punishes everyone who produces cannabis as medicine for

themselves, possesses more than 150 grams or possesses/produces cannabis-based medicines without distinguishing between those who do so safely and securely without any risk to public safety or health.

[261] In response, the Defendant states that it is only required to establish that the personal cultivation of cannabis gives rise to a reasoned apprehension of harm and the evidence of harms set out goes far beyond that standard. Additionally, the Defendant states that the Plaintiffs do not dispute that the personal residential cultivation of medical marihuana entails some inherent risk and the extensive health and safety precautions for commercial LPs are necessary. The aforementioned undermines the contention that the restriction on personal cultivation is overly broad.

[262] The Defendant submits that it has implemented a complex regulatory regime, and the public health and safety objectives of that regime cannot be achieved in the context of home cultivation. The Defendant further submits that it is simply not possible to determine who is a "good" or "bad" grower without an elaborate system of regulatory and inspection requirements.

[263] The Defendant submits that home cultivation requires an expansive and complex regime and without such regime, the inherent risks would persist. Thus the demand is a plea for a *de facto* subsidization of personal production and such positive obligations are not protected by the *Charter*.

[264] There is evidence with respect to the extraordinary cost associated with Health Canada's inspection of a handful of the MMAR residential growing operations. If the medical marihuana program continues to grow at its current pace, it is reasonable to expect tens of thousands of additional home growing operations will materialize. In order to inspect these sites, Health Canada would have to hire numerous inspectors, increasing the cost of the regime. The Defendant also references the costs of inspections to local municipalities to ensure compliance with by-laws. This cost is submitted to be borne by the Canadian public. Even if inspections were economically or logistically feasible, there are still privacy issues that may present hurdles to such inspections.

[265] In contrast to the difficulties of inspecting personal production sites, the regulatory oversight of LPs is achievable and Health Canada conducts four different types of inspections at these facilities.

[266] Relying on the goodwill and best efforts of individual growers to adhere to appropriate health and safety protocols is not a viable means by which a stable, consistent and safe medicine can be produced. Rigorous regular testing conducted by trained individuals is necessary to detect the presence of microbial contaminants and address other safety concerns.

(c) *Analysis*

[267] If this Court was to accept that there was some rational connection between the purposes of the law and some, but not all, of its impacts, the restriction would still be overbroad. As explained in the arbitrary analysis, there is no rational connection between the object of the law

and the limits it imposes; however, it can be argued that eliminating cultivation essentially eliminates all risk associated with that activity and thus, there is a rational connection between the objective and this impact. The Court addresses this argument below.

[268] Firstly, although there was evidence of MMPR participants and the LP market growing, there was no direct evidence on how the law has improved access compared to the MMAR. It may be reasonable to assume, given the previous decisions of the Court in *Stefkopolous* and *Beren* that some individual patients benefit from the LP regime, as they can avoid the time commitment necessary for cultivation and are not limited to purchasing from Health Canada. However, there is no evidence to qualify this assumption as an improvement in access over the previous regime.

[269] Secondly, with respect to health and safety, the Defendant extensively relies on the cost of inspections necessary to reduce risk if cultivation was permitted. I find that this cost consideration, if necessary to discuss, is to be engaged at the section 1 stage. To the extent that the Court considers cost of the regime when justifying an infringement, it does so with scepticism. The reason for scepticism – the all too easy position that budgets trump rights - is well set out in the following paragraph:

> 72 The result of all this, it seems to me, is that courts will continue to look with strong scepticism at attempts to justify infringements of *Charter* rights on the basis of budgetary constraints. To do otherwise would devalue the *Charter* because there are *always* budgetary constraints and there are *always* other pressing government priorities. Nevertheless, the courts cannot close their eyes to the periodic occurrence of financial emergencies when measures must be taken to juggle priorities to see a government through the crisis. It cannot be said that in weighing a delay in the timetable for implementing pay equity

> against the closing of hundreds of hospital beds, as here, a government is engaged in an exercise "whose sole purpose is financial". The weighing exercise has as much to do with social values as it has to do with dollars. In the present case, the "potential impact" is $24 million, amounting to more than 10 percent of the projected budgetary deficit for 1991-92. The delayed implementation of pay equity is an extremely serious matter, but so too (for example) is the layoff of 1,300 permanent, 350 part-time and 350 seasonal employees, and the deprivation to the public of the services they provided.
>
> *Newfoundland (Treasury Board) v N.A.P.E.*, 2004 SCC 66, [2004] 3 SCR 381

[270] Thirdly, if the risks to health and safety are accepted particularly mould, fire and potential criminal abuse, the restriction has no connection to outdoor cultivation as the evidence adduced was largely in the context of indoor cultivation at residential dwellings. More obviously, the restriction catches those whose health and safety were never at risk. Additionally, indoor cultivation issues can be addressed. As mentioned above, the restriction is contrary to both elements of the objective.

[271] Therefore, in addition to being arbitrary, the law is overbroad.

(5) Grossly Disproportionate

(a) *Law*

[272] The Supreme Court in *Bedford* stated the following with respect to gross disproportionality:

> [120] Gross disproportionality asks a different question from arbitrariness and overbreadth. It targets the second fundamental evil: the law's effects on life, liberty or security of the person are

> so grossly disproportionate to its purposes that they cannot rationally be supported. The rule against gross disproportionality only applies in extreme cases where the seriousness of the deprivation is totally out of sync with the objective of the measure. This idea is captured by the hypothetical of a law with the purpose of keeping the streets clean that imposes a sentence of life imprisonment for spitting on the sidewalk. The connection between the draconian impact of the law and its object must be entirely outside the norms accepted in our free and democratic society.
>
> [121] Gross disproportionality under s. 7 of the *Charter* does *not* consider the beneficial effects of the law for society. It balances the negative effect on the individual against the purpose of the law, *not* against societal benefit that might flow from the law. As this Court said in *Malmo-Levine*:
>
> > In effect, the exercise undertaken by Braidwood J.A. was to balance the law's salutary and deleterious effects. In our view, with respect, that is a function that is more properly reserved for s. 1. These are the types of social and economic harms that generally have no place in s. 7. [para. 181]
>
> [122] Thus, gross disproportionality is not concerned with the number of people who experience grossly disproportionate effects; a grossly disproportionate effect on one person is sufficient to violate the norm.
>
> [Court underlining]

(b) *Positions – Summary*

[273] The Plaintiffs submit that the state does not have a legitimate interest in prohibiting medicinal marihuana patients from producing medicine for their own personal consumption, possessing more than 150 grams or choosing modes of ingestion other than smoking the dried cannabis. Even if those interests are legitimate, the criminalization of the conduct is far too extreme of a response.

[274] In this aspect of section 7, the Court is concerned with the negative effect on the individual balanced against the purpose of the restriction. A grossly disproportionate effect on one patient alone is sufficient to violate this principle of fundamental justice. Here, the purpose of the law is to protect the health and safety of medical cannabis consumers (or the public, on a broader conception of the objective). The negative effects of the law on patients include the imposition of criminality; the attendant negatives that flow from criminalizing; the stripping away of autonomy and choice in medical decision-making; tacitly forcing some patients to choose between an adequate supply of medicine and institutionalized poverty; the forced ingestion of cannabis medicine by smoking or vaporization with the attendant harms on account of the restrictions on permissible forms of marihuana; and the removal of the benefits of oral and topical modes of ingestion.

[275] The Plaintiffs submit that the restriction's negative impact on liberty and security of the person is very high. The law imposes unnecessary suffering on some patients, deprives them of self-determination in respect of what they do with their own bodies and confines their choice in how to ingest cannabis to options that are more harmful, less effective and often impractical or impossible.

[276] Further, those who are unable to afford LP prices will continue to be placed in a position where they have to choose between their liberty and their health. Patient health will be negatively impacted if they are unable to access sufficient amounts of the medicine. The Plaintiffs use the example of Ms. Beemish and Mr. Hebert. It is submitted that Ms. Beemish is suffering grossly disproportionate consequences by having to go without her medicine to the point of lengthy

hospitalization, and both are at a risk of grossly disproportionate consequences if Mr. Hebert decides to continue to produce for her notwithstanding the lack of authority to do so under the MMPR.

[277] The Defendant states that the possibility of incarceration as a deterrent for deliberately growing marihuana is not grossly disproportionate to its purposes, particularly given the lack of mandatory minimum sentence. In *Malmo-Levine*, the Supreme Court stated at paragraph 158 that "the lack of any mandatory minimum sentence together with the existence of well-established sentencing principles mean that the mere availability of imprisonment on a marihuana charge cannot, without more, violate the principle against gross disproportionality".

(c) *Analysis*

[278] It is unnecessary to conduct an analysis on gross disproportionality after considering arbitrariness and overbreadth. The considerations assessed under those principles are sufficient to deem the restriction contrary to the principles of fundamental justice.

C. *Section 1*

[279] As outlined above, the objective of the prohibition is the same in both section 7 and section 1 analyses. Accordingly, the same disconnect between the prohibition and its object that renders the restrictions arbitrary or overbroad under section 7 frustrates the requirement under section 1 that the limit on the right be rationally connected to a pressing objective and minimally impairing.

[280] The s 1 analysis applicable in the present case is well supported by the Supreme Court's reasons in *Smith* at paragraph 29:

> [29] The remaining question is whether the Crown has shown this violation of s. 7 to be reasonable and demonstrably justified under s. 1 of the *Charter*. As explained in *Bedford*, the s. 1 analysis focuses on the furtherance of the public interest and thus differs from the s. 7 analysis, which is focused on the infringement of the individual rights: para. 125. However, in this case, the objective of the prohibition is the same in both analyses: the protection of health and safety. It follows that the same disconnect between the prohibition and its object that renders it arbitrary under s. 7 frustrates the requirement under s. 1 that the limit on the right be rationally connected to a pressing objective (*R. v. Oakes*, [1986] 1 S.C.R. 103). Like the courts below, we conclude that the infringement of s. 7 is not justified under s. 1 of the *Charter*.

[281] A "minimal impairment" type of analysis is appropriate at this s 1 stage as set out in *Bedford* at paras 161 and 162:

> [161] The appellant Attorneys General have not seriously argued that the laws, if found to infringe s. 7, can be justified under s. 1 of the *Charter*. Only the Attorney General of Canada addressed this in his factum, and then, only briefly. I therefore find it unnecessary to engage in a full s. 1 analysis for each of the impugned provisions. However, some of their arguments under s. 7 of the *Charter* are properly addressed at this stage of the analysis.
>
> [162] In particular, the Attorneys General attempt to justify the living on the avails provision on the basis that it must be drafted broadly in order to capture all exploitative relationships, which can be difficult to identify. However, the law not only catches drivers and bodyguards, who may actually be pimps, but it also catches clearly non-exploitative relationships, such as receptionists or accountants who work with prostitutes. The law is therefore not minimally impairing. Nor, at the final stage of the s. 1 inquiry, is the law's effect of preventing prostitutes from taking measures that would increase their safety, and possibly save their lives, outweighed by the law's positive effect of protecting prostitutes from exploitative relationships.

[282] I agree that the Plaintiffs have, on a balance of probabilities, demonstrated that cannabis can be produced safely and securely with limited risk to public safety and consistently with the promotion of public health. I again emphasize that the object of the restriction is not to eliminate the risk to health and safety but to reduce it, and on that conception, there are very simple measures that can be taken to minimally impact the section 7 interests.

[283] Accepting that fire, mould, diversion, theft and violence are risks that inherently exist to a certain degree - although I note that these risks were not detailed - this significant restriction punishes those who are able to safely produce by abiding with local laws and taking simple precautions to reduce such risk. A complete restriction is not minimal impairment. As mentioned above, the mould and fire risks are addressed by complying with the *Safety Standards Act* and installing proper ventilation systems. Further, as demonstrated by the Plaintiffs, a security system reduces risk of theft and violence. Finally, risk of diversion is also present in the LP regime; thus, it is not demonstrated how this restriction has the effect of reducing this risk.

[284] The Defendant’s s 1 argument must fail for the same reasons that I have found the restriction arbitrary and overbroad.

[285] I conclude that the infringement of section 7 is not justified under section 1 of the *Charter*.

D. *Possession Limits – Specific Issue*

[286] The Plaintiffs argue the 150 gram restriction is overbreadth and disproportional, while the Defendant approaches the restriction separately. Specifically, the Plaintiffs argue that the 150 gram possession restriction limits their freedom of movement and ability to travel; that the state does not have a legitimate interest in this prohibition; and that it does not acknowledge those who possess it safely without endangering others.

[287] I agree with the Defendant, in the section 7 analysis, that the burden is on the Plaintiffs to establish that the 150 gram possession limit impacts them in a significant way. Although the Plaintiffs may have to purchase their marihuana more frequently and restrict the number of days they travel or transport the drug because of this restriction, the cap is not overbroad or grossly disproportionate because it bears a connection to the objective – it reduces the implied risk of theft, violence and diversion for which there has been no substantial or persuasive evidence.

[288] Overall, this restriction is significantly different than the restriction on cultivation as the cultivation restriction is a complete ban without minimal impairment that affects individuals adversely to the legislation's objective. The possession cap still allows one to possess more than their necessary amount of marihuana. There is nothing stopping Parliament from legislating cultivation in a similar way that ensures that significant measures are taken to reduce risk, such as mandatory installation of security or ventilation systems (assuming that these measures are constitutionally sound).

VIII. Conclusion

[289] For all these reasons, the Court has concluded that the Plaintiffs have established that their s 7 *Charter* rights have been infringed by the MMPR and that such infringement is not in accordance with the principles of fundamental justice or otherwise justified under s 1.

IX. Disposition and Remedy

[290] For these reasons, I find that the MMPR regime infringes the Plaintiffs' s 7 *Charter* rights and such infringement is not justified.

[291] In several decisions regarding the MMAR, the Courts have struck out either certain provisions or certain words in certain provisions, but otherwise left the structure of the regulation in place. Most of these decisions related to criminal charges where such narrow, feasible and effective excising was appropriate.

[292] In the present case, the attack has been on the structure of the new regulation. It would not be feasible or effective to strike certain words or provisions. That exercise would eviscerate the regulation and leave nothing practical in place.

The Defendant has recognized the integrated nature of the MMPR provisions.

[293] It is neither feasible nor appropriate to order the Defendant to reinstate the MMAR (as amended by current jurisprudence). It is not the role of the Court to impose regulations. The MMAR may be a useful model for subsequent consideration; however, it is not the only model,

nor is a MMAR-type regime the only medical marihuana regime, as experience from other countries has shown.

[294] The remedy considerations are further complicated by the fact that there is no attack on the underlying legislation. Striking down the MMPR merely leaves a legislative gap where possession of marihuana continues as a criminal offence. Absent a replacement regulation or exemption, those in need of medical marihuana – and access to a *Charter* compliant medical marihuana regime is legally required – face potential criminal charges.

[295] It would be possible for the Court to suspend the operation of the provisions which make it an offence to possess, use, grow and/or distribute marihuana for those persons holding a medical prescription or medical authorization. However, this is a blunt instrument which may not be necessary if a *Charter* compliant regime were put in place or different legislation were passed.

[296] The appropriate resolution, following the declaration of invalidity of the MMPR, is to suspend the operation of the declaration of invalidity to permit Canada to enact a new or parallel medical marihuana regime. As this regime was created by regulation, the legislative process is simpler than the requirement for Parliament to pass a new law.

[297] The declaration will be suspended for six (6) months to allow the government to respond to the declaration of invalidity.

[298] The Plaintiffs have been successful and have brought a case that benefits the public at large. They shall have their costs on a substantial indemnity basis in an amount to be fixed by the Court.

"Michael L. Phelan"
Judge

Vancouver, British Columbia
February 24, 2016

SCHEDULE A

PLAINTIFFS' LAY WITNESSES

Neil Allard	Plaintiff
Shawn Davey/Brian Alexander	Plaintiffs
Tanya Beemish/Dave Hebert	Plaintiffs
Mike King	Fact Witness on LP situation
Jason Wilcox	Fact Witness on MMAR Coalition
Danielle Lukiv	Fact Witness on MMAR Complaints
Jamie Shaw	Fact Witness on Dispensaries in Canada
Eric Nash	Fact Witness on MMAR/MMPR

PLAINTIFFS' EXPERT WITNESSES

Zachary Walsh	Expert on Affordability and Access and on Medical Evidence including Strain and Dosage
David Pate	Expert on Botany and Pharmacology
Caroline Farris	Rebuttal Expert on Use and Dosage
Robert Clarke	Rebuttal Expert on Cannabis Use
Remo Colasanti	Expert on Cultivation
Thomas Baumann	Expert on Horticulture
Eric Nash	Expert on MMAR/MMPR
Jason Schut	Rebuttal Expert on Mould Remediation
Tim Moen	Rebuttal Expert on Fire Risk
Robert Boileau	Rebuttal Expert on Fire Safety
Scott Wilkens	Expert on Insuring Properties
Susan Boyd	Key Rebuttal Expert (Community Impacts)

Paul Armentano	Rebuttal Expert (United States)

DEFENDANT'S LAY WITNESSES

Jocelyn Kula	Fact Witness on Regulatory Structure
Eric Ormsby	Fact Witness on Treatment of Other Drugs
Jeannie Ritchot	Fact Witness on MMPR and MMAR
Todd Cain	Fact Witness on MMPR and Industry Status

DEFENDANT'S EXPERT WITNESSES

Dr. Grootendorst	Expert on Cost Economics
Yehuda Baruch	Expert on Cannabis Use in Israel
Paul Daenick	Expert on Cannabis Use and Dosage
Harold Kalant	Expert on Medical Cannabis Use
John David Miller	Expert on Mould
Len Garis	Expert on Fire Risk
Shane Holmquist	Expert on Safety Risk
Larry Dybvig	Expert on Property Value
Catherine Sandovos	Expert on Regulatory Structure (Netherlands)
Hendrik J. Van Den Bos	Expert on Medical Practises (Netherlands)
Richard Bardenstein	Expert on Regulatory Structure (Israel)
Mahmoud ElSohly	Expert on US Preferred Cultivation (United States)
Lynn Mehler	Expert on Legislative Structure (United States)
Robert Mikos	Expert on Marihuana Law (United States)

FEDERAL COURT

SOLICITORS OF RECORD

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