Court File No. T-2030-13

FEDERAL COURT

BETWEEN:

NEIL ALLARD
TANYA BEEMISH
DAVID HEBERT
SHAWN DAVEY

Plaintiffs

and

HER MAJESTY THE QUEEN IN RIGHT OF CANADA

Defendant

MEMORANDUM OF FACT AND LAW OF THE DEFENDANT

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PART I: OVERVIEW

1. After consulting extensively with interested stakeholders, the Government of Canada adopted the *Marihuana for Medical Purposes Regulations* ("MMPR"). The objective of the MMPR is to provide reasonable access to a lawful source of quality controlled marijuana for those with a demonstrated medical need while addressing the public health and safety concerns inherent in the production of marijuana. The MMPR do so by entrusting the responsibility for cultivating safe, good quality marijuana destined for patients to a new licensed producer industry subject to stringent standards and government oversight. In this way, the MMPR treats marijuana, a controlled substance, like other medicines whose consumption and production entail risks both for the consumer and society at large.

2. Mr. Allard, Ms. Beemish, Mr. Hebert and Mr. Davey (the "Plaintiffs") do not like certain aspects of the MMPR. They would prefer a regime that permits home cultivation of marijuana. The Plaintiffs claim this would be cheaper for them as they had already invested a significant amount of money and time to establish safe grow operations. While the Plaintiffs agree that strict regulation of commercially licensed producers ("Licensed Producers") is necessary to ensure that they safely produce quality marijuana for vulnerable patients, they say that no such regulation should apply to home growers so long as they produce just for themselves.

3. The irrationality of the Plaintiffs' proposed two track alternative regime for regulating the medical use of a controlled substance is self-evident. The Plaintiffs have effectively acknowledged the public safety risks of marijuana production and consumption through the extensive investments of time and money they have made in their own grow operations to mitigate such risks, and by properly conceding the need for strict regulation of commercial medical marijuana producers. Given these risks, it would be illogical simply to permit individual patients to grow their own marijuana and consume it as medicine in an unregulated manner.

4. Notwithstanding the lack of a coherent basis for the Plaintiffs' preferred hybrid medical marijuana policy, the Plaintiffs now seek to use the courts to compel the government to adopt it. The Plaintiffs argue that there is a constitutional right for patients to grow their own marijuana which the government has taken away without justification. They also say that

the limits imposed by the MMPR on production locations, possession amounts and on making derivative marijuana products are unjustified and therefore unconstitutional.

5. However, the law does not support the Plaintiffs' assertions. There is no constitutional right for individuals to obtain medical marijuana in a specific way, amount or form. There is no constitutional right to cultivate marijuana. There is also no constitutional obligation imposed upon the government to ensure that medicine is made available at a cost that is subjectively acceptable to consumers. So long as government regulation of marijuana allows for reasonable access to a lawful supply for medical purposes, disputes over the wisdom of the particular policies adopted in relation to such access are to be decided in the political arena, not by the courts.

6. Furthermore, the evidence does not support the Plaintiffs' assertions that the MMPR denies them access to medical marijuana on the basis of "affordability". Instead, the evidence shows that the Plaintiffs, who all had the means to establish home grow operations, also have the financial capacity to afford medically justifiable quantities of marijuana to treat their symptoms. Furthermore, what the Plaintiffs characterize as an "inability" to access marijuana from Licensed Producers is in fact a simple unwillingness to do so based on their personal preferences and attitudes.

7. Similarly, the Plaintiffs led no persuasive evidence to show how reasonable access to marijuana for medical purposes would be compromised by the MMPR's limits on production locations, possession amounts or the forms of marijuana that can be produced.

8. Consequently, the Plaintiffs have not established that the MMPR violate their s. 7 *Charter* rights. To the contrary, the evidence before the Court demonstrates that the MMPR represent a considered and valid policy choice that achieves legitimate health and public safety objectives, and does not impede patients' reasonable access to medical marijuana. As this policy choice is lawful and constitutionally sound, the Plaintiffs' action should be dismissed.

PART II: STATEMENT OF FACTS

A. REGULATORY FRAMEWORK

Drug Regulation in Canada

9. In Canada, drugs and controlled substances are regulated primarily by way of the *Controlled Drugs and Substances Act*[1] ("CDSA"), the *Food and Drugs Act*[2] ("FDA"), and their related regulations. Cannabis is a drug under the FDA, a controlled substance scheduled under the CDSA and a narcotic subject to the *Narcotic Control Regulations* ("NCR").

10. The fundamental objective of the CDSA is the maintenance and promotion of public health and safety.[3] The CDSA does so mainly by prohibiting possession, trafficking, and production of the substances listed in its schedules, one of which is cannabis.[4] These activities are illegal unless authorized in the CDSA's Regulations. These include the MMPR[5] and its now repealed predecessor, the *Marihuana Medical Access Regulations* ("MMAR").[6]

11. Canada has international obligations with respect to controlled substances under three United Nations Conventions. The Conventions oblige State parties to put in place a legislative framework that requires the licensing or authorization of persons conducting activities with controlled substances, the issuance of permits authorizing the movement of controlled substances into and out of the country, and the appropriate penalization of unauthorized activities. The State parties to the Conventions, including Canada, have agreed to give effect to the Conventions' terms within their jurisdictions and to cooperate with other signatories in achieving the Conventions' objectives.[7] Canada meets these obligations through the CDSA.[8]

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[1] *Controlled Drugs and Substances Act*, SC 1996, c 19 ("CDSA")
[2] *Food and Drugs Act*, RSC 1985, c F-27.
[3] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44 [***PHS***], paras. 37-41
[4] *CDSA*, Part I, ss. 2(1), 4, 7, and Schedule II.
[5] *Marihuana for Medical Purposes Regulations*, SOR/2013-119 ("MMPR").
[6] *Marihuana Medical Access Regulations,* SOR/2001-227 ("MMAR") at Affidavit #4 of Jeannine Ritchot sworn January 15, 2015 ("Ritchot Aff"), Joint Book of Exhibits ("JBE") Vol. 5, Ex. "A", pp. 1602-1645; CDSA, s.55; Affidavit #1 of Eric Ormsby sworn January 15, 2015 ("Orsmby Aff."), JBE Vol. 4, Tab 27, p. 1284, para.8; see also Affidavit #1 of Jocelyn Kula sworn January 15, 2015 ("Kula Aff."), JBE Vol. Vol. 3 Tab 26, p. 1043 para. 52 describing the *Narcotic Control Regulations*
[7] Kula Aff, JBE Vol. 3, Tab 26, p. 1033, paras.8 and 10
[8] Kula Aff, JBE Vol. 3, Tab 26, p. 1038, para. 29

12. Cannabis, its preparations (including cannabis resin), derivatives (including, tetrahydrocannabinol ("THC") and delta-9-tetrahydrocannabinol) are listed as controlled substances under the Conventions and in Schedule II of the CDSA.[9]

13. The objective of the FDA is to protect the health and safety of Canadians by regulating drugs and food through establishing standards for manufacturing, labelling, and advertising.[10] The FDA also establishes rigorous processes to ensure that drugs made available for therapeutic use meet certain safety, efficacy, and quality standards.[11] Cannabis is classified as a drug under the FDA. Furthermore, the FDA applies to marijuana grown by Licensed Producers under the MMPR. The *Food and Drug Regulations*[12] ("FDR") set out a specific framework for authorizing the sale of drugs in Canada. However, the FDR do not apply to the MMPR, which have their own prescribed good manufacturing practices.[13]

14. The *Natural Health Products Regulations* ("NHPR") govern the sale, manufacture and distribution of natural health products, such as those derived from plants and herbs. The NHPR expressly exclude controlled substances such as marijuana because those substances may produce harm to health and to society when diverted or misused.[14]

The Previous Medical Marijuana Regime

15. As of 1999, it was possible for individuals in Canada to possess marijuana for use as medicine by way of s. 56 of the *CDSA*. Section 56 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.[15]

16. The decision of the Ontario Court of Appeal in *R. v. Parker* changed this approach.[16] The Court in *Parker* held that the prohibition on marijuana possession under s. 4 of the CDSA was of no force or effect, absent a constitutionally acceptable medical exemption from the

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[9] Kula Aff, Ex "A"; CDSA, Schedule II, JBE Vol 3, Tab 26, p. 1047.
[10] Ormsby Aff, JBE Vol 4, Tab 27, p. 1283, paras.4-8; *AstraZeneca Canada Inc. v. Canada (Minister of Health)*, 2006 SCC 49, paras.12, 39
[11] FDA, ss.8-15 and 30
[12] Food and Drug Regulations, CRC, c. 870 ("FDR")
[13] MMPR, Part 2, Division 4; *Marihuana Exemption (Food and Drugs Act) Regulations*, SOR/2013-120, s.4
[14] *Natural Health Products Regulations*, SOR/2003-196, s.1(1) and Schedule II; CDSA, Schedule II. See also Kula Aff, JBE Vol. 3, Tab 26, p. 1036-37, para. 23-25
[15] Ritchot Aff, JBE Vol 5, Tab 28, p. 1524-25, para.10; Kula Aff, JBE Vol. 3, Tab 26, p. 1044-45,paras. 57-59
[16] *R. v. Parker* (2000), 146 CCC (3d) 193 (ONCA) [***Parker***]

prohibition.[17] It was the view of the Court that s. 56 of the CDSA did not provide an adequate exemption.[18] *Parker* did not establish, however, that there is a constitutional right to the personal production of marijuana for medical purposes and, indeed, no court has ever reached that conclusion. Rather, the jurisprudence has consistently held that the government must provide reasonable access to medical marijuana.

17. The MMAR were created in response to *Parker* and, as discussed below, the MMAR have been amended numerous times over the years.[19] In their final form, however, the MMAR permitted individuals who had the support of a medical practitioner to obtain an Authorization to Possess dried marijuana (ATP) from Health Canada.[20] The MMAR did not set any limit on the daily dosage a doctor could authorize, but the MMAR did impose a cap on the amount of marijuana that an ATP holder could possess at thirty times his or her daily dosage.[21]

18. Under the MMAR, as they were upon repeal, ATP license holders could obtain lawful access to marijuana in one of three ways: (1) through a Personal-Use Production License (PUPL) that permitted the individual ATP license holder to grow a certain quantity of marijuana for his or her own use; (2) through a Designated Person Production License (DPPL) that permitted a person designated by an ATP license holder to produce marijuana for that ATP license holder; or (3) through purchasing dried marijuana directly from Health Canada which had contracted with a private company to produce and distribute medical marijuana.[22]

19. Production of marijuana under a PUPL or DPPL could be conducted only at the site designated on that license. Cultivation could be indoors or outdoors but not both at the same time.[23] The number of plants that could be grown by a person with a production license was calculated using a formula set out in the MMAR which was primarily based on the ATP

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[17] *R. v. Hitzig* (2003), 231 DLR (4th) 104, leave to appeal refused [2004] S.C.C.A. No. 5 [***Hitzig***], para. 1
[18] *Parker*, paras. 109-114. Arguably, this view of s. 56 of the CDSA is no longer correct in light of the Supreme Court of Canada's decision in *PHS* where the Court dismissed the plaintiffs' s. 7 challenge to the CDSA on the basis that s. 56 acts as a "safety valve" that prevents the CDSA from applying where such application would be arbitrary, overbroad or grossly disproportionate.
[19] Ritchot Aff, JBE Vol. 5, Tab 28, p. 1525, para. 11, 12, Ex "A"
[20] Ritchot Aff, JBE Vol. 5, Tab 28, p. 1526, para.15 and p. 1604
[21] MMAR, s.11(3) at Ritchot Aff, JBE Vol. 5, Tab 28, Ex. "A", JBE Vol. 4, p. 1607
[22] Ritchot Aff, JBE Vol. 5, Tab 28, p. 1526, paras.16, 129
[23] MMAR, ss. 1(1), 29, 30, 40, and 52 at Ritchot Aff, JBE Vol. 4, Tab 28, Ex. "A", pp. 1602, 1611-12, 1615

license holders' authorized daily dose.[24] The higher the dose, the greater the number of plants. The MMAR placed no limits on plant size, which meant that there could be a considerable variation in cultivation yields between license holders depending upon the size of the plants they chose to grow and their success as growers.[25] The production licenses also set out the maximum quantity of dried marijuana that could be stored at a production site.[26]

Significant Constitutional Challenges to the MMAR and Related Amendments

20. The first significant challenge to the MMAR following their adoption was *Hitzig v. Canada*. In 2003, the Ontario Court of Appeal found the MMAR unconstitutional for two reasons. First, the Court held that not all ATP holders were able to access marijuana through either the personal or designated production options that were originally available under the MMAR. Second, the Court found that the eligibility requirement that an applicant seeking an ATP be approved by two medical specialists was overly onerous.[27] The MMAR were subsequently amended to permit ATP holders to obtain marijuana from Health Canada and to relax the specialist approval process. [28]

21. Canada's response to *Hitzig* was challenged in *R. v. Long*. The Ontario Superior Court of Justice dismissed the challenge, finding that the *Charter* does not place positive obligations on government, but rather "[w]hat the *Charter* requires is that the Government not unjustifiably hinder access to marijuana for those with a demonstrated medical need."[29] The Court held that the response to *Hitzig* did not hinder access.

22. Similarly, in *R. v. Voss and McDermott,* the Alberta Court of Appeal, in dismissing the appellants' appeals from convictions for possession and production of marijuana, commented that administrative inconvenience did not render the relevant provisions of the CDSA unconstitutional. The Court stated: "The *Charter* is there to protect the fundamental rights of Canadians. Mere administrative inconvenience, or the wish to be free from government

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[24] MMAR s. 30 at Ritchot Aff, JBE Vol. 4, Tab 28, Ex. "A", p. 1611
[25] MMAR, ss.30(2)(a)-(c), *ibid.*
[26] MMAR, ss.30(2)(b) and 31, *ibid.*
[27] *Hitzig,* paras.109-145, 150-151, and 159-160
[28] Ritchot Aff, JBE Vol. 4, Tab 28, Ex. "A", pp. 1650-51, 1669
[29] *R. v. Long* (2008), 240 CCC (3d) 88 (ONSCJ) [***Long***], paras. 40-42

regulation, does not entitle the appellants to pick and choose which statutes will be binding on them."[30]

23. In *Sfetkopoulos v. Canada*, the Federal Court declared the MMAR provision limiting a designated producer to producing for one ATP holder unconstitutional. However, the Court agreed with Canada that the requirements identified in *Parker* and *Hitzig* "do not include an obligation on the part of government to supply marihuana to medical users" and that "what the *Charter* requires is that government not hinder for no good reason those with demonstrated medical need to obtain this substance."[31] In response, the MMAR were amended so that a designated person could produce for up to two individuals.[32]

24. The MMAR were again amended in 2010 as a result of the British Columbia Supreme Court's decision in *R. v. Beren and Swallow.*[33] In this case, the court determined that certain limits on collective cultivation by PUPL and DPPL holders were unconstitutional. In response, Canada amended the MMAR to permit up to four production licences to be issued with respect to the same site.[34]

25. Other aspects of the *MMAR* have been the subject of constitutional challenges, albeit ones that did not result in amendments to the regulations. For example, in *R. v. Mernagh*, the Ontario Court of Appeal upheld the requirement to obtain a doctor's authorization in order to access medical marijuana.[35] In concurring reasons, Doherty J.A. explained that the MMAR were not intended to allow for medical access by "all seriously ill persons who decide that it is in their best interest to use marijuana", nor did the Constitution demand a medical exemption scheme in those terms. [36]

26. The British Columbia Provincial Court held that "compassion clubs" are not constitutionally required in *R. v. Hornby* in part because the object of the CDSA is to regulate the distribution of drugs in Canada as a matter of public health and safety:

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[30] *R. v. Voss and McDermott,* 2013 ABCA 38, para. 7
[31] *Sfetkopoulos v. Canada (Attorney General)*, 2008 FC 33 at paras.1, 7, 19-22, and 27, affirmed 2008 FCA 328, leave to appeal refused [2008] S.C.C.A. No. 531 [***Sfetkopoulos***]
[32] Ritchot Aff, JBE Vol. 4, Tab 28, Ex. "A", p. 1694
[33] *R. v. Beren and Swallow*, 2009 BCSC 429 [***Beren and Swallow***], paras.120, 127, and 135, leave to appeal refused [2009] S.C.C.A. No. 272
[34] Ritchot Aff, JBE Vol. 5, Tab 28, Ex. "A", p. 1703
[35] *R. v. Mernagh*, 2013 ONCA 67, paras. 101-104, leave to appeal refused [2013] S.C.C.A. No. 136 [***Mernagh***]
[36] *Mernagh,* para. 133

> This is a legitimate objective. Providing prohibited products to others opens a Pandora's box of problems for both society and for the provider of that product. Clearly, in the pharmaceutical industry, there are strict controls on who may prepare, prescribe and dispense pharmaceuticals. It would be inappropriate, in my view, for the Courts to allow cannabis marijuana to bypass all of those safety provisions. ...[37]

27. Most recently, the British Columbia Court of Appeal in *R. v. Smith* held that the MMAR were unconstitutional to the extent they allowed for production and possession of dried marijuana only.[38] *Smith* is currently on appeal to the Supreme Court of Canada.

Concerns Surrounding the Previous Medical Marijuana Program

28. Over time, numerous concerns with the MMAR began to surface. The rapid increase in the number of individuals authorized to possess and produce increasingly large amounts of marijuana, most of which was grown in dwelling houses that were not constructed to support large scale production, had unintended negative impacts on public health, safety and security. MMAR program participants also expressed dissatisfaction with the program. Furthermore, the taxpayer-funded program was becoming an administrative and financial burden for Canada.[39]

Exponential Expansion of Possession and Production Licenses

29. In 2002, there were 455 individuals authorized to possess marijuana for medical use; as of December 31, 2013, this number had increased to 37,151. It was estimated that by the end of 2014, the number would increase to over 50,000, and then to 433,688 by 2024. The number of production licenses also grew rapidly. In December 2002, 326 PUPLs had been issued; by December 31, 2013, the number had increased to 28,228, of which over half (16,010) were in British Columbia.[40]

30. Authorized daily dosage amounts also increased dramatically. As of December 31, 2013, the average daily dosage was 18.22 grams per day which, depending on the size of the joint, could equate to 18-37 joints per day.[41] The increase in dosage amounts impacted the number

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[37] *R. v. Hornby*, 2003 BCPC 60, paras. 87-88, citing the ABQB, aff'd 2003 BCCA 635; See also *R. v. Wood*, 2006 NBCA 49, paras.2, 8, 32, and 36-38

[38] *R. v. Smith*, 2014 BCCA 322, appeal as of right [2014] S.C.C.A. No. 378 [***Smith***], paras. 134, 140; See also *R. v. Simpson*, 2006 NSSC 404, paras. 42 and 58

[39] Ritchot Aff, JBE Vol. 4, Tab 28, p. 1532, para. 40

[40] Ritchot Aff, JBE Vol. 4, Tab 28, p. 1532-1534; 1536, paras.41, 45, and 51

[41] Ritchot Aff, JBE Vol. 4, Tab 28, p.1538, para. 54, Ex. "G", JBE Vol. 5, Tab 28, p. 2565

of marijuana plants an individual could legally grow. Under the MMAR formula, an individual with a daily authorized dosage of 18 grams would be permitted to grow 89 plants indoors.[42]

Unsolicited Stakeholder Feedback Regarding the MMAR

31. The MMAR were never intended to permit such widespread, large-scale marijuana production and Health Canada realized over time that the MMAR did not adequately address the public health, safety and security concerns that accompanied personal production.[43] Indeed, Health Canada received a significant amount of correspondence from individuals, communities and government agencies complaining about the negative impacts of the increasing number of residential growing operations.

32. For example, municipalities, law enforcement and fire safety officials advised Health Canada that there were numerous problems associated with these residential growing operations, including fire risks, building code violations, electrical violations, diversion, theft and children's safety.[44] Their concerns were echoed by individuals living in residential communities where personal medical marijuana production was taking place.[45]

Inspections Under the MMAR

33. While the MMAR provided for an inspection regime, the inspection power was inadequate to address these public health, safety, and security concerns. Under the MMAR and the CDSA, Health Canada inspectors required consent or a warrant to enter a dwelling place,[46] and having gained access could then only verify compliance with the MMAR and the terms of a PUPL or DPPL. Health Canada inspectors could not require personal cultivators to operate safely or hygienically, or to cultivate a quality, uncontaminated product.

34. Inspection was not only difficult, but costly and less than effective. Health Canada estimated that if inspections of all residential growing operations in existence as of 2013 were to take place, it would have cost over $55 million in that single year. This annual cost would

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[42] Ritchot Aff, JBE Vol. 4, Tab 28, p. 1537, para.54
[43] Ritchot Aff, JBE Vol. 4, Tab 28, p. 1540, paras.60-61
[44] Ritchot Aff. JBE Vol 4, Tab 28, p. 1540-1545, paras.62-78, Ex. "J", JBE Vol. 5, p. 2792
[45] Ritchot Aff. JBE Vol 4, Tab 28, p. 1546-1555, paras.80-104, Ex. "J", JBE Vol 5, p. 2792
[46] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1555.paras.105-107; MMAR, s. 57(2); CDSA s. 31(2)

have continued to escalate because of the projected growth in the number of individuals authorized to possess and cultivate marijuana under the MMAR.[47]

***Program Participant Dissatisfaction with the* MMAR**

35. Program participants expressed dissatisfaction with the MMAR application process, with Health Canada's involvement in their medical decision-making, and with the single strain of marijuana available from Health Canada's supplier. For example, Mr. Allard expressed his intense dislike of the requirement to apply to Health Canada for authorization to possess and produce marijuana.[48] The rapid expansion of the MMAR also caused a spike in applications for ATPs and license approvals that resulted in longer wait times for which Health Canada had to make administrative adjustments to manage.[49]

***Cost of Administering the* MMAR**

36. The administrative cost of running the MMAR Program and supplying dried marijuana became significant as the program rapidly expanded. In 2005 to 2006, the cost of the Program was under $5 million per year. By 2012, that cost was projected to increase to more than $15 million per year. Further, the most recent contract between Health Canada and its authorized supplier had a value of $16.8 million for a three-year period, ending on March 31, 2013. An additional option year was exercised, the cost of which was estimated at $9.7 million. Health Canada also subsidized the cost of its marijuana at about 50% of the product cost, including shipping. Many individuals were also in arrears to Health Canada for their purchases of dried marijuana; as of July 31, 2014, these outstanding accounts totaled approximately $1.5 million.[50]

Government Regulatory Reform Initiative and Consultation

37. The rapid expansion of the medical marijuana program and the attendant problems required a reassessment of the ways in which Canada could provide reasonable access to marijuana for medical purposes for persons with an established medical need. In 2010, Health

[47] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1556-57, paras.108-111, Ex. "K," JBE Vol. 5, p. 2931
[48] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1527, paras. 19, p. 1561, para. 122; Ex. "B", JBE Vol. 5, p. 1712
[49] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1562-63, paras. 125-126
[50] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1563, paras.127-129, p. 1564-65, para 134, Ex. "F", JBE Vol. 6, p.2378

Canada outlined the objectives that would guide the development of a new medical marijuana regime. The new regime was intended to reflect certain key principles, including:

(a) treating marijuana as much as possible like any other medication;

(b) restoring Health Canada to its traditional role of regulator and eliminating the government role in supplying and distributing marijuana for medical purposes;

(c) creating a new supply and distribution system using fully regulated, inspected, and audited Licensed Producers;

(d) phasing out personal and designated production and instituting mechanisms for compliance and enforcement;

(e) reducing the risk of abuse and exploitation of the regulatory regime and improving the way program users access marijuana for medical purposes;

(f) addressing the public health and safety risks that police, fire authorities, and municipalities had expressed to Health Canada; and

(g) providing physicians with up to date information on the use of marijuana for medical purposes.[51]

38. In developing a new regulatory framework, Health Canada considered and analyzed various issues, including: the potential role of pharmacies and product distribution generally; the range of health care practitioners that could be authorized to support access to marijuana for medical use; indoor versus outdoor cultivation of marijuana; labelling and quality assurance requirements; physical security requirements; price regulation; possession limits; proof of lawful possession; the limitation to dried marijuana; business models for Licensed Producers; security screening; and the need for Licensed Producers to interact with local authorities.[52]

39. Health Canada conducted public consultations on the new regulatory framework in three phases: (1) online consultation (the "First Process"); (2) consultation meetings with key stakeholders (the "Second Process"); and (3) consultation following the publication of the draft MMPR in the Canada Gazette, Part I (the "Third Process").[53]

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[51] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1565, para.136, p. 1567, para.141
[52] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1568-73, paras.143-145, Exs. "P"-"GG", JBE Vol. 6, p. 3044-3212
[53] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1573-74, para. 146

40. The First Process took place over 45 days during which anyone could provide input online regarding reform of the medical marijuana regime. Health Canada received and considered a wide range of perspectives.[54]

41. In the Second Process, Health Canada held consultation meetings with targeted stakeholders, including face-to-face meetings with provincial and territorial ministries of health and public safety, municipalities, law enforcement and fire officials, medical associations, pharmacists' associations, prospective Licensed Producers, and compassion clubs.[55]

42. The Third Process took place following publication of the draft MMPR in the Canada Gazette Part I. It entailed both stakeholder input and the provision of a response by Health Canada to the comments that were received. These can be generally summarized as follows:

> (a) Program participants: Program participants raised concerns about the affordability of marijuana and indicated a desire for current growers to be 'grandfathered' under the MMPR. Health Canada, however, was concerned that to do so would allow the public safety risks associated with personal production to persist, particularly given the impracticality of ensuring that the marijuana produced by such growers would be of a quality suitable for ingestion by ill individuals. Health Canada also was aware that prospective Licensed Producers expressed a willingness to consider compassionate pricing for patients with limited financial means.[56]
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> (b) Health care practitioners: Physicians, nurse practitioners, pharmacists, and their respective professional associations expressed concern about the absence of scientific evidence regarding issues such as dosage, as well as safety and efficacy of marijuana for therapeutic purposes. To address these concerns, Health Canada created an Expert Advisory Committee which led to the drafting of an "Information for Health Care Professionals" document to provide guidance. [57]
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> (c) Municipalities, law enforcement, and fire officials: These groups were supportive overall of the new framework, but worried about the lack of remediation and disclosure provisions for ex-MMAR sites. The MMPR require that potential producer applicants notify and provide information to local government, police, and fire officials at various stages of the licensing process.[58]

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[54] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1575-81, paras.148-155, Ex. "HH", "II", "JJ", JBE Vol. 6, p.3213; p. 3224; p. 3226

[55] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1582-87, paras.156-160 and Ex."KK"-"WW", JBE Vol. 6, p. 3524; p. 3697

[56] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1589-90, paras.161-164; Ritchot Transcript, p. 780, ll. 14-21, p. 782, ll. 5-25

[57] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1590-91, paras.166-167, Exs. "XX"-"YY", JBE Vol. 6, p. 3702; p. 3710

[58] Ritchot Aff, JBE Vol. 4, Tab 28, p. 1590-92, paras.168-169, Exs. "ZZ"and"AAA", JBE Vol. 6, p. 3744; p. 3747

(d) Provinces and territories: Concerns were raised about the role of health care practitioners and pharmacists, a need for more education and guidelines for health care professionals, the lack of information on marijuana dosage amounts and strains, and a potential obligation to fund marijuana for medical use. Health Canada noted that the MMPR aimed to treat dried marijuana as much as possible like other narcotics used for medical purposes by creating conditions for a new commercial industry that would produce and distribute dried marijuana. Licensed Producers would be responsible for setting prices; however, the MMPR would contain conditions necessary to establish a competitive industry, with prices falling over time.[59] Health Canada also removed pharmacists as a dispensing option from the MMPR.

(e) Prospective industry: Comments were received from parties interested in becoming Licensed Producers, including compassion clubs, the majority of which concerned consumer cost for dried marijuana. Other comments pertained to the limit to dried marijuana. Health Canada's view was that the new system would provide a secure, efficient and cost-effective way to provide access to marijuana for medical use while reducing the harms cited by law enforcement, fire officials, and municipalities. The cost to provide access to marijuana for medical use by way of government supply contract or PUPL/DPPL was considered unsustainable. Furthermore, some Licensed Producers were willing to consider compassionate pricing. Finally, the limit to dried marijuana was maintained because there were no clinical studies on the therapeutic use of edibles or topicals, and these were not FDR approved products; persons seeking to access or to make a new cannabis-based drug available in Canada may use existing FDA/FDR processes and FDA approved cannabis products are already available in Canada.[60]

The New Medical Marijuana Regime: the MMPR

43. Following the consultation process described above, the MMPR came into force on June 7, 2013 and for a transitional period the two regulatory schemes operated together, until the MMPR replaced the MMAR upon the repeal of the latter on March 31, 2014. The MMPR authorize three relevant key activities: (1) the possession of dried marijuana for medical use by individuals who have the support of an authorized health care practitioner; (2) the production of dried marijuana by regulated Licensed Producers; and (3) the sale and distribution of dried marijuana by Licensed Producers to authorized individuals.[61]

a) Possession under the MMPR

44. Like the MMAR, the MMPR allow authorized individuals to possess dried marijuana. Unlike the MMAR, however, authorization is provided exclusively by medical practitioners.

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[59] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1592-93, paras.171-172
[60] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1593-94t, paras.173-176, Ex. "BBB", JBE Vol. 6, p. 3767
[61] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1597, para. 182

Health Canada approval is no longer necessary.[62] Individuals who are authorized to consume marijuana for medical use may obtain dried marijuana from a licensed producer with which they are registered. Under the MMPR, an individual must not possess more than either 30 times the daily quantity outlined in the medical document or 150 grams, whichever is less.[63]

b) Production under the MMPR

45. Either an individual or a corporation is eligible to be a licensed producer; however, a number of conditions have to be met before a license will be issued.[64] The MMPR impose various health and safety requirements on Licensed Producers.[65] In particular, the marijuana they cultivate must be tested for contaminants and active ingredients.[66] It cannot be treated with pest control products other than those registered or otherwise authorized for use under the *Pest Control Products Act*.[67] A licensed producer must also establish and maintain a system that permits the recall of marijuana made available for sale.[68]

46. Strict security measures at production sites are also required by the MMPR, including site and video monitoring, employee security clearances, physical barriers, records of access, and intrusion detection systems.[69] Health Canada may conduct warrantless, unannounced inspections of Licensed Producers for compliance with the MMPR.[70]

c) Sale and Distribution under the MMPR

47. Under the MMPR, the primary means of distributing marijuana is directly from a licensed producer to the registered client using secure shipping methods.[71] A licensed producer must abide by strict packaging and shipping protocols.[72] For instance, the marijuana must be securely packaged with a label that includes such information as the expiry date, the THC and CBD levels and a warning to keep the product away from children.[73] Licensed Producers

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[62] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1599, para. 187
[63] MMPR, s. 5
[64] MMPR, ss.21-40; Affidavit #2 of Todd Cain sworn January 15, 2015 ("Cain Aff."), JBE Vol. 7, Tab 29, p. 4050, para.10 and Exs. "B"-"D", Vol. 7, p. 4071-4118
[65] MMPR, Division 4
[66] MMPR, s. 53
[67] MMPR, s. 54
[68] MMPR, s. 59
[69] MMPR, Division 3
[70] Cain Aff. JBE Vol. 7, Tab 29, p. 4061-62, para. 42; MMPR, ss.9, 26, 41-51 and 89-100
[71] MMPR, s. 122
[72] MMPR, Division 5
[73] MMPR, ss. 64-66

are also not permitted to deliver to clients in any 30-day period a total quantity of marijuana exceeding 30 times the daily quantity referred to in the client's medical document.[74]

Medical Marijuana Regulations in Other Jurisdictions

a) Israel

48. Marijuana for medical use is available to patients in Israel who obtain a license from the Health Ministry. As of July, 2014 there were over 17,000 licensed users of marijuana for medical purposes.[75] While Israel previously permitted licensed patients to grow marijuana for medical use in their residences, they have moved to a commercially licensed producer system because of health and safety concerns.[76]

49. The Health Ministry has licensed eight private entities to grow marijuana and permits distribution through three hospitals by way of direct delivery. The licensed growers are allowed to charge patients a fixed price of about $100 USD per month, regardless of the amount of marijuana supplied.[77]

50. Israel permits marijuana to be used for only certain medical conditions.[78] Physicians in Israel may recommend marijuana for medical use starting at 20 grams per month. The dose can then be increased, with the support of a physician, up to a maximum dose of 100 grams per month.[79] Requests for dosages exceeding 100 grams per month may be submitted to the Health Ministry if they meet certain requirements. Dosages for patients in Israel average about 30 grams per month or one gram per day.[80]

51. Licensed individuals may purchase marijuana in the form of cannabis buds or cannabis oil (extract), and children who require marijuana for medical purposes are provided with cannabis cookies made using dried cannabis.[81] Cannabis oil was introduced for religious reasons.[82] As of 2014, there were eight varieties of cannabis buds, six varieties of cannabis

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[74] MMPR, ss. 121-124, and 129(1)(d)
[75] Affidavit of Yehuda Baruch made on October 26, 2014 ("Baruch Aff"), JBE Vol. 10, Tab 37, p. 5949
[76] Baruch Aff, JBE Vol. 10, Tab 37, pp. 5947-48; Baruch Transcript, p. 1607, ll. 25-p. 1609, ll. 1
[77] Affidavit of Richard Bardenstein made on October 20, 2014 ("Bardenstein Aff"), JBE Vol. 11, Tab 57, p. 6318-19, para.17, p.6332, para. 28; Baruch Aff, JBE Vol. 10, Tab 37, p. 5947-48
[78] Bardenstein Aff, JBE Vol. 11, Tab 57, p. 6327-29,para.24; Baruch Aff, JBE, Vol. 10, Tab 37, p. 5946-47
[79] Baruch Aff, JBE Vol. 10, Tab 37, p 5945-46
[80] Bardenstein Aff, JBE Vol. 11, Tab 57, p. 6332, para.29; Baruch Aff, JBE Vol. 10, Tab 37, pp. 5945-46, 5948-49
[81] Baruch Aff, JBE Vol. 10, Tab 37, p.5945-46
[82] Baruch Transcript, p. 1609, ll. 21-28, p. 1610, ll. 1-7

oil, and five varieties of cannabis cookies with varying levels of active ingredients (THC and CBD). [83]

b) The Netherlands

52. Since September 2003, marijuana for medical use in the Netherlands has been regulated by the Dutch government's Office/Bureau for Medical Cannabis ("BMC").[84] It requires medical marijuana to be prescribed by physicians and dispensed by pharmacists.[85] When prescribing marijuana to a patient, the physician must include in the prescription the amount prescribed, a description of the method by which the patient should consume the marijuana, and the maximum amount that the patient may use in a 24-hour period.[86]

53. While there are no statutory restrictions regarding dosages or the medical conditions for which marijuana can be prescribed, the government has provided recommendations on these matters.[87] The BMC recommends that the initial dose be low and that it can subsequently be increased.[88] The BMC estimates that average daily dose of medical marijuana in the Netherlands is about 0.68 grams per patient.[89] The BMC also recommends that marijuana only be used if treatment with registered pharmaceuticals is not effective or has too many side-effects.[90]

54. Due to patient health and safety concerns, as well as concerns regarding diversion, medical marijuana is not permitted to be grown in residences and, instead, can only be grown by a company that has an agreement with the Minister of Health.[91] There are various rules and regulations in place concerning the production and supply of medical marijuana in the Netherlands, including standards for production and quality.[92] This stands in contrast to the

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[83] Bardenstein Aff, JBE Vol. 11, Tab 57, paras.22-23; Baruch Aff, JBE Vol. 10, Tab 37, pp. 5945-46
[84] Affidavit of Catherine Sandvos made on January 20, 2015 ("Sandvos Aff"), JBE Vol. 11, Tab 53, p. 6060, para. 7
[85] Sandvos Aff, JBE Vol. 11, Tab 53, p. 6062, para. 15, p. 6064, para. 22
[86] Affidavit of Hendrik J. van den Bos dated October 13, 2014 ("van den Bos Aff"), JBE Vol 12, Tab 64, p.6987, para 8
[87] van den Bos Aff, JBE Vol 12, Tab 64, p.6987-88, paras. 9-11
[88] *Ibid.*
[89] Sandvos Aff, JBE Vol. 11, Tab 53, p. 6064, paras. 23-25, Ex. "C", JBE Vol. 11, Tab 53, p. 6088
[90] van den Bos Aff, JBE Vol 12, Tab 64, p.6988-89,para.16; Sandvos Aff. JBE Vol. 11, Tab 53, p. 6062-63, paras.17-18, Ex. "B", JBE Vol. 11, Tab 53, p. 6081
[91] Sandvos Aff, JBE Vol. 11, Tab 53, p. 6060, para. 8, p. 6063-64, paras, 19-20 ; Sandvos Transcript, p. 1729, ll. 27- p. 1730, ll. 19
[92] Sandvos Aff, JBE Vol. 11, Tab 53, p. 6067-70, paras.34-51, Exs. "D"-"H", JBE Vol. 11, Tab 53, p. 6094-6177; van den Bos Aff. JBE Vol 12, Tab 64, p.6989, para.20

marijuana that is available through so-called "coffee shops", which are not subject to any quality controls or production practices.[93]

55. There are currently five varieties of dried marijuana for medical use available for patients in the Netherlands, each with different THC and CBD contents.[94] The BMC makes available only a small number of varieties for reasons of cost and efficiency.[95] The BMC also understands that patient preference for a particular variety is a matter of taste that is unrelated to efficacy.[96] Once patients receive their marijuana from the pharmacy, they may ingest it using any method; the BMC recommends ingesting it using tea or inhaling a few puffs once or twice daily.[97] The Netherlands is currently working to permit the prescription of cannabis oil which will be prepared in a standardized manner for patients by pharmacies. This product is intended primarily to treat children with epilepsy.[98]

56. Marijuana for medical use is set at a fixed price of 38 Euros for 5 grams (not including taxes or pharmacy costs).[99] The price is determined by calculating the cost to make marijuana available to patients.[100]

c) The United States

57. United States federal law does not permit marijuana to be used for medical purposes. Nonetheless, many states have adopted laws that permit such use.[101] Marijuana and THC are both listed as schedule I substances under the federal *Controlled Substances Act* (CSA), which is the most restrictive schedule. A schedule I substance under the CSA is one for which there is currently no accepted medical use and has a high potential for abuse. Unless otherwise provided for in the CSA, cultivating, distributing, or possessing any amount of such a substance is prohibited and can be sanctioned by both criminal and civil penalties.

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[93] Sandvos Aff, JBE Vol. 11, Tab 53, p. 6059, para.5, p. 6061, para. 12 and p. 6070-71, paras. 52-53, Ex. "A", JBE Vol. 11, Tab 53, p. 6072
[94] Sandvos Aff, JBE Vol. 11, Tab 53, p. 6065, para. 26
[95] Sandvos Aff, JBE Vol. 11, Tab 53, p. 6065, para. 27
[96] Sandvos Aff, JBE Vol. 11, Tab 53, p. 6065, para. 27
[97] van den Bos Aff, JBE Vol 12, Tab 64, p.6988 paras.12 and 14; Sandvos Aff, JBE Vol. 11, Tab 53, p. 6061, paras.10-11, p. 6062, paras. 13-14 and p. 6065, paras 26-27 and Ex. "B", JBE Vol. 11, Tab 53, p. 6081
[98] Sandvos Aff, JBE Vol. 11, Tab 53, p. 6062, para. 13; Sandvos Transcript, p. 1772, ll. 5-26
[99] Sandvos Aff, JBE Vol. 11, Tab 53, p. 6066, paras. 28-29
[100] *Ibid.*
[101] Affidavit of Lynn Whipkey Mehler made on October 20, 2014 ("Mehler Aff"), JBE Vol. 12, Tab 62; Affidavit of Robert Mikos made on October 10, 2014 ("Mikos Aff"), JBE Vol. 10, Tab 36

The federal laws pertaining to marijuana are not affected by state laws, and can be enforced notwithstanding contrary state laws.[102]

58. Thirty-five states in the United States have enacted laws permitting the use of marijuana for medical purposes.[103] Of these 35 states, 15 permit patients or their caregivers to grow marijuana for medical use. Most of these states also permit the manufacture or cultivation of marijuana by other sources, such as through dispensaries. Nearly all of these states impose restrictive limits on the amount permitted to be possessed and/or grown.[104]

59. Of the states that do not permit the personal production of marijuana for medical use, the majority provide for alternative sources of obtaining marijuana, such as by way of state-registered dispensaries. The remaining states do not provide an alternative source for obtaining marijuana, which effectively prevents patients from obtaining marijuana for medical use from legal sources within the state. [105]

60. Some of the states that permit marijuana for medical use have restricted the form of marijuana available or the medical conditions for which marijuana may be used. These states generally either exclude from their programs hashish or potent THC products, or limit their programs exclusively to low-THC products.[106]

61. Two trends have emerged in the permissive states. The first is that states are increasingly prone to authorize commercial cultivation centres to supply marijuana for medical use to qualified patients. The second is that it is increasingly common for states to ban or limit personal cultivation of marijuana for medical use by qualified patients. [107] The emergence of these trends can be traced back to the federal government's announcement in 2009 of its willingness to respect state marijuana policy decisions. This shift in the federal government's stance enabled states to choose a supply model without fear of federal reprisal.[108]

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[102] Mehler Aff, JBE Vol. 12, Tab 62, p. 6895, paras. 9-10, p. 6898-6900, paras 19-23
[103] Mehler Aff, JBE Vol. 12, Tab 62, p. 6901, para. 26
[104] Mehler Aff, JBE vol. 12, Tab 62, p. 6900 para. 24, p. 6901, para. 27, p. 6908, para. 35
[105] Mehler Aff, JBE Vol. 12, Tab 62, p. 6900 para. 24, p. 6901-12, paras. 26-43
[106] Mehler Aff, JBE Vol. 12, Tab 62, p. 6908-12, paras. 36-44
[107] Mikos Aff, JBE Vol. 10, Tab 36, p. 5903,paras. 2, p. 5913-15, paras. 37-45
[108] Mikos Aff, JBE Vol. 10, Tab 36, p. 5904, para.4, p. 5916-19, paras. 46-57

B. MARIJUANA CONSUMPTION

Medicinal Value of Marijuana

62. All of the experts in this proceeding agree that marijuana does have some medicinal value for certain individuals, particularly in terms of offering pain relief, reducing nausea and stimulating appetite.[109] However, the benefits of using marijuana as a medicine should not be overstated given the current levels of scientific knowledge and the limited research that has been conducted on marijuana as a medicine.[110] While marijuana is an "ancient drug", the way it works as medicine in the human body has only recently been studied and, to date, very few clinical trials have tested the medical utility of marijuana.[111] For these reasons, marijuana is not generally considered a drug of first choice for the treatment of many of the conditions for which it may be useful; it is generally accepted that other drugs of known composition with standardized dosages available by prescription should be tried first.[112]

63. In other words, marijuana is not a "miracle drug" or a panacea for all ailments.[113] Some of the Plaintiffs' unbridled enthusiasm for marijuana appears to far surpass the available scientific evidence of its efficacy and, in the absence of medical records, it is not possible to ascertain the objective effectiveness of marijuana on any of their medical conditions.

Risks of Consuming Marijuana

64. It is generally accepted that the consumption of marijuana poses risks to human health. In *R. v. Malmo-Levine*, the Supreme Court of Canada discussed some of the health risks posed to "chronic users" of marijuana (which, by definition, would include those, like the Plaintiffs, who use marijuana on a daily or near-daily basis). These risks include respiratory diseases associated with smoking, psychological dependence, amotivational syndrome and subtle forms of cognitive impairment such as attention and memory problems.[114] The existing studies demonstrate that marijuana should not be used at all by persons under the age of 18,

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[109] Affidavit of Harold Kalant sworn September 30, 2014 ("Kalant Aff."), JBE, Vol. 12, Tab 61, pp. 6811-6817; Affidavit of David Pate sworn October 29, 2014("Pate Aff."), JBE, Vol. 2, Tab 15, pp. 608-609; Affidavit of Paul Daeninck sworn October 27, 2014 ("Daeninck Aff."), JBE, Vol. 11, Tab 58, pp. 6353-6355; Affidavit of Carolyn Ferris sworn December 18, 2014, JBE Vol. 13, Tab 69, p. 7371; Baruch Aff., JBE, Vol. 10, Tab 37, p. 5946-5947

[110] Kalant Aff, JBE, Vol. 12, Tab 61, p. 6810-6816

[111] Baruch Transcript, p. 1640, ll. 14-22; Kalant Aff, JBE, Vol. 12, Tab 61, pp. 6810-6811, 6831-6832

[112] Kalant Aff, JBE, Vol. 12, Tab 61, p. 6809

[113] Baruch Transcript, p. 1639-1640, ll. 18-28 and 1-23

[114] *Malmo-Levine*, paras. 3, 41-43; Kalant Aff, JBE, Vol. 12, Tab 61, pp. 6822-6827

by patients with severe cardio-pulmonary disease or those who suffer from schizophrenia.[115] Marijuana is also not recommended for women who are pregnant, breastfeeding or of childbearing age who are not using a reliable contraceptive.[116]

65. No one has filed a submission with Health Canada to have dried marijuana approved for use as a medication in Canada under the FDA drug approval process that is meant to ensure the efficacy and safety of pharmaceuticals consumed by Canadians.[117] Instead, the need to provide reasonable access to marijuana for medical purposes has occurred as a result of jurisprudence. There is a need for studies of adverse effects in long-term users of marijuana for medical purposes and until the results of such studies are known, it is prudent to take a cautious approach in the authorization of marijuana for medicinal use.[118]

Medically Appropriate Dosages of Marijuana

66. All of the experts in this proceeding agree that, for the vast majority of individuals, the medically appropriate maximum dosage of marijuana should not exceed five grams per day.[119] Dosages beyond this amount do not provide any additional therapeutic benefit and may result in adverse effects.[120]

67. The limited available literature on medically appropriate dosages suggests that the average medically appropriate dosage of marijuana actually ranges from just one to three grams per day.[121] This range is consistent with the consumption amounts in the Netherlands (0.68 grams per day) and Israel (appx. 1 gram per day), as well as the amounts ordered from Health Canada under the MMAR (appx. 1 – 3 grams per day) and Licensed Producers under the MMPR (appx. 1 gram per day).[122]

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[115] Kalant Aff, JBE, Vol. 12, Tab 61, pp. 6822-6827; Ritchot Aff, JBE, Vol. 5, Tab 5G, pp. 2653-2665
[116] Kalant Aff., JBE, Vol. 12, Tab 61, pp. 6827, 6833; Ritchot Aff, JBE, Vol. 5, Tab 5G, pp. 2650, 2657
[117] Three cannabis products have been approved for use in Canada pursuant to the FDA process: Cesamet; Sativex; and, Marinol. See Ormsby Aff, JBE Vol. 4, Tab 27, p. 1299, para. 55
[118] Kalant Aff, JBE, Vol. 12, Tab 61, p. 6822
[119] Kalant Aff, JBE, Vol. 12, Tab 61, p. 6832; Baruch Aff, JBE, Vol. 10, Tab 37, p. 6354; Ferris Aff, JBE, Vol. 13, Tab 69, p. 7371; Daeninck Aff, JBE, Vol. 11, Tab 58, p. 6354, para. 34; Affidavit of Robert Clarke sworn December 20, 2014, JBE, Vol. 13, Tab 68, p. 7322
[120] Kalant Aff, JBE, Vol. 12, Tab 61, p. 6832; Baruch Aff, JBE, Vol. 10, Tab 37, p. 5951
[121] Ritchot Aff, JBE, Vol. 4, Tab 28, p. 1538, para. 55, Ex. "G", Vol. 5, p. 2595
[122] Sandvos Aff, JBE, Vol. 11, Tab 53, p. 6090; Baruch Aff, JBE, Vol. 10, Tab 37, p. 5950; Ritchot Aff, JBE, Vol. 4, Tab 28, p. 1539, para. 56; Cain Transcript, p. 923, ll. 6-22

Methods of Consuming Marijuana

68. Marijuana can be consumed in multiple ways, of which the most common involve inhalation (through smoking or vaporizing) or ingestion (through orally consuming marijuana in edibles, teas or oils). A less common method is to apply a marijuana infused salve or lotion to the skin.[123]

69. There is little scientific research regarding the advantages and disadvantages of these various methods, although there appears to be a consensus that inhalation will result in a more rapid onset and dissipation of marijuana's effect than is the case with ingestion.[124] 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.[125] Several of the witnesses also testified that there is little to no difference between the quantity of marijuana a patient must consume through inhalation to obtain relief compared with the quantity of marijuana a patient must consume orally to obtain the same effect.[126]

Marijuana Strains

70. Marijuana can be grown in different varieties or "strains" that may differ in appearance, taste, smell, etc. These strains are often given colourful names such as "Bubba Kush", "White Berry", "Hash Passion" and "Big Bang".[127]

71. While the Plaintiffs and other advocates of medical marijuana claim, based on their subjective experience, that some strains are more effective, no scientific evidence was led to demonstrate that certain strains are better in terms of treating medical conditions than others.

C. MARIJUANA CULTIVATION

Public Health and Safety Risks of Personal Marijuana Cultivation

72. The parties are in general agreement that cultivation of marijuana in a residential setting poses certain inherent public health and safety risks, including the risk of mould and other

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[123] Kalant Aff, JBE, Vol. 12, Tab 61, pp. 6817-6819
[124] Pate Aff., Schedule C, JBE, Vol. 2, Tab 15, p. 608, para 32; Kalant Aff. JBE Vol. 12, Tab 61, pp. 6817-18
[125] Kalant Aff, JBE Vol. 12, Tab 61, pp. 6817-19
[126] Baruch Aff, JBE Vol. 10, Tab 37, p. 5950; Pate Transcript, p. 615; Kalant Aff, JBE Vol. 12, Tab 61, pp. 6819-20
[127] See, for example, the strains listed by Mr. Davey, Davey Aff, Ex. "A", JBE Vol. 1, Tab 1, p. 3, para. 17

contamination, fire, home invasion, violence, diversion, as well as various negative impacts on the surrounding community.

a) Mould and Contamination

73. Marijuana plants release a significantly larger amount of moisture than most houseplants.[128] This fact, combined with the large numbers of plants that individuals were permitted to grow under the MMAR, means that the risk of mould developing in residential medical marijuana growing operations is significant. The average residential dwelling in Canada was not constructed to deal with the humidity produced by hundreds of marijuana plants.[129]

74. Mould may also develop on the marijuana itself because marijuana, when drying, loses up to 80% of its weight in water.[130] This mould is not always visible and may be consumed by individuals whose health is already compromised. Other contaminants may also be present in or on the marijuana, such as heavy metals or pesticides, which can only be detected through laboratory testing.[131]

b) Fire

75. The production of marijuana, especially in the large quantities authorized under the MMAR, generally involves the use of powerful growing lights, air conditioners, humidifiers and other high voltage equipment that places a strain on residential electrical wiring systems that were not designed for such high loads of consumption.[132] Modifications to the residence's wiring or electrical panel are frequently done in order to accommodate the electrical demands of this equipment.[133]

76. These modifications may pose a significant fire risk if not carried out by certified electricians who obtain all the requisite permits.[134] The available data on the extent of these risks shows that a high percentage of residential medical marijuana growing operations that

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[128] Affidavit of David Miller sworn October 3, 2014 ("Miller Aff."), JBE, Vol. 12, Tab 63, p. 6930-31
[129] Miller Aff, JBE, Vol. 12, Tab 63, p. 6931-32; Affidavit of Len Garis sworn October 8, 2014 (Garis Aff.), JBE, pp. 4895-4896, para. 155-158
[130] Colasanti Transcript, p. 488, ll. 4-12; Affidavit #2 of Shane Holmquist sworn October 9, 2014 ("Holmquist Aff."), JBE, Vol. 8, Tab 30, p. 4382, para. 25; Miller Aff, JBE, Vol. 12 Tab 63, pp. 6934-6936
[131] Colasanti Transcript, p. 489-90, ll 12-28 and 1-2; Nash Transcript, p. 1959, ll. 16-20
[132] Garis Aff, JBE, Vol. 9, Tab 31, pp. 4855-4866, paras. 50-73; Holmquist Aff, JBE, Vol. 8, Tab 30, paras. 128-129
[133] Garis Aff, JBE, Vol. 9, Tab 31, p. 4858, para. 59
[134] Garis Aff, JBE, Vol. 9, Tab 31, pp. 4855-4866, paras. 50-73; pp. 4893-95, para. 145-154

were inspected in Surrey, British Columbia, had deficiencies in their electrical wiring or panels.[135] It is reasonable to expect that a significant portion of MMAR growing operations across the country have similar deficiencies.

c) Home Invasion and Violence

77. Residential marijuana growing operations, whether legal or illicit, are at risk of home invasions and theft because of the monetary value of marijuana. There have been instances in which these "grow rips" have resulted in serious injuries to the occupants of the residence.[136]

78. The evidence as a whole, including the Plaintiffs' own testimony, substantiates the risk of these "grow rips". Mr. Allard and Mr. Davey, as well as the Plaintiffs' expert on marijuana cultivation, each explained that they installed comprehensive security systems at their growing operations in an attempt to prevent such thefts.[137]

d) Diversion

79. Diversion of medical marijuana occurs when an individual who is authorized to produce marijuana under a PUPL or a DPPL chooses to share with or sell a portion of their production. The Plaintiffs acknowledge that diversion occurred under the MMAR; in fact, Mr. Allard admitted that he on occasion would consume excess marijuana produced by other individuals under their own authorizations at their collective growing facility, and Mr. Davey believed that one of his previous designated growers was abusing his license by diverting marijuana to the illicit market.[138] The Plaintiffs' cultivation expert, Remo Colasanti, testified that "sharing" is common in the medical marijuana community.[139]

80. The evidence also shows that the diversion of medical marijuana to the illicit market under the MMAR was difficult for law enforcement to detect because of the "cover" provided

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[135] Garis Aff, JBE, Vol. 9, Tab 31, pp. 4894-4895, paras. 147-154
[136] Holmquist Aff, JBE, Vol. 8, Tab 30, pp. 4434-4442, paras. 139-147
[137] Davey Aff, JBE, Vol. 1, Tab 1, p. 19, paras. 22, 33, 43; Davey Transcript, pp. 73-74; Allard Affidavit, JBE, Vol. 1, Tab 5Aa, pp. 223-224, para. 17; Allard Transcript, pp. 322-25; Alexander Affidavit, JBE, Vol. 1, Tab 2A, pp. 95-96, para. 5; Affidavit of Remo Colasanti sworn October 30, 2014 ("Colasanti Aff."), JBE, Vol. 2, Tab 7, pp. 559-560, paras. 37-40; Colasanti Transcript, pp. 474-475
[138] Allard Aff, JBE, Vol. 1, Tab 5A, p. 215; Allard Transcript, pp. 291-292, ll. 21-28 and 1-7; Davey Transcript, pp. 52-53, ll. 20-28 and 1-7; Davey Aff, JBE, Vol. 1, Tab 1Aa, p. 33, para. 7
[139] Colasanti Transcript, p. 484, ll. 21-22

by the individuals' authorizations to produce and possess.[140] While there is no statistical data on the extent of this problem, the various law enforcement reports before the Court provide evidence that diversion is a real and serious issue.

e) Community Impacts

81. The production of marijuana in residential settings impacts the surrounding community in a number of ways. The strong, skunk-like odour that is emitted during certain stages of the growing process can be overwhelming and neighbours of growing operations complain of illnesses caused by this noxious odour.[141] Even if these odours do not result in illness, they significantly impact the quality of life of neighbouring residents.

82. Property values are also negatively affected by the presence of a home-based marijuana growing operation. The stigma attached to these operations as well as the extensive remediation that is often required once a growing operation is removed, may affect not only the resale value of the residence housing the growing operation but the resale value of neighbouring properties as well.[142]

83. The evidence also shows that it is difficult to obtain home insurance in respect of a residence that contains a marijuana growing operation. This is an issue that affects not only the homeowner but the residents of neighbouring properties.[143]

84. Finally, personal production may expose children and adolescents to marijuana in a home environment. This risk is even more pronounced in the case of marijuana edibles because they often look and smell like non-marijuana cookies, candies, etc.[144]

f) The Plaintiffs' Public Safety Rebuttal Evidence

85. The Plaintiffs' rebuttal evidence fails to undermine the genuineness of these public health and safety risks. Professor Boyd does not dispute the existence of these risks but, instead, claims that they are exaggerated. Professor Boyd posits in her report and in her book, *Killer*

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[140] Holmquist Aff, JBE, Vol. 8, Tab 30, p. 4378, para. 9, p. 4387, para. 49, p. 4388-4429, paras. 58-122; Affidavit of Eric J.M. Nash sworn December 19, 2014 ("Nash Aff."), JBE, Vol. 11, Tab 55, pp. 6267-6268, para. 31

[141] Ritchot Aff, JBE, Vol. 4, Tab 28, p. 1541, para. 64, p. 1547, para. 82, p. 1559, para. 118; p. 1579, para. 153

[142] Ritchot Aff, JBE, Vol. 4, Tab 28, p. 1548, para. 84-85, pp. 1550, 1552, paras. 90, 92, 98, p. 1554, para. 102; Affidavit of Larry Dybvig sworn October 29, 2014 ("Dybvig Aff."), JBE, Vol. 12, Tab 59, pp. 6661-6663

[143] Dybvig Aff, JBE, Vol. 12, Tab 59, pp. 6599-6660

[144] Holmquist Aff, JBE, Vol. 8, Tab 30, para. 92, p. 4403 and Annex W, pp. 4588-4596; Ritchot Aff, JBE Vol. 4, Tab 28, para. 101, p. 1553

Weed, that the news media and first responders have created negative myths about medical marijuana growing operations.[145] However, Professor Boyd offers no concrete evidence that the public health and safety harms associated with medical marijuana residential growing operations do not exist, and her report offers no observations with respect to the actual conditions at these sites. Indeed, there is no evidence that Professor Boyd has even visited a medical marijuana growing operation. Accordingly, no weight should be accorded to Professor Boyd's evidence.

86. In rebuttal, the Plaintiffs also filed the expert report of Mr. Nash, a long-time designated producer under the MMAR. Mr. Nash agreed, in cross-examination, that many of these health and safety risks can occur at medical marijuana growing operations if proper mitigation steps are not undertaken.[146] While he has personally visited 17 or 18 medical marijuana residential growing operations out of the thousands of sites that exist across Canada and claims that each of these sites is free from these risks, his claims are based solely on his personal observations of these sites.[147] He provided no evidence to substantiate these observations and he agreed that does not have the formal training or professional credentials to assess these risks.[148]

87. The Plaintiffs' other rebuttal expert in respect of the issue of public safety risks posed by personal production of marijuana was Tim Moen, a firefighter from Fort McMurray, Alberta, who is also the leader of the Libertarian Party of Canada. In this latter capacity, his campaign slogan was: "I want gay married couples to be able to protect their marijuana plants with guns".[149] Mr. Moen took issue with the conclusion reached by Surrey Fire Chief Len Garis that marijuana grow operations pose genuine public safety risks because, in Mr. Moen's view, Chief Garis is "biased".[150] Mr. Moen, however, has no "expertise" in assessing bias, nor can he point to any practical experience, research or knowledge of marijuana grow operations that would entitle him to reasonably opine on whether Chief Garis' conclusions are flawed. As such, no weight should be afforded to Mr. Moen's rebuttal opinion.

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[145] Affidavit of Susan Boyd sworn December 22, 2014 ("Boyd Aff.), JBE, Vol. 13, Tab 67
[146] Nash Transcript, pp. 1953, ll. 6-11
[147] Nash Transcript, pp. 1956-1957, p. 1965, ll. 12-28, p. 1966, ll. 1-28, p. 1967, ll. 1-13
[148] Nash Transcript, pp. 1950-1952
[149] JBE, Vol. 10, Tab 34, p. 5851
[150] Affidavit of Tim Moen sworn December 19, 2014, JBE, Vol. 10, Tab 32, para. 9, p. 5548

Challenges of Addressing the Risks of Personal Marijuana Cultivation

88. Some of their rebuttal evidence notwithstanding, the Plaintiffs fundamentally accept and concede the existence of the public safety and health risks that are inherent in personal marijuana cultivation. This is demonstrated most clearly by the significant investments made by the Plaintiffs to establish and maintain their grow operations. However, it is not realistic to expect that all individuals who wish to grow medical marijuana for themselves will have the skill, time, financial means and access to infrastructure, equipment and assistance that the Plaintiffs apparently have. Even with these advantages, health and safety risks remain. For example, the Plaintiffs admit that they have never had their medical marijuana tested for the presence of contaminants or levels of active ingredients.

89. Accordingly, if widespread home production of medical marijuana were to be permitted, management of the public safety and health risks would necessitate a system of regulatory oversight involving government imposition of standards for personal marijuana production coupled with an intrusive home inspection regime. However, there are legal and administrative impediments to government oversight of marijuana cultivation in dwelling houses that render such oversight impractical.

a) Legal Impediments to Inspections under the MMAR

90. The vast majority of personal medical marijuana growing operations under the MMAR were housed in dwelling-places. Even in the regulatory inspection context, individuals have an enhanced privacy interest in their homes.[151] Under the MMAR, Health Canada inspectors had to obtain either the consent of the individual or a warrant pursuant to the CDSA in order to inspect growing operations in these residences. The evidence demonstrates the difficulty of obtaining consent from medical marijuana growers to enter their residences.[152]

91. Even if growing operations were located in outbuildings such as garages or barns, similar privacy concerns may apply. The jurisprudence is not settled on the parameters of "dwelling-places" but there is precedent to suggest that individuals may also have an enhanced privacy interest with respect to these types of buildings.[153]

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[151] *R. v. Silveira*, [1995] 2 S.C.R. 297 [***Silveira***], paras. 140, 148
[152] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1556, para. 108
[153] *R. v. Laplante*, [1987] S.J. No. 723 (CA)

b) Administrative Impediments to Inspections under the MMAR

92. By the end of 2013, there were over 30,000 personal or designated production licenses issued under the MMAR and it was not logistically or financially possible for Health Canada to regularly inspect thousands of production sites located in every region of the country. All of the evidence points to increasingly dramatic increases in the number of users of medical marijuana. By 2024, it is likely that there could be as many as 500,000 users and if personal production is permitted to continue, it is reasonable to expect a corresponding increase in the number of residential growing operations.

93. Further, compliance inspections would need to include assessments of various health and safety risks such as fire, mould, contamination, structural damage and so forth. It would be necessary for several different types of inspections with specifically trained inspectors to take place on a regular basis. Such inspections are not economically feasible and would involve the creation of an extensive administrative regime.

Licensed Producer Cultivation of Medical Marijuana

94. The policy solution adopted by the Government of Canada to address the public health and safety risks inherent in the production of medical marijuana is the establishment of a Licensed Producer industry.[154] The MMPR requires prospective Licensed Producers to go through a rigorous application process to demonstrate their capacity to safely produce quality marijuana under conditions which would minimize, if not eliminate entirely, the risks identified above.[155]

95. The MMPR provide for pre-license inspections and once a Licensed Producer is authorized to begin production, they are then subject to inspections by Health Canada to ensure compliance with the MMPR.[156] Such inspections are directed at verifying that Licensed Producers are adhering to good manufacturing practices and are abiding by rigorous security guidelines.[157] Because there are considerably fewer Licensed Producers than personal cultivators, and because they operate as businesses in industrial facilities where there is a lowered expectation of privacy in respect of regulatory inspections by the state,

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[154] Cain Aff. JBE Vol. 7, Tab 29, p. 4050, para. 10, Exs. "B"-"D", Vol. 7, p. 4071-4118
[155] Cain Aff, JBE Vol. 7, Tab 29, p. 4058-59, paras. 32-35
[156] Cain Aff, JBE Vol. 7, Tab 29, p. 4061-4065, paras. 42-56, Exs. "H"-"K", JBE Vol. 7, p. 4242-4365
[157] *Ibid.*

there are fewer practical impediments to government oversight of these commercial operations.

a) Status of the Industry

96. The Licensed Producer regime is still in its infancy and its establishment has taken place in the shadow of the injunction order issued in this case. Licensed Producers were permitted to begin selling dried marijuana on June 7, 2013, when the MMPR came into force.

97. As of early March, 2015, Health Canada had issued licenses to 25 Licensed Producers, 16 of which are currently selling marijuana.[158] Also, 330 applications are in various stages of the Licensed Producer review process. Over the past year, approximately 17,000 authorized users of medical marijuana registered with Licensed Producers.[159] In any given month, there are around 10,000 shipments of medical marijuana from Licensed Producers and the average shipment equates to approximately 1 gram of marijuana per day.[160]

98. Health Canada has conducted rigorous inspections of the Licensed Producers, which have resulted in a number of recalls of defective product.[161] This demonstrates that the new MMPR is achieving its objective of ensuring that patients are given access only to quality controlled medical marijuana.

b) Pricing and Availability of Medical Marijuana

99. Health Canada does not regulate the price of marijuana sold by Licensed Producers although this was an issue considered during the development of the MMPR.[162] Prices offered by the Licensed Producers are the result of a competitive free market structure similar to that of other prescription medications.

100. The continued growth of the market for medical marijuana will result in a decline of the per gram cost of purchasing marijuana from a Licensed Producer.[163] Even over the past year, the prices offered by Licensed Producers have declined. Setting aside the many compassionate and low-income discounts currently offered, prices now range from $1.75 to

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[158] Cain Transcript, p. 926
[159] Cain Transcript, p. 935
[160] Cain Transcript, pp. 917 and 923
[161] Cain Aff, JBE Vol. 7, Tab 29, p. 4066-67, para. 58
[162] Ritchot Aff, JBE, Vol. 4, Tab 28, p. 1593, para. 172; p. 1570, para. 143, Ex. "AA", JBE Vol. 6, p. 3144
[163] Affidavit of Paul Grootendorst sworn October 14, 2014 ("Grootendorst Aff."), JBE, Vol. 11, Tab 54, p. 6181, para. 8, pp. 6182-6195, paras. 13-46

$15 per gram.[164] Individuals who qualify for discount pricing (usually based on income levels) can obtain their medical marijuana at significant price reductions.[165] One Licensed Producer is offering 30 grams a month for free to low income users.[166]

101. Drug insurance plans, both public and private, are beginning to include medical marijuana purchased from Licensed Producers in their prescription drug coverage.[167] It is reasonable to anticipate that as the Licensed Producer regime becomes more established, this coverage will expand to other insurers and provincial drug insurance may also extend to medical marijuana.[168]

102. Health Canada has placed no restrictions on the varieties or "strains" of marijuana that Licensed Producers may offer. Currently, over 100 strains are being cultivated and Licensed Producers have over 300 strains in their collection of seeds or genetic plant stock.[169]

D. THE PLAINTIFFS AND MEDICAL MARIJUANA

103. The Plaintiffs are all individuals who, prior to the repeal of the MMAR, had chosen to access medical marijuana through personal or designated production. Collectively, their evidence constitutes the Plaintiffs' primary "adjudicative facts" upon which their constitutional challenge is based. This evidence relates to three distinct factual backgrounds, as follows:

(a) **Neil ALLARD**: Mr. Allard held both an ATP and a PUPL, and had been accessing marijuana for medical purposes by growing it in the basement of his home residence in Nanaimo.[170] He continues to do so presently pursuant to the interlocutory injunction issued by the Court (Manson J.) on March 21, 2014.

(b) **Tanya BEEMISH** and **David HEBERT**: Ms. Beemish and Mr. Hebert are common law spouses who held an ATP and a DPPL, respectively.[171] Ms. Beemish had been accessing medical marijuana grown for her by Mr. Hebert in the attached garage of their

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[164] Cain Aff, JBE Vol. 7, Tab 29, p. 4060, para. 38, Ex. "G", JBE Vol. 7, p. 4172
[165] Cain Aff. JBE Vol. 7, Tab 29, p. 4060, para. 39, Ex. "G", JBE Vol. 7, p. 4172
[166] Cain Transcript, p. 954, ll. 6-11
[167] Grootendorst Aff., JBE, Vol. 11, Tab 54, p. 6186, para. 26; Wilkins Transcript, p. 1436-1438
[168] Grootendorst Aff, JBE, Vol. 11, Tab 54, p. 6186, para. 26; Grootendorst Transcript, pp. 1871-1873
[169] Cain Transcript, pp. 915-916
[170] Allard Aff, JBE Vol 1, Tab 5, p. 228, para 33-34 and para 13
[171] Beemish Aff, JBE Vol. 1, Tab 4, p. 171, para 13; Hebert Transcript, p. 162 ll. 3-5

former residential townhouse in Surrey.[172] They have since moved to a residence where it is not possible to grow marijuana and Mr. Hebert now chooses to access marijuana for Ms. Beemish by purchasing it illegally on the black market.[173]

c) **Shawn DAVEY** (and Brian Alexander): Mr. Davey held both an ATP and a PUPL, and had been accessing medical marijuana by growing it in an outbuilding located at a property on which he resides in Mission.[174] Mr. Davey shares this production location with a non-plaintiff, Brian Alexander, an ATP and a PUPL holder who assisted Mr. Davey with marijuana cultivation.[175] They continue to cultivate pursuant to the interlocutory injunction order.

Plaintiffs' Use of Medical Marijuana

a) Plaintiffs' Medical History

104. The three plaintiff-patients (Mr. Allard, Ms. Beemish and Mr. Davey) all require medicine to alleviate the symptoms of their conditions.[176] Their preferred medicine is marijuana. That said, no evidence was presented by the Plaintiffs to demonstrate that, from a medical perspective, marijuana is the only medicine they can use to effectively treat their conditions. Indeed, all three Plaintiffs have, at various times, used other medicines to deal with their health issues.[177]

105. Mr. Allard was diagnosed with myalgic encephalomyelitis (chronic fatigue syndrome) and clinical depression in 1995.[178] He suffers from nausea, cramping, gastro-intestinal problems, headaches, pain, fatigue and orthostatic intolerance.[179] While the intensity of Mr. Allard's symptoms has varied over the years, his overall health has, on average, remained stable since 1995.[180]

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[172] Hebert Transcript, p. 226, ll. 4-12
[173] Hebert Transcript, p. 171, ll. 6-24 and p. 173, ll. 17-22
[174] Davey Aff, JBE Vol. 1, Tab 1, p. 34, paras 8- 9; Davey Transcript p. 50, ll. 14-28; p.51, ll.1-18
[175] Davey Transcript p. 50, ll. 14-17 and p. 58, ll. 7-16; Alexander Affidavit, JBE Vol. 1, Tab 1, p. 91, para 1
[176] Allard Aff, JBE Vol. 1, Tab 5, p. 220-221, paras 4-6; Beemish Aff, JBE, Vol. 1, Tab 4, p. 169-170, para 8; Davey Aff, JBE Vol. 1, Tab 1, p. 33, para 6
[177] Allard Aff, JBE Vol. 1, Tab 5, pp. 269-70; Beemish Aff, JBE Vol. 1, Tab 4, p. 170-171, para 11; Davey Aff, JBE Vol. 1, Tab 1, p. 33, para 6
[178] Allard Aff, JBE Vol. 1, Tab 5, p. 220, para 4
[179] Allard Transcript p. 274, ll. 22-28; p. 275, ll. 1-11
[180] Allard Transcript p. 276, ll. 17-24

106. Ms. Beemish was diagnosed with diabetes in 2000 and gastroparesis in 2005.[181] She suffers from nausea, vomiting, pain, lack of appetite, difficulty sleeping, anxiety and depression.[182] Ms. Beemish's condition has steadily worsened over time, and she went on medical disability leave in 2012.[183] More recently, she has been hospitalized for extended periods and there is little prospect that her condition will improve in the near future.[184]

107. Mr. Davey suffered a brain injury as a result of a car accident that took place in 2000.[185] He is in constant pain and has memory problems.[186] While Mr. Davey also expects that these symptoms will persist for the rest of his life,[187] his overall medical condition has been stable since 2000.[188]

b) Plaintiffs' Marijuana Use and Dosages

108. The plaintiff-patients have each chosen to use marijuana to treat their symptoms.[189] While their physicians have agreed to authorize the use of medical marijuana, none of the plaintiff-patients can be said to be under any formal physician-supervised therapy involving medical marijuana. In particular, their doctors all seem to have simply accepted the plaintiff-patients' assertions regarding both their need for medical marijuana and the amount of marijuana they wish to consume as medicine.[190]

109. Mr. Allard started to use marijuana for medical purposes in 1998, which he acquired illegally through a "compassion club". At that time, he was consuming approximately 2 grams per day.[191] In 2004, Mr. Allard received his first ATP whose authorization limits were based on a dosage level of 5 grams per day. In 2006, Mr. Allard's ATP was modified to reflect a dosage level that had doubled to 10 grams per day. Then, in 2012, Mr. Allard's ATP was modified to reflect a further doubling of his dosage level, this time to 20 grams per

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[181] Beemish Aff, JBE Vol. 1, Tab 4, p. 169, para 4
[182] Hebert Transcript, JBE Vol. 1, Tab 3, p. 244, ll. 13-28; p. 245, ll. 1-9
[183] Hebert Transcript, p. 245, ll. 15-26
[184] Hebert Transcript, p. 245, ll. 19-23
[185] Davey Transcript, p. 31, ll. 26-28; p. 32, ll. 4-7
[186] Davey Transcript p. 32, ll. 8-14
[187] Davey Transcript p. 33, ll. 23-26
[188] Davey Transcript p. 33, ll. 8-22
[189] Allard Aff, JBE, Vol. 1, Tab 5, p. 220-221, para 6; Hebert Transcript p. 247, ll. 27-28; p. 248, ll. 1-2; Davey Aff, JBE Vol. 1, Tab 1, p. 33, para 6
[190] Allard Aff, JBE, Vol. 1, Tab 5, p. 190, para 11; Beemish Aff, JBE, Vol. 1, Tab 4; p. 151; Davey Aff, JBE Vol. 1, Tab 1, p. 9, para 11
[191] Allard Transcript, p 277, ll. 22-28; Allard Aff, JBE Vol. 1, Tab 5, p 220-221, paras 6-7; Allard Transcript, p. 282, ll. 11-14

day.[192] However, Mr. Allard testified that his actual current daily use varies between 10 and 20 grams, meaning that his average dose is around 15 grams per day, although he does not actually weigh or otherwise accurately calculate the volume of marijuana he consumes.[193]

110. Ms. Beemish started to use marijuana for medical purposes in around 2005, but only on an occasional basis.[194] In January 2013, Ms. Beemish received an ATP and Mr. Hebert received a DPPL to grow marijuana for her based on a daily dosage of 5 grams per day.[195] Mr. Hebert ceased growing marijuana in September 2013 because they moved to another residence at which cultivation was not possible. They then turned to the black market to purchase marijuana.[196] As of January 2015, Ms. Beemish was consuming an average of 2 grams of marijuana per day. Mr. Hebert purchases this marijuana for her illegally, even though they have the option of purchasing medical marijuana lawfully from a Licensed Producer.[197]

111. Mr. Davey started to use marijuana for medical purposes in 2002.[198] His initial marijuana dosage was 1 or 2 grams per day which he obtained illicitly from friends.[199] In July 2010, Mr. Davey received his first ATP whose authorization limits were based on a dosage level of 10 grams per day. In July 2011, Mr. Davey's ATP was modified to reflect a dosage level of 12 grams per day, and then to 14 grams per day in July 2012. In September 2013, Mr. Davey's final ATP was issued based on a dosage level of 25 grams per day.[200]

112. Mr. Davey explained the enormous increase in his daily dosage from 14 to 25 grams per day on the basis that he had decided to consume some of his marijuana by eating it. Apparently, Mr. Davey's physician has expressed no concern with the quantity of medical marijuana for which he was seeking authorization to possess and produce.[201]

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[192] Allard Transcript p. 285, ll. 10-21
[193] Allard Transcript p. 286, ll. 3-17; p. 290, ll. 12-18; p. 292, ll. 4-5
[194] Hebert Transcript, p 247, ll. 21-27
[195] Beemish Aff, JBE Vol 1, Tab 4, p. 171, para 12; Hebert Aff, JBE Vol 1, Tab 3, p. 126-127, para 2; Beemish Aff, JBE Vol 1, Tab 4, p. 169, para 7
[196] Hebert Transcript, p. 172, ll. 4-28, 173, ll. 1-13; p. 173, ll. 17-22
[197] Hebert Transcript, p. 203, ll. 18-28; p 204, ll. 1-9; p. 211, ll. 8-p. 215, l. 22
[198] Davey Transcript, p. 34, ll. 22-28
[199] Davey Transcript, p. 37, ll. 6-14
[200] Davey Transcript, p. 37, ll. 18-p. 38, ll. 14
[201] Davey Transcript, p. 40, ll. 3-26

c) Plaintiffs' Methods of Consuming Marijuana

113. For all of the plaintiff-patients, their primary method of consuming marijuana is inhalation of dried marijuana vapor or smoke through the lungs.[202] Mr. Allard testified that the "vast majority" of his marijuana consumption is done through vaporizing and smoking. The remaining smaller portion of his marijuana consumption involves oral ingestion of marijuana juice, edible oils and baked goods, as well as the application of topical oils.[203]

114. Ms. Beemish's evidence was that ninety-eight (98) percent of her current marijuana consumption involves smoking and vapourizing dried marijuana.[204] While Mr. Hebert occasionally bakes Ms. Beemish brownies with marijuana butter, Ms. Beemish uses such edibles only rarely since her medical condition renders it difficult for her to handle solid food.[205]

115. Mr. Davey explained that he consumes marijuana every half-hour while he is awake, or approximately 32 times per 16-hour day. Mr. Davey does so primarily by using his vaporizer, which he says is "going pretty much all day", although he also smokes one joint when he wakes up in the morning.[206] In addition, Mr. Davey eats a small marijuana cookie in the middle of the day, and then a big marijuana cookie before he goes to sleep.[207] These marijuana cookies, which are baked with marijuana butter, are made in batches of 50 to 60 approximately every two months.[208] Mr. Davey believes that he uses about one ounce (28 grams) of marijuana per day, with approximately half of that amount consumed through inhalation every half-hour, and the balance being used to bake the two cookies.[209] Mr. Davey will also, on occasion, consume some marijuana by drinking it in a tea and by applying a grape seed oil containing marijuana extract topically to his body. He does not, however, take steps to accurately measure his actual consumption.[210]

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[202] Allard Transcript, p. 293, ll. 10-p. 296, ll. 10; Davey Transcript, p. 40, ll. 27-p. 421, ll. 26; Hebert Transcript, p. 250, ll. 12-p. 255, ll. 3
[203] Allard Transcript, p. 296, ll. 4-10
[204] Hebert Transcript, p. 253, ll. 19-23
[205] Hebert Transcript, p. 253, ll. 23-28, p. 254, ll. 1-16
[206] Davey Transcript, p 38, ll. 26-28; p.39, ll. 16-28; p. 41, ll. 10-15
[207] Davey Transcript, p. 99, ll. 2-4; p. 98, ll. 23
[208] Davey Transcript, p. 80, ll. 1-3
[209] Davey Transcript, p. 80, ll. 1-8
[210] Davey Transcript, p 99, ll. 15-23; p. 39, ll. 5-12

116. No evidence was led by any of the plaintiff-patients that they would be incapable of obtaining the medical relief they need if they are limited to consuming dried marijuana or forbidden from manufacturing edible marijuana products.

d) Plaintiffs' Marijuana Strains and Effectiveness in Alleviating Symptoms

117. While the plaintiff-patients testify that they have used various strains of medical marijuana over the years, none of them consistently employed a methodical system for assessing the effectiveness particular strains beyond simple "trial and error".[211]

118. Mr. Allard grows approximately a dozen or so strains. He says that he has to keep switching them because he builds up a tolerance to particular strains. After ceasing to use a strain for a time, he can later return to consuming the old strain again. Mr. Allard says that some of the strains he has tried are ineffective in relieving his symptoms and that some strains make him feel worse.[212] While Mr. Allard referred to the fact that he may have taken some notes about these strains, they were not provided as evidence to the Court.[213]

119. Mr. Hebert grew six strains for Ms. Beemish and testified that he attempted to document their effectiveness. These records were not, however, provided as evidence to the Court.[214] Mr. Hebert and Ms. Beemish explained that while one strain ("White Berry") was particularly effective, none of the other strains were ineffective for her.[215]

120. Mr. Davey is now using a single strain ("Bubba Kush") which he consumes both through inhalation and ingestion. He says it is effective for managing his pain. Mr. Davey has used many strains in the past, not all of which have been effective. However, even when he uses ineffective strains, Mr. Davey says that they do not worsen his symptoms. Mr. Davey believes in continuously experimenting with new strains to see what impact they may have on his condition.[216]

121. Notwithstanding their extensive experimentation with strains, the plaintiff-patients led no evidence to support the assertion that any particular strains of marijuana are uniquely

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[211] Allard Transcript, p. 298, ll. 18-24; Davey Transcript, p. 44, ll. 26-28, p. 45, ll. 1-2; Hebert Transcript, p. 258, ll. 2-6
[212] Allard Transcript, p. 299, ll. 2-9
[213] Allard Transcript, p. 300, ll. 2-9
[214] Hebert Transcript, p. 256, ll. 3-9; p. 258, ll. 2-16
[215] Hebert Transcript, p. 256, ll. 9-12
[216] Davey Transcript, p. 44, ll. 1-28, p. 45, ll. 1-28, p. 46, ll. 1-4

and exclusively medically suited to treat their particular ailments such that no other strains could offer them comparable relief from their symptoms. As the plaintiff-patients did not provide their medical records, there is no substantiation for the claims that any one strain may or may not have been indicated from a medical perspective.

122. Similarly, none of the plaintiff-patients produced documentary evidence that would demonstrate that they used anything resembling a rigorous scientific approach to ascertaining the effectiveness of marijuana generally as a treatment for their symptoms.[217] In particular, they do not methodically and consistently record the frequency and volume of their marijuana use, and its impact on their medical condition. None of the Plaintiffs established with any precision that the quantities of marijuana they use are in fact medically necessary, relying instead on their own subjective notions of how much they feel they "need" on a given day.

Plaintiffs' Cultivation of Medical Marijuana

a) Plaintiffs' Marijuana Production History

123. The three plaintiff-growers (Mr. Allard, Mr. Hebert and Mr. Davey) have been producing marijuana in varying amounts over different periods of time. Their evidence demonstrates that marijuana cultivation is not a straightforward exercise that can easily be undertaken by anyone who chooses to do so. Instead, their experience shows that safe and effective cultivation of medical marijuana requires knowledge, skill, time and access to significant human and financial resources.[218]

124. Mr. Allard started growing marijuana in 2004 and has done so at three different houses in which he resided. He estimates that the total financial cost of constructing his grow rooms and purchasing all of the equipment at the three different sites is approximately $35,000.[219] Mr. Allard takes pride in cultivating marijuana, which he finds to be therapeutic in and of itself, and has invested time in learning how to do so by speaking to other people, reading books, researching on the internet and through trial and error.[220] In spite of his

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[217] Davey Transcript, p. 48, ll. 1-3; Hebert Transcript, p.259, ll. 22-28; p. 260, ll. 1-3; Allard Transcript, p. 292, ll. 4-5, p. 300, ll. 2-28

[218] Allard Transcript, p. 287, ll.11-28; p. 288, ll. 1-16; Davey Transcript, p. 64, ll. 5-19; Hebert Transcript, p. 166, ll. 20-24

[219] Allard Transcript, p. 309, ll. 14-23

[220] Allard Transcript, p. 305, ll. 23-28; p. 306, ll. 1-10; p. 329, ll. 16-28; p. 330, ll. 1-16

extensive experience, however, Mr. Allard candidly admits that sometimes his plants will die, particularly when his health does not allow him to tend to them properly.[221]

125. Mr. Hebert has extensive training, education and experience with biology, plant science and gardening.[222] He personally set up a growing facility in the attached garage of the townhouse he shared with Ms. Beemish in 2013.[223] Mr. Hebert grew marijuana at that location from January to September 2013, successfully producing three cycles of marijuana plants.[224] However, Mr. Hebert and Ms. Beemish felt that they were paying too much rent at this residence and moved to another cheaper residence in October 2013.[225] Their new residence proved unsuitable for growing marijuana and Mr. Hebert testified that, even if they were lawfully permitted to do so, personal marijuana production is now impossible for them.[226] Instead, Mr. Hebert now purchases marijuana for Ms. Beemish on the black market, paying approximately $300 per month.[227]

126. When Mr. Davey was first authorized by Health Canada to possess medical marijuana in July 2010, he used a designated grower who had a DPPL. However, he was dissatisfied with the quality of the marijuana and was concerned that his grower was abusing his license by diverting marijuana illegally.[228] Mr. Davey then decided to obtain a PUPL and from July 2011 to February 2013, he attempted to grow marijuana for himself.[229] However, Mr. Davey was not able to successfully produce any usable medical marijuana on his own.[230] Then, from February 2013 to September 2013, Mr. Davey tried to use another designated grower. This grower (who apparently was not lawfully authorized to grow since the DPPL was in his mother's name), also disappointed Mr. Davey in terms of the quality of his product.[231] Finally, in September 2013, Mr. Davey entered in to an arrangement with a neighbour, Brian Alexander, to grow marijuana collectively in an outbuilding located on a property that they

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[221] Allard Transcript, p. 314, ll. 1-28
[222] Hebert Transcript p. 164, ll. 6-14
[223] Hebert Transcript, p. 174, ll. 17-22
[224] Hebert Transcript, p. 167, ll 22-26
[225] Hebert Aff, JBE Vol 1, Tab 3, p. 131, para 14
[226] Hebert Transcript, p. 171, ll 3-24
[227] Hebert Transcript, p. 173, ll. 23-28p; p. 174, ll. 1-13
[228] Davey Transcript, p.59, ll 7-12
[229] Davey Transcript, p. 61, ll 10-25
[230] Davey Transcript, p. 66, ll. 24-28; p. 67, ll. 1-6
[231] Davey Transcript, p. 65, ll. 6-14;p. 66, ll. 1-20; p. 66, ll. 24-28, p. 67, ll. 1-6

rent from a third party. Mr. Davey now also rents a residence on that same property, near the outbuilding.[232]

127. Mr. Alexander is a skilled marijuana cultivator who assists Mr. Davey with growing marijuana at their collective growing facility.[233] But for Mr. Alexander's talent, dedication and willingness to assist, Mr. Davey would be completely unable to access medical marijuana through personal production.[234]

128. During the period from July 2010 to September 2013 when he began to receive assistance from Mr. Alexander, Mr. Davey's inability to grow personally and the unreliability of the supply he received from his designated growers placed him in a situation where he felt compelled to purchase marijuana from the black market.[235] Mr. Davey would buy one ounce (28 grams) every 3 days (or approximately 9 grams per day), paying $100 to $125 per ounce (approximately $5 per gram).[236]

b) Plaintiffs' Marijuana Production Facilities

129. The three plaintiff-growers (Mr. Allard, Mr. Hebert and Mr. Davey) all invested significant time and money to establish their personal grow operations.[237] From their perspective, they have not caused harm to themselves, their neighbours or their community because they have built safe and secure facilities in order to mitigate the inherent risks of marijuana cultivation. It is evident that their growing operations were the result of a combination of hard work, good management and some good fortune in terms of their access to locations and infrastructure that permit personal cultivation in a secured environment.[238]

130. Mr. Allard's current production facility cost $6,766 to buy the equipment needed to produce marijuana and $14,365.06 for the structural work that had to be done to his basement,

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[232] Davey Transcript, p. 50, ll. 10-28
[233] Alexander Transcript, p. 132, ll. 22-28; p. 133, ll. 1-12
[234] Davey Transcript, p. 75, ll. 2-8
[235] Davey Transcript, p. 67, ll. 7-26
[236] Davey Transcript, p. 68, ll. 2-12
[237] Allard Aff, JBE Vol. 1, Tab 5Aa, p. 222, para 13; Davey Transcript, p. 69, ll. 11-24; Hebert Aff, JBE Vol. 1, Tab 3, p. 175, ll. 6-28, p. 176, ll. 1-13
[238] Allard Transcript, p. 324, ll. 23-28, p. 325, ll. 1-7; Davey Afft, JBE Vol. 1, Tab 1, p. 34-35, para 11; Hebert Aff, JBE Vol 1, Tab 3, p. 128, para 8

for a total of $21,131.06. In addition to this start-up cost, Mr. Allard estimates that his monthly expenses for growing marijuana amount to approximately $200 to $300.[239]

131. Mr. Hebert spent approximately $5,000 in equipment and supplies to establish a relatively modest growing operation in the garage of his former residence. While this amount is significantly less than what the other Plaintiffs had spent on their larger operations, Mr. Hebert testified that this expense brought him to the brink of bankruptcy. His estimated monthly cost for growing marijuana was approximately $125.[240]

132. Mr. Davey's current production facility cost $27,040 to buy the equipment needed to produce marijuana in the outbuilding he shares with Mr. Alexander on a rental property. Mr. Alexander estimates that the building itself would likely have cost between $50,000 and $60,000 to build.[241] Mr. Davey estimates that his monthly expense for growing marijuana there is approximately $830 per month.[242]

133. None of the plaintiff-growers actually used a "grow box" (also known as a "bloom box"), a home appliance that is alleged to facilitate production of marijuana in a residence, to cultivate their marijuana.[243] Mr. Hebert initially acquired one at a below market price (he testified that while in his experience such appliances cost around $8,000, he was able to buy one for somewhere between $500 to $800), but it proved to be unsuitable for marijuana growing because it does not permit the growing of tall marijuana plants. Mr. Hebert described purchasing the grow box as a "lesson learned", and he now uses the device for growing tomatoes.[244]

134. Furthermore, none of the plaintiff-growers' production facilities described above involved any outdoor production. Indeed, the Plaintiffs led absolutely no evidence that could conceivably support an argument that the prohibition on outdoor production imposed by the MMPR would cause prejudice to the Plaintiffs in any way.

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[239] Allard Transcript, p. 311, ll. 23-28, p. 312, ll. 1-7; p. 340, ll.21-28, p. 341, ll. 1-8
[240] Hebert Transcript, p. 125, ll. 1-28, p. 126, ll. 1-13; Hebert Aff, JBE Vol. 1, Tab 3, para 13
[241] Davey Transcript, p. 69, ll. 11-24; Alexander Transcript p. 119, ll. 24-28, ll. 120, ll.1
[242] Davey Transcript, p. 71, ll. 19-26
[243] Davey Transcript, p. 74, ll. 17-23; Alexander Transcript, p. 131, ll. 20-28, p. 132, ll. 1
[244] Hebert Transcript, p. 183, ll. 2-28, p. 184, ll. 1-5

Plaintiffs' Financial Capacity to Access Medical Marijuana

135. The Plaintiffs' financial circumstances are all such that they have the capacity to access medical marijuana, either by spending money to purchase marijuana directly from suppliers (be they licit or illicit) or by spending money on the infrastructure, equipment and supplies necessary to grow marijuana. None of the Plaintiffs can reasonably be described as indigent, destitute or impoverished. Indeed, the Plaintiffs' evidence is consistent with the common sense notion that individuals who have sufficient financial resources to establish and maintain safe and productive personal marijuana grow operations will also have the resources to purchase medically justifiable quantities of marijuana to treat their symptoms.

136. Mr. Allard is a retired public servant who receives a pension that provides him with a monthly after-tax income of approximately $3,000 per month.[245] He owns a house whose value has been assessed for property tax purposes at $241,300, and whose insurance replacement cost is $279,000.[246] Mr. Allard has no debts or dependants.[247] Mr. Allard's monthly expenses amount to $2,305.52, of which approximately $200 to $300 relate to marijuana cultivation.[248]

137. As such, Mr. Allard could spend approximately $900 to $1,000 on medical marijuana per month without modifying his other expenditures or using his assets to access income (for example, by obtaining a reverse mortgage on his house). At a hypothetical price of $5 per gram, this means that Mr. Allard could in principle purchase 6 grams of marijuana per day from Licensed Producers without impacting his current lifestyle.

138. While Ms. Beemish is on medical disability and in receipt of a pension, her common law spouse Mr. Hebert is employed by the Government of British Columbia as an environmental protection officer.[249] Collectively, their after-tax income is $4,771 per month. Their collective monthly expenses are $4,745.34, of which approximately one-half ($2,375.19) represents the carrying charges for Mr. Hebert's significant debts.[250] These

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[245] Allard Aff, JBE Vol. 1, Tab 5A, p. 198, para. 27
[246] Allard Transcript, p. 341, ll. 11-27
[247] Allard Transcript, p. 273, ll. 23-25, p. 343, ll. 3-5
[248] Allard Transcript, p. 337, ll. 24-28, p. 340 l. 21- p.341 l. 6; Allard Aff, JBE, Vol. 1, Tab 5, p. 224, para 18
[249] Hebert Transcript, p.160, ll. 2-4; p. 197, ll. 6-28; p.198, ll. 1-5
[250] Hebert Transcript p. 198, ll. 6-16; Hebert Transcript p. 200, ll. 3-11

expenses include the cost of purchasing marijuana for Ms. Beemish on the black market which Mr. Hebert estimated to be $300 per month.[251]

139. Mr. Hebert also candidly admitted in response to a hypothetical question by his own counsel that he can afford to purchase medical marijuana for Ms. Beemish from a Licensed Producer if it were to charge $5 per gram.[252]

140. Mr. Davey was employed in the automotive industry until his accident in 2000.[253] Since that time, he has been in receipt of a disability annuity and pension that provide him with a monthly income of approximately $5,000 per month.[254] While he does not currently own any real estate or valuable assets other than several used motor vehicles, Mr. Davey has no debts and no dependents. Mr. Davey's monthly expenses amount to $3,747, of which approximately $830 relate to marijuana cultivation.[255]

141. As such, Mr. Davey could spend over $2,000 on medical marijuana per month without modifying his other expenditures.[256] Indeed, Mr. Davey was spending approximately $3,000 per month on pharmaceuticals to treat his pain for several years prior to his decision to use medical marijuana.[257] At a hypothetical price of $5 per gram, this means that Mr. Davey could in principle purchase 14 grams of marijuana per day from Licensed Producers without impacting his current lifestyle.[258]

142. The plaintiff-patients' financial evidence also revealed that two of them (Ms. Beemish and Mr. Davey) do not engage in travel for recreational or other reasons.[259] While Mr. Allard does occasionally travel from Nanaimo to Vancouver, he does not leave home for more than a few days at a time because he must tend his marijuana plants. As such, the Plaintiffs led no evidence that could conceivably support an argument that the 150 gram possession limit imposed by the MMPR would cause prejudice to these individuals in any

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[251] Hebert Transcript, p. 207, ll. 7-11
[252] Hebert Transcript, p. 234, ll. 27-28, p. 235, ll. 1-13
[253] Davey Aff, JBE Vol 1, Tab 1, p. 33, para 5
[254] Davey Transcript, p. 85, ll. 7-11; Davey Aff, JBE Vol. 1, Tab 1a, p. 33, para. 5
[255] Davey Transcript, p. 86, ll. 7-27; p. 30, ll. 23-28, p. 85, ll. 27-28, p. 86, ll. 1-5, p. 89, ll. 1-4
[256] Davey Transcript, p. 89, ll. 8-19
[257] Davey Aff, JBE Vol 1, Tab 1, p. 33, para 6
[258] Davey Transcript, p. 88, ll. 13-28, p. 89, ll. 1-9
[259] Davey Aff, JBE Vol 1, Tab 1, p. 17, para 30 (g); Hebert Transcript, p. 235, ll. 5-10

way, such as by impeding them from travelling for extended periods with an adequate supply of medical marijuana.

Plaintiffs' Attitude Towards Licensed Producers

143. The Plaintiffs expressed strong negative opinions towards the MMPR Licensed Producers. None of them have bothered to recently contact any of the Licensed Producers to ascertain whether they might be able to obtain medical marijuana strains that could be effective in relieving their symptoms at reasonable prices. Instead, they all share the impression that the Licensed Producers will be unable to provide them with suitable marijuana at a price they are willing to pay.[260] In fact, if they become unable to personally cultivate marijuana, the Plaintiffs all indicate an apparent preference to pursue illicit sources of supply of marijuana of an unknown quality to treat their medical conditions.

144. Mr. Allard is not interested in contacting Licensed Producers to obtain concrete information about their prices and strains so long as he is able to lawfully grow marijuana at his home under the terms of the interlocutory injunction. In response to questions about how he would deal with a situation where he could no longer grow his own marijuana if the injunction were to be lifted or if he became physically incapable of doing so, Mr. Allard simply hopes that he might be able to find a friend or somebody to help him rather than having to purchase marijuana himself from a Licensed Producer.[261]

145. Mr. Hebert explained that he views the Licensed Producer system as "a bunch of bullshit" that he has no faith in.[262] While Mr. Hebert claims to have telephoned Licensed Producers in the past, he has not attempted to contact one for over six months. He vaguely claims that it "was really difficult to interact with these organizations", fears being "poisoned" by them, and does not want to provide Licensed Producers with his financial information or medical information.[263] At the same time, Mr. Hebert is nevertheless content to obtain marijuana from the unregulated black market where he is "avoiding shipping, taxes, everything".[264]

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[260] Allard Transcript, p. 344-345; p. 354; Davey Transcript, p. 87, ll. 26-28; p. 89-90; p. 91, ll. 1-5; Hebert Transcript, p. 211, ll. 25-28; p. 212-215
[261] Allard Transcript, p. 353
[262] Hebert Transcript, pp. 213-215
[263] *Ibid.*
[264] *Ibid.*, p. 215

146. Mr. Davey said that he has not made any effort to obtain information from Licensed Producers regarding the possibility of purchasing marijuana because he believes that their prices are not lower than $10 per gram, and that he does not feel that their product is of good quality. Indeed, Mr. Davey candidly admitted that his reluctance to source marijuana from Licensed Producers is not really an issue of affordability, but rather that he simply does not "trust" them.[265]

147. In sum, while the Plaintiffs clearly expressed their animosity towards Licensed Producers, they led no direct evidence to support the assertion that it would be impossible for them to access medical marijuana from Licensed Producers in the quantities and form that they actually need to treat their medical conditions.

E. THE PLAINTIFFS' CONSTITUTIONAL CHALLENGE

148. On December 10, 2013, the Plaintiffs commenced the present litigation by filing a statement of claim in the Federal Court commencing an action against the defendant Canada. The claim seeks five declarations pursuant to s. 52(1) of the *Canadian Charter of Rights and Freedoms* ("*Charter*"), which can be summarized as follows:

> (a) a declaration that "a constitutionally viable exemption" from the CDSA must exist to enable the medical use of cannabis, by medically approved persons, in any of its effective forms—including the right to possess, use, cultivate or produce cannabis for the treatment of a patient's medical condition (either directly or through a designated "caregiver");
>
> (b) a declaration that to the extent that the MMPR fail to provide for the continued personal production of medical marijuana as was allowed under the MMAR, the MMPR violate s. 7 of the *Charter* and are not saved by s. 1;
>
> (c) a declaration that the limits on the form of permissible medical marijuana contained in the MMPR and the NCR to dried marijuana only are arbitrary and unreasonable, and therefore in violation of s. 7 of the *Charter* and not saved by s. 1;
>
> (d) a declaration that the limits on permissible medical marijuana production locations prescribed by the MMPR to indoor and non-residential locations are arbitrary and unreasonable, and therefore in violation of s. 7 of the *Charter* and not saved by s. 1; and
>
> (e) a declaration that the limits on the amount of medical marijuana that can be possessed prescribed by the MMPR are arbitrary and unreasonable, and therefore in violation of s. 7 of the *Charter* and not saved by s. 1.[266]

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[265] Davey Transcript, pp. 89-91

[266] Amended Statement of Claim, para. 1

149. In addition, the Plaintiffs' claim an order pursuant to s. 24(1) of the *Charter* as follows:

> (a) a permanent constitutional exemption from ss. 4, 5 and 7 of the CDSA (the provisions that criminalize possession, trafficking and production of cannabis) for all persons medically approved under the MMPR, MMAR and NCR; or, in the alternative
>
> (b) a permanent exemption/injunction that preserves the provisions of the MMAR relating to personal production, possession, production location and storage, while limiting the applicability of the provisions of the MMPR that are inconsistent with s. 7 of the *Charter*.[267]

150. Although not pled, the Plaintiffs now request in their Memorandum of Fact and Law that cannabis should be removed from Schedule II of the CDSA and Schedule 2 of the NHPR, "thereby making activities related to medical cannabis no longer criminal in nature and, instead, subject to the NHPR."[268]

151. The Plaintiffs' statement of claim also included a plea for interim relief in the form of an injunction that would effectively preserve and maintain those aspects of the old MMAR regime that provided for personal production of medical marijuana pending the outcome of the action. This was the subject of a motion for an interlocutory injunction which was granted in part by the Court (Manson J.) on March 21, 2014.[269] As a result of the interlocutory injunction, a significant number of MMAR permit holders, including the Plaintiffs Mr. Allard and Mr. Davey, continue to be able to lawfully produce and possess home grown medical marijuana pending the outcome of this action.

152. At trial, the parties submitted a significant volume of evidence. Specifically, the Plaintiffs tendered affidavits from 22 individuals (9 factual witnesses, 12 experts, and 1 witness who provided both factual & expert evidence) and the Defendant tendered affidavits from 18 individuals (5 factual witnesses and 13 experts). In order to ensure that the cross-examinations could be completed within the three-week trial, the parties were judicious in deciding whether or not to cross-examine witnesses.

153. The fact that many of the witnesses were not subject to cross-examination resulted in the raising of a question by the Court as to whether the rule in *Browne v. Dunn* applies in

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[267] Amended Statement of Claim, para. 1
[268] Plaintiffs' Memorandum of Fact and Law, para. 206
[269] *Allard v. Canada,* 2014 FC 280. See also *In the matter of numerous filings...* 2014 FC 537, para. 5

relation to expert witnesses. Written and verbal submissions on this issue were made by counsel for the parties on March 2, 2015. Ultimately, the Court issued a declaration regarding the question as follows:

> In respect of expert evidence, the Court is not required to accept an expert opinion offered merely because it is not contradicted by cross-examination or other evidence. The principle in *Browne v. Dunn* does not operate to create a presumption of persuasiveness in expert testimony. In particular, the weight, if any to be accorded to an expert's opinion is not contingent on whether cross-examination has taken place, nor is cross-examination a precondition to a party leading contradictory expert evidence, or taking issue with an expert's testimony in argument.

PART III: POINTS IN ISSUE

154. The Plaintiffs' constitutional challenge to the MMPR is directed at four specific aspects of the regime, thereby giving rise to five questions, as follows:

a. Does a regulatory regime that provides for reasonable access to medical marijuana through Licensed Producers in the manner prescribed by the MMPR violate the Plaintiffs' s. 7 *Charter* rights?

b. Does the requirement that medical marijuana be grown indoors and in buildings other than dwelling places as prescribed by the MMPR violate s. the Plaintiffs' s. 7 *Charter* rights?

c. Does the limit on the amount of marijuana that can be possessed to the lesser of 150 grams or 30 times what has been authorized by a medical practitioner as prescribed by the MMPR violate the Plaintiffs' s. 7 *Charter* rights?

d. Does the limit on production and possession of medical marijuana to its dried form as prescribed by the MMPR violate the Plaintiffs' s. 7 *Charter* rights?

e. If any of the above aspects of the MMPR are found to constitute violations of the Plaintiffs' s. 7 *Charter* rights, are they justifiable under s. 1 of the *Charter*?

155. It is the Defendant Canada's position that the MMPR is constitutional, and that questions (a) to (d) must be answered in the negative. As such, question (e) is moot and need not be answered. In the alternative, if any of questions (a) to (d) are answered in the affirmative, then it is the Defendant Canada's position that the answer to question (e) is also affirmative (i.e., that any violation of the Plaintiff's' s. 7 *Charter* rights are reasonably justifiable under s. 1 of the *Charter*).

PART IV: SUBMISSIONS

A. SECTION 7 OF THE *CHARTER*: GENERAL PRINCIPLES

156. Section 7 of the *Charter* states that "[e]veryone 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." In order to demonstrate a violation of s. 7, the Plaintiffs must first show that the law interferes with, or deprives them of, their life, liberty or security of the person. Once they have established that s. 7 is engaged, they must then show that the deprivation in question is not in accordance with the principles of fundamental justice.[270]

157. The principles of fundamental justice set out the minimum requirements that a law that negatively impacts on a person's life, liberty or security of the person must meet.[271] The three principles of fundamental justice at issue in these proceedings are "arbitrariness", "overbreadth" and "gross disproportionality".

158. The arbitrariness analysis 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 purpose of the measure that causes the s. 7 deprivation and the limits it imposes on life, liberty or security of the person.[272] An arbitrary law is one that is not capable of fulfilling its objectives.[273]

159. Overbreadth deals with a law that is so broad in scope that it includes some conduct that bears no relation to the purpose of the law.[274] As with the arbitrariness analysis, the question is whether there is no connection between the effects of a law and its objective.[275] The overbreadth inquiry allows courts to recognize that the law is rational in some cases but overreaches in its effect in others. The overbreadth analysis is not concerned with

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[270] See, for example, *Carter v. Canada (Attorney General)*, 2015 SCC 5 [***Carter***] at paras. 54-55 and *Canada (Attorney General) v. Bedford*, 2013 SCC 72 [***Bedford***], paras. 57-72
[271] *Bedford*, para. 94
[272] *Bedford*, para. 111
[273] *Carter*, para. 83
[274] *Bedford*, para. 112
[275] *Bedford*, para. 117

competing social interests or ancillary benefits to the general population but is focused instead on the impact of the law on the individuals whose s. 7 interests are engaged.[276]

160. The gross disproportionality inquiry asks whether the law's effects on life, liberty or security of the person are so grossly disproportionate to its purposes that they cannot be rationally supported. The rule against gross disproportionality applies only in extreme cases where the seriousness of the deprivation is totally out of sync with the objective of the measure.[277]

161. All three of these principles of fundamental justice compare the rights infringement caused by the law with the objective of the law, not with the law's effectiveness.[278] The overarching consideration in assessing these principles is 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.[279]

162. The principles of fundamental justice are about "the basic values underlying our constitutional order."[280] The Supreme Court of Canada has noted that the s. 7 analysis is concerned with capturing "inherently bad laws", that is, laws that take away life, liberty or security of the person "in a way that runs afoul of our basic values."[281] Regulations designed to address the serious risks associated with the residential personal cultivation of marijuana for medical purposes, while facilitating access to medical marijuana through an appropriately regulated regime, cannot be characterized as "inherently bad" or antithetical to basic Canadian values.

163. The Plaintiffs' central complaint is that the Licensed Producer regime is unconstitutional because it does not permit them to cultivate their own marijuana for medical purposes. The Plaintiffs' evidence and argument is directed primarily at this issue and, accordingly, Canada's argument below focuses on this aspect of the Plaintiffs' claim.

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[276] *Carter*, para. 85
[277] *Bedford*, para. 120
[278] *Bedford*, para. 123
[279] *Bedford*, para. 125
[280] Bedford, para. 96
[281] *Bedford*, para. 96

The subsidiary issues of outdoor cultivation, possession limits and non-dried forms of marijuana are addressed briefly at the end of the s. 7 analysis.

B. THE LICENSED PRODUCER REGIME COMPLIES WITH S. 7 OF THE *CHARTER*

No Engagement of Security Interests; Limited Engagement of Liberty Interests

a) Introduction

164. The Plaintiffs argue that by eliminating the possibility of personally cultivating marijuana for medical purposes in one's residence, the MMPR engages their interests in liberty and security of the person. Specifically, the Plaintiffs assert that the cost of purchasing medical marijuana from a Licensed Producer is prohibitively expensive when compared to the cost of home cultivation. They also argue that the particular "strains" of marijuana they require will not be available from Licensed Producers. They say that in order to obtain suitable marijuana for medical purposes they will have to break the law and continue to grow marijuana themselves, or purchase marijuana from the black market, thereby risking imprisonment.

165. For these reasons, the Plaintiffs allege that the MMPR engage their liberty interest with respect to making decisions of fundamental personal importance ("personal decision liberty interest"), as well as their liberty interest with respect to the possibility of being imprisoned for committing criminal offences ("risk of incarceration liberty interest"). The Plaintiffs also allege that the MMPR engages their security of the person interest with respect to their bodily integrity and the risk of suffering psychological stress ("security of the person interest").

166. Canada acknowledges only that the MMPR engage the Plaintiffs' "risk of incarceration liberty interest" in the limited sense that they do face the possibility of being sanctioned with imprisonment if they choose to cultivate their own marijuana or to buy it from the black market as opposed to availing themselves of the lawful option to purchase marijuana from Licensed Producers. These activities are criminal offences under the CDSA potentially punishable by imprisonment.

167. Canada denies, however, that the MMPR engage either the Plaintiffs' "personal decision liberty interest" or "security of the person interest". This is because the evidence

does not substantiate the Plaintiffs' claims with respect to either a lack of affordability or a lack of suitable strains under the Licensed Producer regime. It is the Plaintiffs' attitude towards Licensed Producers, rather than any concrete evidence regarding their ability to access marijuana under the MMPR, that is at the heart of their *Charter* challenge. Furthermore, s. 7 of the *Charter* does not protect economic interests and personal preferences, as claimed by the Plaintiffs.

b) The Licensed Producer Regime Is Not Prohibitively Expensive

168. With respect to the issue of affordability, the evidence does not support the Plaintiffs' contention that the cost of purchasing marijuana from Licensed Producers is prohibitively expensive. First, the Plaintiffs' calculation of the costs associated with home cultivation does not accurately depict the true cost of growing marijuana in a dwelling place. Second, a careful examination of the Plaintiffs' personal financial circumstances reveals that they could afford to purchase their marijuana from Licensed Producers. The Plaintiffs' testimony during the trial highlighted the fact that they have rejected the Licensed Producer regime not because it is unaffordable but because they "don't trust" the Licensed Producers. Third, the testimony of several experts, as well as the currently available medical and scientific research, establishes that an average dosage of 1 to 3 grams, and no more than 5 grams, of dried marijuana a day is appropriate for medical purposes; obtaining this amount from a Licensed Producer cannot reasonably be said to be prohibitively expensive.

169. There is also no legal basis for the Plaintiffs' affordability arguments. The crux of their claim is that the government has taken away their asserted "right" to home cultivation which they contend enables them to produce lower cost medicine. Section 7, however, does not protect economic interests or the notion that medicine must be accessible at a cost that is subjectively acceptable to consumers. The Supreme Court of Canada has stated that "[t]he Charter does not confer a freestanding constitutional right to health care."[282] The evidence does not establish that purchasing marihuana in medically appropriate amounts is prohibitively expensive for anyone. As such there is no interference with their right to "reasonable access" and, as a result, no interference with security of the person. The

[282] *Chaoulli v. Quebec,* 2005 SCC 35, para. 104

economic impact of incrementally higher prices, where reasonable access is not precluded, relates to an economic interest not protected under s. 7.

(i) The Actual Cost of Home Cultivation

170. The Plaintiffs have consistently characterized the home cultivation of marijuana for medical purposes as a low cost option that allows them to produce marijuana for a fraction of the price offered by Licensed Producers. This characterization ignores the realities of home cultivation and the true costs of growing marijuana in residential dwellings. When assessing the actual cost of home cultivation, it is important to remember that the typical personal medical marijuana growing operation did not involve simply tending to a few additional houseplants. As previously noted, the average authorized dose of marijuana under the previous regime was over 18 grams per day which translated into a production license for 98 plants grown indoors.[283]

171. Setting up a growing operation in one's home is, by the Plaintiffs' own admissions, a complex and costly endeavour. For example, the structure used by Mr. Davey and Mr. Alexander to grow their marijuana is a 35 by 45 feet outbuilding that, by Mr. Alexander's estimate, would cost $50,000 to $60,000 to construct. The growing equipment they use cost them about $27,000 and their security system cost $3,000 to install. It took Mr. Alexander at least a month to set up their growing operation. If Mr. Alexander's labour is taken into account, it would not be unreasonable to estimate the value of the marijuana growing facility set up by Messrs. Davey and Alexander to be approximately $100,000. In addition to these set-up costs, Mr. Davey estimates he spends $830 each month to maintain their operation.[284]

172. Mr. Allard also testified that setting up his growing operation was a costly endeavour. Over the years he has set up three sites at a cost of approximately $35,000.[285] The cost of setting up his current operation, which is located in the basement of his home,

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[283] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1538, para. 54
[284] Davey Transcript, p. 69, ll. 11-24, p. 71, ll. 19-26; Alexander Transcript, p. 119, ll. 24-28, p. 120, ll. 1
[285] Allard Transcript, p. 309, ll. 14-23; Allard Aff, para. 18

was about $21,000. He estimates his ongoing cultivation expenses to be approximately $200 to $300 per month.[286]

173. Mr. Hebert testified that it cost him approximately $5000 and 40 hours of his own labour to set up his relatively modest growing operation in the garage of his previously rented townhouse. His estimated monthly cost of cultivation was approximately $125.[287]

174. In terms of a per gram cost of producing marijuana, the Plaintiffs' baldly claim that it is only $0.50 to $2.00 per gram.[288] This calculation is highly misleading because there are a number of factors that ought to be considered in order to obtain an accurate picture of the true costs of cultivating marijuana in one's residence. Dr. Grootendorst, who is a health economist and a tenured professor in the Faculty of Pharmacy at the University of Toronto, noted that in determining a user's cost of growing medical marijuana, both "money costs" and "opportunity costs" must be considered.[289]

175. With respect to "money costs", the Plaintiffs have included only "ongoing" costs such as electricity, soil, water, and so forth in their per gram cost estimate. "Money costs" must also include the one-time cost of setting up a growing operation.[290] As outlined above, these costs are significant and would increase the per gram cost estimate provided by the Plaintiffs.

176. With respect to "opportunity costs", Dr. Grootendorst testified that the value of the time devoted to cultivating medical marijuana, as well as the value of the time spent learning how to do so, ought to be included in calculating the per gram cost of marijuana.[291] The Plaintiffs have not included these opportunity costs despite the fact that each of the Plaintiffs testified that learning how to grow marijuana successfully was a time-consuming process and that cultivating marijuana for medical purposes is akin to holding down a second job.

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[286] Allard Transcript, p. 311, ll. 23-28, p. 312, ll. 1-7, p. 340, ll21-28, p. 341, ll. 1-8
[287] Hebert Transcript, p. 125, ll. 1-28, p. 126, ll. 1-13; Hebert Aff, JBE Vol 1, Tab 3a, para. 13
[288] Davey Aff, JBE Vol. 1, Tab1a, p. 35, para. 12; Hebert Aff, JBE Vol. 1, Tab 3a, p. 129, para. 10
[289] Grootendorst Aff, JBE Vol. 11, Tab 54, p. 6196, para 50
[290] Grootendorst Aff, JBE Vol. 11, Tab 54, p. 6196, para 51
[291] Grootendorst Aff, JBE Vol. 11, Tab 54, p. 6196-97, para 52

177. Mr. Alexander, who assists Mr. Davey in the cultivation process, stated that he spent 2-3 hours every night on the internet researching how to grow and that even so, he had many unsuccessful crops.[292] Mr. Davey estimated that he has spent 150 hours researching marijuana cultivation on the internet and that he continues this research on a regular basis.[293] Mr. Allard testified that he invested a significant amount of time researching cultivation techniques, strains and so forth on the internet and in books.[294] Mr. Hebert's extensive training, education and experience with biology and plant science provided him with the knowledge necessary to cultivate for Ms. Beemish.[295]

178. The time spent by the Plaintiffs learning how to cultivate is perhaps not surprising in light of the testimony of Dr. ElSohly, a Professor of Pharmaceutics at the University of Mississippi who has been involved in the production of marijuana for clinical studies for over 35 years. He testified that growing marijuana for medical purposes requires not only the proper equipment and facilities, but also extensive knowledge with respect to plant genetics and chemical profiles.[296] According to Dr. ElSohly, all personnel working with medical marijuana "must have proper education, training, and experience to perform the assigned functions."[297]

179. The Plaintiffs also testified that tending to their marijuana crops takes a significant amount of time. Mr. Hebert testified that he spent 50 to 100 hours a month tending to his marijuana growing operation and that growing marijuana was like a "part-time job".[298] Mr. Allard, whose health prevents him from devoting as much attention to his plants as they need, still agreed on cross-examination that he may spend up to 30 hours a month cultivating his marijuana plants.[299] Mr. Davey relies upon Mr. Alexander, who is an experienced and skilled cultivator, to assist him with growing marijuana. While Mr. Davey spends 20 to 25 hours per month on cultivation, he admitted in cross-examination that

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[292] Alexander Transcript, pp. 135-136
[293] Davey Transcript, p. 83
[294] Allard Transcript, pp. 329-330
[295] Hebert Transcript, p. 164
[296] Affidavit of Mahmoud ElSohly sworn October 15, 2014 ("ElSohly Aff."), JBE Vol. 12, Tab 60, pp. 6727-6728
[297] ElSohly Aff, JBE Vol. 12, Tab 60, p. 6727
[298] Hebert Transcript, pp. 166, 186
[299] Allard Transcript, p. 315

without Mr. Alexander's help, he could not grow his own marijuana.[300] Mr. Alexander confirmed that, to the detriment of the time he has to spend with his family, he spends approximately 20 to 25 hours a month assisting Mr. Davey.[301]

180. The Plaintiffs' marijuana cultivation expert confirmed the labour-intensive nature of cultivating marijuana plants. When asked how many hours a week he spent cultivating his own plants, Mr. Colasanti stated that while he had not counted up the hours, "[i]t is a full time job" and that half of every day, seven days a week, is dedicated to tending his marijuana plants.[302] Mr. Colasanti added that such care was necessary because "the thing about growing cannabis is if you drop the ball, anywhere along the line here, plants die, you don't get a harvest, you have to start all over again."[303] Despite the investment of time and money, patients cultivating for themselves may still end up without consumable marijuana, and have to purchase it from another source.

181. In addition to the "private costs" that the grower of medical marijuana personally incurs, the production of medical marijuana may also impose costs on others, which Dr. Grootendorst described as "external costs".[304] These external costs may include the risks to others caused by home-based medical marijuana production as well as the administrative and inspection costs associated with a regulatory regime that permits home cultivation.[305] External costs may also include the costs associated with illegal activity such as diversion of home-grown medical marijuana on to the black market or the theft of electricity at residential medical marijuana growing operations.[306]

182. The Plaintiffs have also not included the cost of having their dried marijuana tested for contaminants or levels of active ingredients. The Plaintiffs generally acknowledged that they were concerned with the quality of their dried marijuana and that testing would provide important information about the contents of the medicine they were ingesting.[307] Mr. Colasanti testified that he was aware of four labs in the Lower Mainland that would

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[300] Davey Transcript, pp. 74-75
[301] Alexander Transcript, pp. 133-135
[302] Colasanti Transcript, pp. 484-485
[303] Colasanti, Transcript p. 485
[304] Grootendorst Aff, JBE Vol. 11, Tab 54, p. 6198, para 59
[305] Grootendorst Aff, JBE Vol. 11, Tab 54, p. 6198-99, para 60-61
[306] Grootendorst Aff, JBE Vol. 11, Tab 54, p. 6199, para 62
[307] Alexander Transcript, p. 140; Hebert Transcript, p. 193; Allard Transcript, p. 363

test dried marijuana and that the cost of testing would be approximately $75-100 per sample.[308] He agreed that it would be ideal to have the marijuana tested after each crop and that samples would have to be taken from several locations on each plant, but he noted that not a lot of patients could afford to do that.[309]

183. The Plaintiffs' claim that home cultivation can be done cheaply, effectively and safely fails to take into consideration the extensive financial and other resources enumerated above. When these costs are factored into the equation, it is reasonable to conclude that the per gram cost of producing marijuana that is safe for consumption by medically vulnerable individuals is significantly higher than the Plaintiffs assert and is more in line with the prices offered by Licensed Producers.

184. Perhaps in acknowledgment of the actual costs and the health and safety risks of cultivating medical marijuana, the Plaintiffs have suggested self-contained grow boxes as an alternative mode of cultivation. This is, however, an illusory and unworkable solution given the actual number of plants that individuals have been authorized to grow under the MMAR and given the fact that a number of the risks associated with home cultivation would persist.

185. In terms of the actual utility of grow boxes, these units would not be a practical option for either Mr. Davey or Mr. Allard because of the sheer number of plants they are authorized to grow. Even Mr. Hebert, for whom a grow box would appear to be a practical option because of Ms. Beemish's lower dosage amount, testified that he would not choose a grow box for cultivating his marijuana. He stated that the size of a grow box would limit the height of the plants and would give significantly less yield per plant. According to Mr. Hebert, who has studied plant biology, if marijuana plants were housed in a grow box, the plants could not grow to their full potential: "[c]annabis plants like to grow really tall. They don't like to be pushed down. You have to put a lot more effort to band and prune and do things to them. They prefer to stretch."[310]

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[308] Colasanti Transcript, p. 491
[309] Colasanti Transcript, p. 491
[310] Hebert Transcript, p. 184

186. Mr. Colasanti noted that out of the hundreds of residential medical marijuana growing sites that he claims to have visited, he has never seen a grow box being used and that of the thousands of videos posted on his YouTube channel, only two show grow boxes being used for marijuana cultivation.[311]

187. Grow boxes could potentially be an option for individuals with consumption amounts of 1 to 2 grams per day because, under the MMAR formula, these individuals would be entitled to cultivate only 5 to 10 plants. It cannot be reasonably argued, however, that purchasing this amount of marijuana from a Licensed Producer is prohibitively expensive. In other words, the only individuals for whom grow boxes may be a viable option are individuals with medically appropriate dosages whose ability to afford marijuana under the Licensed Producer system is not in question.

188. Perhaps most fatal to the Plaintiffs' argument that grow boxes are the inexpensive solution to the risks associated with home cultivation is the Plaintiffs' failure to acknowledge that the average cultivator of marijuana for medical purposes under the MMAR would require far more than a single grow box. Mr. Colasanti demonstrated for the Court how a grow box capable of housing nine mature plants worked and he noted that the cost of such a unit was approximately $3300.[312] The average license-holder under the MMAR (authorized to consume 18 grams per day and cultivate 98 plants) would need at least 10 of these grow boxes at a cost of approximately $33,000. In the words of Mr. Colasanti: "I'm not sure how many patients could afford to buy 10 of those."[313]

189. Even if grow boxes could provide a practical, cost-effective means of cultivating marijuana in one's home, they do not mitigate a number of the harms associated with home cultivation, including: the risk of medically compromised individuals ingesting mould and other contaminants that may be present on their dried marijuana; the consumption of marijuana whose levels of active ingredients have not been tested; the risks of diversion and theft; and, the problems associated with compliance inspections. These harms are discussed in greater detail below in the section on the principles of fundamental justice.

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[311] Colasanti Transcript, p. 521
[312] Colasanti Transcript, p. 464
[313] Colasanti Transcript, p. 522

(ii) The Plaintiffs' Financial Circumstances and Affordability of Medical Marijuana

190. Dr. Grootendorst explained that in considering the affordability of medical marijuana, the full financial picture of an individual ought to be considered because "affordability is not so much can you afford it or not afford it. It's how you choose to spend your limited resources. [...] Are you willing to sacrifice other goods and services to acquire what you want?"[314] The Plaintiffs have led no evidence to establish that purchasing medical marijuana from Licensed Producers is unaffordable for individuals below a certain income level and the personal evidence of the Plaintiffs shows that they have the financial ability to afford medically appropriate dosages of marijuana.

191. While the plaintiffs have relied upon the evidence of Dr. Walsh in an attempt to demonstrate the unaffordability of purchasing medical marijuana under the MMPR, his study focused exclusively on issues related to the previous medical marijuana regime and he has not conducted any research with respect to the new regime. Unlike Dr. Grootendorst, Dr. Walsh has not examined the current prices or the expected price trends in the licensed producer system, nor has he addressed how to accurately calculate the per gram cost of personally producing marijuana for medical purposes or the actual costs associated with setting up a personal growing operation. His bald, unsubstantiated assertion that the MMPR will result in a "significant price increase" is not borne out by the evidence before the Court.[315] Further, Dr. Walsh's fundamental opinion relates not to the relative cost of obtaining marijuana through home cultivation versus Licensed Producers but, rather, to the fact that the choice to use marijuana therapeutically is a costly one, no matter where the medicine is obtained.

192. With respect to the Plaintiffs ability to purchase medical marijuana from a licensed producer, Mr. Allard is a retired public servant whose pension provides him with a monthly after-tax income of approximately $3,000. He has no debts or dependants and modest monthly expenditures. Without even altering his current lifestyle, Mr. Allard could afford to spend about $900 to $1000 a month on medical marijuana.[316]

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[314] Grootendorst Transcript, p. 1892
[315] Affidavit of Zachary Walsh sworn October 29, 2014 ("Walsh Aff."), JBE Vol. 2, Tab 6, p. 312, para. 16
[316] Allard Aff, JBE Vol. 1, Tab 5A, paras. 27, 30, 37, 41, Ex. "E", "F", "K", "L"

193. Mr. Davey receives a disability pension that provides him with a monthly income of approximately $5,000. He has no debts or dependents and was previously spending approximately $3,000 per month on pharmaceuticals to treat his pain prior to his decision to use medical marijuana. Without modifying his lifestyle, Mr. Davey could spend over $2,000 per month on medical marijuana.[317]

194. Mr. Hebert, when asked on re-examination if he could afford to purchase Ms. Beemish's marijuana from a Licensed Producer at $5 per gram, candidly admitted that he could.[318] He attests in his affidavit that since he is no longer able to cultivate marijuana at home, he has chosen to purchase Ms. Beemish's marijuana on the black market for $5 per gram.[319]

195. The cost of purchasing medical marijuana from Licensed Producers currently ranges from nothing at all to $15 per gram.[320] Mr. Cain testified that since filing his affidavit, one of the Licensed Producers, CannTrust, has started to offer 30 grams of marijuana a month free of charge to users who meet their financial means test.[321] Without factoring in any price reduction programs, the price range per gram for marijuana from Licensed Producers is currently approximately $1.75 to $15 per gram.[322] The majority of strains currently offered by Licensed Producers appear to fall within a range of $5 to $8 per gram.

196. Additionally, at least eight of the Licensed Producers offer compassionate pricing for low-income users of medical marijuana.[323] The Plaintiffs' witness, Mr. King, sets out the terms of several of these compassionate pricing programs in his affidavit and his evidence shows that Licensed Producers are offering discounts of up to 50% for low income or disabled individuals.[324] Dr. Grootendorst opined that he would expect to

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[317] Davey Aff, JBE Vol. 1, Tab 1, p. 33, paras. 5-6; Davey Transcript, p. 85, ll. 7-11, p. 89, ll. 8-19
[318] Hebert Transcript, pp. 234-235
[319] Hebert Aff, JBE Vol. 1, Tab 3, p. 107, para. 6
[320] Cain Aff, JBE Vol. 7, Tab 29, p. 4060, para. 38
[321] Cain Transcript, p. 954
[322] Cain Aff, JBE Vol. 7, Tab 29, p. 4060, para. 38
[323] Cain Aff, JBE Vol. 7, Tab 29, p. 4060, para. 39
[324] Affidavit of Mike King sworn January 8, 2015 ("King Aff."), JBE Vol. 2, Tab 20, p. 744, para. 7

continue to see Licensed Producers engage in this type of "price discrimination" because "this appears to be a profitable strategy in this market."[325]

197. Further, there is cogent evidence that the price of medical marijuana will continue to decline over time. Dr. Grootendorst explained that as the production of medical marijuana expands, producers will gain expertise in production and distribution which will translate into greater yields and lower costs per kilogram.[326] Similarly, as the pool of skilled labour increases, wages will decrease, thereby lowering production costs.[327] Finally, Licensed Producers will be able to exploit "economies of scale" as their production capacity increases.[328]

198. It is also reasonable to expect that drug plan insurance coverage for medical marijuana will continue to increase across the country. At present, Veterans' Affairs Canada covers the cost of purchasing medical marijuana for veterans who suffer from Post-Traumatic Stress Disorder and Dr. Grootendorst opined that "[g]iven this precedent, it seems plausible that other drug plans will extend coverage for medical marijuana as well".[329] In fact, the Plaintiffs' insurance expert, Mr. Wilkins, testified that his private drug insurance company, Green Shield, has recently started to offer coverage for the cost of purchasing medical marijuana.[330] In terms of drug coverage under provincial insurance plans, it is up to each province to determine if medical marijuana should be included. Nothing in the MMPR precludes such coverage. As Ms. Ritchot testified, it may be pressure from users of medical marijuana that ultimately influences provincial governments to cover the cost of marijuana as medicine under their respective plans.[331]

199. Most importantly, the Plaintiffs' testimony on cross-examination suggests that their ability to afford to purchase medical marijuana from Licensed Producers is not the real reason they want to be permitted to continue home cultivation. Rather, in Mr. Davey's opinion, Licensed Producers are not to be trusted because they exist just to make money.[332]

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[325] Grootendorst Aff, JBE Vol. 11, Tab 54, p. 6186, para 29
[326] Grootendorst Aff, JBE Vol. 11, Tab 54, p. 6190, para 36
[327] Grootendorst Aff, JBE Vol. 11, Tab 54, p. 6191, para 38
[328] Grootendorst Aff, JBE Vol. 11, Tab 54, p. 619, para 39-40
[329] Grootendorst Aff, JBE Vol. 11, Tab 54, p. 6186, para 26
[330] Wilkins Transcript, p. 1437
[331] Ritchot Transcript, pp. 778-779
[332] Davey Transcript, pp. 89-91

Similarly, Mr. Hebert testified that while he could afford to purchase from a Licensed Producer, he does not trust the system and does not want to participate in it. In his own words, "the whole system is really sketchy" and he feels he "shouldn't be forced to purchase" from a Licensed Producer.[333] Mr. Allard stated that he has not obtained further information from Licensed Producers with respect to prices or strains because he is simply uninterested in the system. He admitted in cross-examination that if he is not permitted to grow for himself, he would still refuse to utilize the Licensed Producer regime.[334]

200. The Plaintiffs' testimony starkly reveals the real reason they have brought this lawsuit. It is not that the Plaintiffs cannot afford to purchase medical marijuana from a Licensed Producer, it is that they do not want to. They want the right to grow a controlled substance on their own property because they believe they are entitled to do so. However, the decisional liberty interest does not extend to preferences for a "drug of choice". It would be an unprecedented expansion of the right to make medical decisions of fundamental importance if it were held to extend to the right to grow a controlled substance at home, particularly if such a right is grounded on an uninformed dislike of the commercial producers who lawfully can provide that medicine. Section 7 of the *Charter* does not protect personal preferences of this nature.

(iii) Medically Appropriate Dosages

201. A significant underpinning of the Plaintiffs' unaffordability claim is the fact that many participants in the MMAR program seem to have persuaded their physicians that they require enormous amounts of marijuana per day to treat their symptoms. There are, however, numerous reasons to call into question the medically appropriate nature of these extraordinarily high dosages.

202. First, the average daily dosages recently authorized under the MMAR (approximately 18 grams per day) were significantly higher than what is recommended in the available medical and scientific literature on appropriate dosages. Similarly, all of the physicians who testified with respect to their experiences prescribing medical marijuana agree that dosages between 1 to 5 grams per day are medically appropriate for almost all

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[333] Hebert Transcript, pp. 213-215
[334] Allard Transcript, p. 353

patients. Second, the Plaintiffs' dosages are also significantly higher than the average daily doses in other countries with long-established medical marijuana regimes. Third, the evidence demonstrates that in Canada when individuals purchase from either Health Canada or Licensed Producers, the average is approximately one gram per day. Fourth, the Plaintiffs' contention that they require high dosages because they consume their marijuana in edibles and oils is not supported by international literature comparing dosages across modes of ingestion. Finally, the medical appropriateness of the Plaintiffs' dosages is undermined by their own testimony with respect to the reasons (or lack thereof) for their dosage increases.

The Medical Literature and Medical Experience on Appropriate Dosages

203. The available literature on medically appropriate dosages of marijuana for medical purposes generally recommends dosages of approximately 1 to 3 grams per day.[335] The medical doctors who have testified in these proceedings with respect to appropriate dosages also agree that based on their clinical experience with patients who use marijuana for medical purposes, dosages of approximately 1 to 5 grams per day are typically appropriate.

204. Dr. Daeninck testified that in his experience, most of his patients "generally use 3-5 g a day (some use much less), and only when they need it."[336] He also noted that "[t]here are no medical indications, nor any retrospective evidence, for the use of amounts in excess of 5 g per day."[337] Dr. Ferris provided a rebuttal report to Dr. Daeninck's affidavit and stated that "I agree [with Dr. Daeninck] in general with doses of 3-5 grams/day as being adequate for most patients."[338] She further opined that she is "suspicious of doses around 20 g/day and higher. I believe a small number of growers have abused their licenses and have profited from selling surplus product."[339]

205. Dr. Baruch, a medical doctor who was the head of the Israeli Medical Marijuana Program from 2003-2012, testified that it was appropriate to start with doses of up to 20

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[335] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1438, para. 55, Ex "G", p. 2595; Daeninck Aff, JBE Vol. 11, Tab 58, p. 6353-6354, para. 31, Annexes A and B, p. 6391 and 6542; Kalant Aff. JBE Vol. 12, Tab 61, p.6820; Clarke Aff, JBE Vol. 13, Tab 68, p. 7321

[336] Daeninck Aff, JBE Vol. 11, Tab 58, p. 6353, para 28

[337] Daeninck Aff, JBE Vol. 11, Tab 58, p. 6353, para 28

[338] Ferris Aff. JBE Vol. 13, Tab 69, p. 7371

[339] Ferris Aff, JBE Vol. 13, Tab 69, p. 7372

grams a month and that he saw no further improvement in patients with doses above 100 grams per month.[340] He 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].[341]

206. Dr. Kalant, a Professor Emeritus in the Department of Pharmacology and Toxicology at the University of Toronto, testified that a number of studies of medical marijuana have found that progressive increases in dose at first increases the therapeutic effect, but that further increases lead to loss of therapeutic effect and replacement by adverse effects.[342] He elaborated on the "inverted U shape" phenomenon described by Dr. Baruch:

> The endocannabinoid system exhibits a phenomenon that has been referred to as 'receptor overload' [...] If the dose of cannabis or cannabinoid is increased beyond a certain point, further increases no longer produce a greater effect but actually decrease or abolish it because of desensitization of the receptors, so that the therapeutic effect disappears or is even replaced by adverse effects."[343]

207. Dr. Kalant also noted that two Canadian studies have found that medically appropriate dosages of marijuana are far lower than the average authorization under the MMAR. One study of 30 patients found that relief of pain was achieved by amounts of marijuana ranging from less than one gram to five grams a day. A second study found a significant reduction of neuropathic pain with a dosage of 0.75 grams of dried marijuana per day.[344]

208. Dr. Kalant ultimately concluded that, while the appropriate dosage ranges for different medical purposes has not yet been fully defined, "there is sufficient knowledge to demonstrate that it lies in the range of less than 1 to at most 4 to 5 grams of dried cannabis

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[340] Baruch Aff, JBE Vol. 10, Tab 37, p. 5949
[341] Baruch Aff, JBE Vol. 10, Tab 37, p. 5951
[342] Kalant Aff. JBE Vol. 12, Tab 61, p. 6810
[343] Kalant Aff. JBE Vol. 12, Tab 61, p. 6820
[344] Kalant Aff., JBE Vol. 12, Tab 61, p. 6820

a day."[345] The available evidence demonstrates that, "[l]arger amounts decrease or abolish the therapeutic effect because of receptor desensitization, and there is no evidence medical reason for prescribing larger amounts."[346] The Plaintiffs' rebuttal expert, Robert Clarke, agreed with Dr. Kalant that the existing studies show that "daily medicinal usage averages 1-3 grams."[347]

209. The College of Family Physicians of Canada also agrees that 1-3 grams per day is a medically appropriate dosage. The College recently issued a set of recommendations for practitioners who authorize marijuana for medical purposes. With respect to dosage, the College notes that, "[w]e expect that the upper level to the safe use of dried cannabis will be on the order of 3.0 g per day, and that even this level of use should be considered in only *very circumscribed conditions*" [as written].[348]

Consumption Amounts in Other Jurisdictions

210. Canada provided evidence on the dosage amounts in two long-established medical marijuana regimes: Israel and the Netherlands. In both of these countries, the consumption amounts are dramatically lower than those authorized under the MMAR.

211. As of July 2014, the Israeli medical marijuana program had over 17,000 patients with an average dose of 33.5 grams per month or just over one gram per day.[349] Dr. Baruch, testified that the maximum dose permitted by the Israeli program is 100 grams a month, although higher dosage requests may be submitted to an exemption committee for approval.[350] Only 86 permits for an amount of marijuana 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.[351] In other words, 99.5% of medical marijuana patients in Israel consume approximately one gram of marijuana per day and absolutely no one in Israel is permitted to consume seven grams a day or more.

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[345] Kalant Aff. JBE Vol. 12, Tab 61, p. 6832
[346] Kalant Aff. JBE Vol. 12, Tab 61, p. 6832
[347] Clarke Aff, JBE Vol. 13, Tab 63, p. 7321
[348] Daeninck Aff, Annex "B", JBE Vol. 11, Tab 58, p. 6542
[349] Baruch Aff, JBE Vol. 10, Tab 37, p. 5949
[350] Baruch Aff, JBE Vol. 10, Tab 37, p. 5949
[351] Baruch Aff, JBE Vol. 10, Tab 37, p. 5949

212. The Netherlands has permitted doctors to prescribe the use of marijuana for medical purposes since 2001 and currently there are approximately 1200 individuals who are authorized to use medical marijuana.[352] In the Netherlands, as in Canada, there is no legislated maximum daily dosage of medical marijuana; a patient's daily dosage is determined by his or her doctor.[353] While the Bureau of Medical Cannabis in the Netherlands is not involved in prescribing or dispensing medical cannabis, it estimates that the average daily dose is approximately 0.68 grams.[354]

213. These estimates have been confirmed by an academic study on daily dosages of medical marijuana in the Netherlands.[355] The study assessed the prescription history of all patients with at least one medicinal cannabis prescription in the period 2003-2010.[356] The study identified 5,540 individual patients who received a combined total of approximately 35,000 medicinal cannabis dispensations from pharmacies.[357] Patients had an average daily dose of 0.68 grams per day.[358] The study further noted that despite differences in composition of active ingredients in the cannabis prescribed, there were no clear differences in average daily dose between the four cannabis varieties offered at the time of the study.[359]

Amounts Purchased from Health Canada and Licensed Producers

214. Statistics on the amounts of marijuana for medical purposes purchased from Health Canada under the MMAR, as well as information on the current amounts of marijuana that are being purchased from Licensed Producers, provide further evidence that actual consumption amounts are far lower than the amounts authorized for use under the MMAR. In other words, the high daily dosage authorizations under the MMAR do not accurately reflect the amount of marijuana that individuals are actually consuming on a daily basis.

215. Individuals authorized to use marijuana under the MMAR once had the option of purchasing their marijuana from Health Canada. These individuals, on average, purchased

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[352] Sandvos Aff. JBE Vol. 11, Tab 53, p. 6059, para. 4 and p. 6064, para. 25
[353] Sandvos Aff. JBE Vol. 11, Tab 53, p. 6064, para. 23
[354] Sandvos Aff. JBE Vol. 11, Tab 53, p. 6064, paras. 24-25
[355] Sandvos Aff. JBE Vol. 11, Tab 53, p. 6064, para. 25 and Exhibit "C", JBE Vol. 11, Tab 53, p. 6088
[356] Sandvos Aff., Exhibit. "C", JBE Vol. 11, Tab 53, p. 6088
[357] Sandvos Aff, Exhibit "C", JBE Vol. 11, Tab 53, p. 6089
[358] Sandvos Aff, Exhibit "C", JBE Vol. 11, Tab 53, p. 6090
[359] Sandvos Aff, Ex. "C"JBE Vol. 11, Tab 53, p. 6090

1.2 grams per day at a cost of $5 per gram despite the fact that the average authorized dose was about 4 grams per day.[360] This suggests that the average actual consumption amount was in line with the literature on medically appropriate dosages as well as the dosage averages in established medical marijuana regimes.

216. A similar pattern is emerging under the new Licensed Producer regime. The amounts that individuals are currently purchasing from Licensed Producers are consistent with the amounts purchased from Health Canada under the previous regime and the amounts consumed in Israel and the Netherlands. Todd Cain testified that as of November 30, 2014, there were 14,682 users of medical marijuana registered with Licensed Producers and that, to date, there have been approximately 70,000 shipments of medical marijuana and that "[t]he average shipment is about 30 grams, which we are equating to about a gram a day [...] Although not everyone reorders every month."[361] Mr. Cain further noted that the average authorization for individuals who have registered with a Licensed Producer is between three and a half to four grams per day.[362]

The Lack of Dosage Differences Between Ingestion Methods

217. The Plaintiffs also assert that they require higher dosages of medical marijuana because they make edibles, teas and other marijuana products out of their dried marijuana. Leaving aside the lack of scientific or medical evidence with respect to the efficacy of marijuana products, the Plaintiffs' claim is not supported by the existing international data on consumption patterns with respect to various forms of marijuana.

218. The most extensive research on dosing of medical cannabis users is a study published by Arno Hazekamp in 2013.[363] Dr. Hazekamp analyzed the data compiled from a survey of 953 patients from 31 countries who were all using or had used medical cannabis. He found that the mean dose for all forms of using cannabis, including smoking, vaporizing, drinking tea, or ingesting marijuana edibles, was approximately 3 grams per day.[364]

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[360] Cain Transcript, p. 925; Ritchot Aff, JBE Vol. 4, Tab 28, p. 1539, para. 56
[361] Cain Transcript, p. 923
[362] Cain Transcript, p. 923
[363] Baruch Aff, JBE Vol. 10, Tab 37, p. 5950
[364] Baruch Aff, JBE Vol. 10, Tab 37, p. 5950-51

219. In the Netherlands and Israel, there are no restrictions on modes of ingestion, the average dose is approximately one gram or less. In the Netherlands, for instance, the Bureau of Medical Cannabis recommends that patients consume their cannabis orally as tea by consuming one cup of tea in the evening that is prepared by boiling 0.5 grams of cannabis in 0.5 litre of water. If, after two weeks, the effect is insufficient, the Bureau recommends increasing the dose by one additional cup of tea per day.[365]

220. The Plaintiffs' expert witness, Dr. Pate, acknowledged in cross-examination that there is little scientific research on the efficacy of marijuana products or the medically appropriate dosages that of these products.[366] He did postulate, however, that orally ingesting "cannabis-based medicines" may require "lesser dosages".[367] In fact, this is one reason he suggests the oral ingestion of marijuana may result in the amelioration of unwanted side effects.[368]

221. In any event, as previously noted, the Plaintiffs' primary mode of ingestion is smoking or vaporizing rather than consuming marijuana products and their use of edibles, oils or juices does not appear to be medically necessary and certainly there is no evidence as to their individual medical need before the courts.

Dosage Increases Unrelated to Medical Need

222. The Plaintiffs' apparent response to the assertion that they may not need to consume as much marijuana as they currently do in order to obtain adequate medical benefits is that their doctors have "approved" these amounts and, therefore, these amounts must be justified even though they do not accord to the notion of appropriate dosages that are set out in the medical literature, the testimony of medical practitioners, the recommendations of the College of Family Physicians of Canada and Health Canada, as well as the evidence on appropriate dosages in other medical marijuana regimes.

223. The evidence strongly suggests that the high dosages authorized under the MMAR were likely authorized for reasons unrelated to medical efficacy. For example, Mr. Allard

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[365] van den Bos Aff, JBE Vol 12, Tab 64, p.6987, para. 10
[366] Pate Transcript, p. 615
[367] Pate Aff, Schedule C, JBE Vol. 2, Tab 15, p. 607, para. 31
[368] Pate Aff, JBE Vol. 2, Tab 15, Schedule C, p. 607, para. 31

and Mr. Davey each admitted in cross-examination that their medical conditions have remained stable since they first began using marijuana for medical purposes under the MMAR.[369] Despite this, Mr. Allard's dose of medical marijuana increased from 5 grams a day in 2004 to 10 grams a day in 2006 and then doubled again to 20 grams a day in 2012.[370] Similarly, Mr. Davey's dose was 10 grams a day in 2010 but had increased to 25 grams a day by 2013.[371] The Plaintiffs have not pointed to any change in their medical conditions that would justify these dramatic increases.

224. Dosages authorized under the MMAR are also called into question by the fact that, for a variety of reasons, patients may attempt to persuade their doctor to agree to a higher dosage. Dr. Daeninck noted in his expert report that despite the fact 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 and the majority were approved for over 10 grams per day.[372] Dr. Daeninck opined on several reasons for these high dosages, including patients who try to legitimize recreational use and doctors who bring in extra income by charging fees for authorizing medical marijuana for hundreds or even thousands of patients.[373]

225. Most significantly, the evidence demonstrates that dosages under the MMAR were influenced by the connection between an individual's authorized consumption amount and the number of plants he or she could cultivate. Mr. Allard, for example, stated on cross-examination that he requested a higher dose from his physician *not* because his condition had worsened or because he needed a higher dose to prepare edibles and juices but, instead, because he was having difficulty with his plants and a higher dose would mean, under the MMAR formula, that he would be permitted to grow more plants. He candidly admitted that he told his doctor he was having "problems" with his yields and that he wanted to grow more plants in order to try different strains.[374] Mr. Allard agreed that he did not need an average of 20 grams to dose each day but that he had to ask for that amount in order to grow enough plants to hedge against the possibility of crop failure.[375] In other words, Mr.

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[369] Allard Transcript, p. 276; Davey Transcript, p. 33
[370] Allard Transcript, p. 285, ll. 10-21
[371] Davey Transcript, p. 37, ll. 18-p. 38, ll. 14
[372] Daeninck Aff, JBE Vol. 11, Tab 58, p. 6356, para 38
[373] Daeninck Aff, JBE Vol. 11, Tab 58, p. 6356, para 38-39
[374] Allard Transcript, p. 287
[375] Allard Transcript, p. 288

Allard did not obtain a higher dose because he actually required it for managing his medical condition. Rather, he convinced his doctor that he needed a higher dose so he could cultivate more plants.

226. Mr. Colasanti, the plaintiffs' expert on growing marijuana, who also holds an ATP and PUPL, explained that his dosage increase from 5 to 20 grams was the result of lobbying his physician to approve a higher amount. When Mr. Colasanti originally approached his doctor about using marijuana for medical purposes, he was given a 5 gram per day dosage. According to Mr. Colasanti, his doctor was uncomfortable authorizing a higher dose. Over the years, however, Mr. Colasanti "educated" his doctor about the benefits of using marijuana and was able to convince his doctor to increase his authorization to 20 grams per day.[376]

227. It is questionable, then, to what extent the dosages of marijuana authorized by doctors under the MMAR reflect the patients' actual medical needs. The average dosages authorized for individuals who are registering with Licensed Producers, as well as the emerging consumption patterns under the new regime, suggest that the high dosages previously authorized under the MMAR may have been, at least in part, the result of persuasive patients who were concerned with the yield of their plants and their own cultivation skills. Further, given that the dosages in established international medical marijuana regimes are almost identical to those under the Licensed Producer regime, it appears that the high amounts authorized under the MMAR are a reflection of patient-driven rather than medically appropriate dosages. In the words of Dr. Kalant, "[i]t seems reasonable [...] to infer that use of much higher daily dosages [...] represents either very inefficient use of the drug, or use for non-medical purposes."[377]

228. In sum, the evidence does not support the Plaintiffs' contention that purchasing marijuana from Licensed Producers is prohibitively expensive. To the contrary, the Plaintiffs' own evidence shows that they are able to afford to buy marijuana in medically appropriate dosages. The Plaintiffs have not even attempted to obtain current information on the prices offered by Licensed Producers nor have they contacted Licensed Producers

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[376] Colasanti Transcript, p. 482
[377] Kalant Aff, JBE Vol. 12, Tab 61, p. 6820

to discuss their eligibility for compassionate pricing programs. The Plaintiffs' lack of affordability arguments are also undermined by the significant costs associated with safely cultivating quality marijuana for medical purposes in a residential setting. Clearly, the real motivation for the Plaintiffs' challenge to the Licensed Producer regime established by the MMPR is uninformed distrust of the industry as opposed to real concerns about the affordability of their product.

c) Section 7 Does Not Protect Economic Interests

229. While the previously discussed medical marijuana jurisprudence has established the proposition that legislation regulating marijuana must allow for reasonable access to a lawful supply for medical purposes, it has never asserted that such regulation must ensure that marijuana is priced inexpensively or that it must permit the possibility of home cultivation for individuals who prefer to do so in order to avoid purchasing marijuana commercially.

230. Furthermore, Canadian courts have consistently held that s. 7 does not protect property or other predominantly economic interests.[378] More particularly, the Supreme Court has explained that "[t]he *Charter* does not confer a freestanding constitutional right to health care."[379] The stark reality is that many medically necessary prescription drugs are prohibitively expensive for some individuals and governments must make difficult choices with respect to deciding which drugs they will choose to subsidize.

231. Given that s. 7 does not place positive obligations on the government to subsidize the cost of accessing a particular medicine in a particular way and given that s. 7 does not encompass a right to "affordable" health care in the sense of an individual entitlement to accessing medicine at a cost that is subjectively acceptable to a patient, the Plaintiffs' affordability arguments cannot succeed. A reduction in the standard of living is not a deprivation contemplated by s. 7 of the *Charter*.[380] While the Plaintiffs may have to allocate more of their monthly income to purchase their marijuana from Licensed Producers than

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[378] See, for example, *Irwin Toy Ltd. v. Quebec (Attorney General)*, [1989] 1. S.C.R. 927, p. 1003; *Gosselin v. Quebec (Attorney General)*, [2002] 4 S.C.R. 429 ["*Gosselin*"], paras. 80-83; *Reference re Marine Transportation Security Regulations (CA)*, 2009 FCA 234, para. 47

[379] *Chaoulli v. Québec (Attorney General)*, [2005] 1 S.C.R. 791, para. 104

[380] *Brown v. British Columbia (Minister of Health)*, [1990] 66 DLR (4th) 444 ["***Brown***"], p. 467

might be the case if they could continue to grow marijuana at home, such a lifestyle choice does not fall within the ambit of rights protected by s. 7 of the *Charter*.

d) The Licensed Producer Regime Facilitates Access to Marijuana Strains

232. The Plaintiffs also claim that their s. 7 liberty and security of the person interests are engaged by their need to use particular "strains" of marijuana to alleviate particular medical conditions. They say this is a choice of fundamental personal importance and they ought to be able to determine which variety of marijuana is best for them.

233. There are two reasons why this argument must fail. First, while the courts have determined that individuals are entitled to make decisions of fundamental personal importance, there is little, if any, medical or scientific evidence to substantiate the Plaintiffs' claims that certain strains of marijuana are required for their particular conditions. Second, the MMPR places no limits on the number of strains that Licensed Producers may offer and the evidence demonstrates that the number of strains offered by Licensed Producers is rapidly increasing as the market increases.

234. The Plaintiffs have offered no scientific or medical evidence that certain strains of marijuana are necessary for treating their particular medical conditions. Instead, they assert that through "trial and error" they have discovered that some strains are more effective for their conditions than others.[381] While the Plaintiffs claim that different strains of marijuana are effective for different illnesses, such a claim has not been scientifically substantiated.

235. Dr. Kalant explained 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."[382] He also noted that "the very numerous fancifully named 'strains' of cannabis advertised on the internet are not accompanied by any evidence that they meet these criteria [to be defined as strains], or that they have been analysed chemically for their contents of various cannabinoids."[383] The alleged medical efficacy of particular strains is not the result of

[381] Davey Transcript, pp. 44-45; Hebert Transcript, p. 258; Allard Transcript, pp. 297-300
[382] Kalant Aff, JBE Vol. 12, Tab 61, p. 6820
[383] Kalant Aff, JBE Vol. 12, Tab 61, p. 6821

clinical testing or scientific research but is, instead, "based either on subjective anecdotal reports, or promotional advertising by producers."[384]

236. Dr. Kalant unequivocally 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.[385] The Plaintiffs' expert, Dr. Pate, also acknowledges the lack of scientific knowledge with respect to the medical efficacy of certain strains over others. He notes that "[d]ifferent strains *are reputed to* produce differing effects" and speculates that these differing effects are "*probably due* to varying amounts and ratios of the therapeutically active compounds" but he is unable to point to any scientific or other research on this issue [emphasis added].[386]

237. It is also noteworthy that in the Netherlands and Israel, there are a very limited number of strains available for users of marijuana for medical purposes. In the Netherlands, 5 varieties with differing levels of THC and CBD are offered, while in Israel, 8 varieties of dried marijuana with differing levels of THC, CBD and CBN are available to users along with 5 varieties of cannabis oil and 5 varieties of cannabis cookies that each also contain specific levels of active ingredients.[387] The medical marijuana programs in those jurisdictions have not determined that specific strains are needed for specific medical conditions.

238. The absence of medical or scientific evidence with respect to the connection between strains of medical marijuana and the treatment of certain conditions undermines the Plaintiffs' assertions that they "require" specific strains in order to relieve their symptoms. While the security of the person interest under s. 7 protects decisions of fundamental importance, this interest ought not to be expanded to encompass the unscientific, untested personal opinions of the Plaintiffs regarding the efficacy of particular marijuana strains.

239. Even if the Plaintiffs' claims with respect to the efficacy of certain strains were substantiated by credible research, the MMPR does not limit the number of strains that

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[384] Kalant Aff, JBE Vol. 12, Tab 61, p. 6821
[385] Kalant Aff, JBE Vol. 12, Tab 61, p. 6832
[386] Pate Aff, JBE Vol. 2, Tab 15, p. 603, paras. 15-16
[387] Sandvos Aff. JBE Vol. 11, Tab 53, p. 6060, p. 8; Bardenstein Aff. JBE Vol. 11, Tab 57, pp. 6324-26

Licensed Producers may offer. In fact, the number of strains offered by Licensed Producers has been steadily increasing since the MMPR came into force on April 1, 2014. Todd Cain testified that the Licensed Producers have, as of March 2015, approximately 300 strains in the form of seeds or other genetic material and approximately 100 of those strains are currently in production.[388]

240. It is also important to note that until March 31, 2014, persons holding valid production licenses were permitted under the MMPR to sell or provide their marijuana seeds or plants to Licensed Producers. This aspect of the MMPR provided a mechanism through which individuals could seek to have their preferred strains made available to them by a Licensed Producer. While the Plaintiffs decided not to take advantage of this opportunity, this does not mean that the MMPR prevented them from having access to their preferred strains of marijuana.

241. The Plaintiffs have not provided any evidence that they will be unable to obtain their preferred strain of marijuana from Licensed Producers. In fact, the Plaintiffs have not even recently contacted any Licensed Producers to discuss the availability of strains.[389] It is far more reasonable to anticipate that, based on the number of strains available as well as the number of strains in development, the Plaintiffs will have access to a wide variety of strains, at least one of which they are likely to find effective. Given the potential availability of an unlimited number of strains from Licensed Producers, the Plaintiffs' claim that their choice will be constrained under the new regime is unfounded.

242. Further, unlike home cultivation, if the Plaintiffs were to purchase from a Licensed Producer they could "sample" various strains of marijuana to determine whether or not a particular strain was effective for them. The Plaintiffs' current ability to "sample" various strains is restricted by the seeds or clones that are available to them as well as the length of time it takes to cultivate a crop from germination to harvest and the success of the cultivation cycle. Mr. Allard testified that if a strain turns out not to be effective for him, those particular plants are not useful and a new crop of a different strain must be started.[390]

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[388] Cain Transcript, p. 916
[389] Allard Transcript, p. 345; Hebert Transcript, pp. 214, 265-266; Davey Transcript, p. 89
[390] Allard Transcript, p. 299

Under the Licensed Producer regime, the Plaintiffs would avoid this time-consuming and labour-intensive process.

243. In sum, the Licensed Producer regime does not prevent the Plaintiffs from gaining reasonable access to safe, high quality dried marijuana in medically appropriate amounts. The Plaintiffs have failed to establish, on the evidence, that the MMPR engages their ability to make medical decisions of fundamental importance or that the MMPR imposes psychological or physical suffering because medical marijuana must be obtained through the Licensed Producer regime.

244. Instead, the Plaintiffs' real complaint is that they do not trust the Licensed Producer regime and would prefer to continue cultivating their own marijuana. The *Charter* protects the fundamental rights of Canadians. Personal preferences or the desire to avoid a particular government regulation does not engage the interests protected by s. 7.

245. Accordingly, the only aspect of s. 7 that is engaged is the Plaintiffs' "incarceration risk liberty interest", that is to say the fact that they face the possibility of incarceration as a penalty should they choose to deliberately violate the law and to produce their own marijuana or purchase it from the black market rather than from a Licensed Producer. As set out in the next section, however, such a possibility does not violate the principles of fundamental justice.

No Violation of the Principles of Fundamental Justice

246. The principles of fundamental justice are not a source of rights, but a qualifier on the right to life, liberty, and security of the person under s. 7 of the *Charter*.[391] In general, the question to be addressed is whether the manner in which the impugned law restricts or deprives life, liberty, or security of the person interests accords with the principles of fundamental justice. The burden is on the party asserting a violation of s. 7 of the *Charter* to show that the legislation does not accord with the principles of fundamental justice.[392]

247. As noted above, the relevant principles of fundamental justice in this case are arbitrariness, overbreadth, and gross disproportionality. These principles ensure that the

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[391] *Bedford*, para. 94

[392] *R. v. Malmo-Levine; R. v. Caine*, para.97; *Bedford*, para.127

means by which the state seeks to attain its objective are not "fundamentally flawed".[393] Identifying the state objective is a key step in the constitutional analysis. The court must ascertain the objective of the impugned law before determining whether the means used to attain it are arbitrary, overbroad, or grossly disproportionate. With respect to these principles of fundamental justice, 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.[394] The focus of the analysis is not on the legitimacy of the state objective, but the means used to attain it.

248. The judiciary's role under the *Charter* is to determine constitutional protections and limits, not to pass judgment on the wisdom of the legislation or the policy choices underlying it.[395] The principles of fundamental justice do "not mandate a perfect system of government which is required to meet the desires and demands of its citizens even in the area of personal health."[396] What the *Charter* requires is that the government not unjustifiably hinder access to marijuana for those with a demonstrated medical need.[397] The evidence demonstrates that by promulgating the MMPR, Canada has met this objective.

a) Objective of the MMPR: Protecting Public Health and Public Safety

249. The MMPR's Regulatory Impact Analysis Statement (RIAS) states that the overall objective of the regulations 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."[398] More specifically, by treating marijuana 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.[399]

250. Under the MMAR it was not practically possible to impose quality and safety standards on the production of marijuana by personal growers who may lack the capacity,

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[393] *Bedford*, para.105
[394] *Bedford*, para. 125
[395] *R. v. Clay*, para.4; *R. v. Malmo-Levine; R. v. Caine*, para.5
[396] *Wakeford v. Canada*, [2000] O.J. No. 1479 (ONSCJ), para. 46, aff'd [2002] O.J. No. 85 (ONCA), leave to appeal refused [2002] S.C.C.A. No. 147.
[397] *Long*, para. 42
[398] Ritchot Aff, JBE Vol. 4 Tab28, p. 1595, para. 179 and Exhibit "CCC", JBE Vol. 7, p. 3795
[399] Ritchot Aff, JBE Vol. 4, Tab 28, p. 1596-97 paras. 180-181

knowledge or motivation to implement such standards.[400] Without regular laboratory testing of the marijuana produced by personal growers, individuals who consumed this marijuana faced health and safety risks. It is only with such testing that microbial or chemical contamination that may be present on the dried marijuana can be identified. Similarly, the testing of each crop is necessary in order to determine the levels of the active ingredients in the dried marijuana. Given the tens of thousands of individuals across the country who were growing for themselves or others under the MMAR, it was impossible for Health Canada to impose and monitor the quality and safety of the marijuana they were consuming for medical purposes.

251. The MMPR require Licensed Producers to adhere to good production practices and to apply rigorous testing procedures that are designed to ensure that individuals receive an uncontaminated product whose levels of active ingredients remain consistent from one crop to the next.[401] The fact that Health Canada conducts unannounced inspections of these commercial growing sites further ensures that Licensed Producers adhere to the regulations and that any issues that may arise are addressed appropriately through mechanisms such as product recalls and the destruction of contaminated plants.[402]

252. The MMPR also aim to address the safety risks and other problems associated with production in residential settings that were reported to Health Canada by municipalities, first responders, police, and neighbours.[403] By moving the production of marijuana for medical purposes into a regulated commercial environment, the MMPR intend to reduce the risks to individual growers as well as other individuals and communities who may be negatively impacted by the problems associated with home cultivation.

253. The MMPR are intended to return Health Canada to its traditional role as a regulator rather than a body that authorizes individuals to consume a particular medicine and that produces and sells a product for medical use. The Licensed Producer regime was created, in part, to facilitate the development of a legitimate, regulated business environment in

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[400] Ritchot Aff, JBE Vol. 4, Tab 28, p. 1596, para. 180
[401] Ritchot Aff, JBE Vol. 4, Tab 28, p. 1597, para. 181; Cain Aff, JBE Vol. 7, Tab 29, p. 4066-67, paras. 57-59 and Ex "K", JBE vol. 7, p. 4334
[402] Cain Aff, JBE Vol. 7, Tab 29, p. 4066-67, paras. 57-59
[403] Ritchot Aff, JBE Vol 4, Tab 28, p. 1596, para. 180

which the production of marijuana for medical purposes is undertaken in sanitary, secure facilities with enforceable standards of record keeping and packaging.[404] In short, the MMPR attempt to provide access to dried marijuana for medical purposes in a way that minimizes the health and safety risks associated with its production and consumption.

b) Restricting Personal Cultivation Does Not Violate the Principles of Fundamental Justice

254. The conversion to the new supply model under the MMPR is not arbitrary, overbroad or grossly disproportionate. The evidence demonstrates that the health and safety risks associated with home cultivation are genuine. The Plaintiffs and their experts do not dispute that the risks of contamination, fire, damage to building structures, theft and diversion are real. They claim, however, that these risks can be minimized if the proper precautionary steps are taken. Canada agrees that these particular risks have the potential to be minimized if growing operations are properly constructed with all the requisite permits, if appropriate safety-approved cultivation equipment is properly installed, if comprehensive security systems are in place, if the marijuana is tested regularly by a certified laboratory and if unannounced inspections take place. This is precisely what the Licensed Producer regime intends to accomplish.

(i) The Restriction is Not Arbitrary

255. With respect to arbitrariness, the question that must be addressed is "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"[405] A law that imposes limits on these interests in a way that bears no connection to its objective arbitrarily impinges on those interests. 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 marijuana for medical purposes.

256. This Court has before it extensive evidence of the real risks associated with the personal cultivation of medical marijuana. Several of the Plaintiffs' witnesses concede that unless properly constructed and inspected, the cultivation of medical marijuana in

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[404] Ritchot Aff, JBE Vol. 4, Tab 28, p. 1597, para. 181
[405] *Bedford*, para. 111

residential dwellings can be a risky, unsafe endeavour.[406] Others concede that some medical marijuana growers abused their personal and designated production licences by diverting their marijuana to the illicit market.[407] Several of Canada'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. Additionally, the evidence from international medical marijuana regimes suggests a trend away from home cultivation in favour of commercial production because of the risks and abuses associated with the personal production of medical marijuana.

Health and Safety Risks

257. While common sense dictates that residential dwellings are not typically built in order to accommodate marijuana growing operations, several witnesses have provided cogent evidence to illustrate the risks associated with these operations.

258. Len Garis, the Fire Chief of Surrey, British Columbia, 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. Chief Garis' expert report sets out data compiled from inspections carried out at illicit and MMAR residential growing operations in Surrey.[408]

259. Despite the fact that one of the conditions of obtaining a personal or designated production license from Health Canada under the MMAR was that producers must be compliant with zoning bylaws and other municipal legislation, Chief Garis found that a significant portion of medical marijuana growing operations exhibited similar, and sometimes greater, safety hazards than illicit growing operations.[409] Chief Garis testified that in 2013, for example, the Surrey inspection team inspected 198 medical marijuana grows and that repair notices were issued for nearly all of these sites.[410] He also noted that

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[406] Colasanti Aff. JBE Vol. 2, Tab 7, p. 557, para. 31, p. 558, para 32, p. 558, para 35, p. 559, para 37, p. 559, para 38; Affidavit of Robert Boileau sworn on December 19, 2014 ("Boileau Aff"), JBE Vol. 13, Tab 66, pp. 7061-7063; Affidavit of Jason Schut sworn on December 11, 2014 ("Schut Aff"), JBE Vol. 13, Tab 70, pp. 7475, 7483, 7500-7506; Nash Aff, JBE Vol. 11, Tab 55, p. 6238, para. 32, p. 6239, para.38, p. 6242, para. 51

[407] See, for example, Nash Aff, JBE Vol. 11, Tab 55, p. 6240, para. 41

[408] Garis Aff, JBE Vol. 9, Tab 31, p. 4893-4900

[409] Garis Aff, JBE Vol. 9, Tab 31, p. 4847, para. 21

[410] Garis Transcript, p. 1147

none of these sites had the requisite permits or licenses necessary for the modifications that were undertaken.[411]

260. Other Canadian municipalities have discovered the same types of risks at residential medical marijuana growing locations. As of December, 2014, the City of Calgary had inspected 33 medical marijuana growing operations and of those, 26 were issued orders by Alberta Health Services for violations under the Alberta *Public Health Act* and 29 had safety code violations identified by the inspectors. Twenty-five of the 33 houses inspected were required to be remediated.[412] The City of Port Coquitlam, British Columbia has found that medical growing operations in their municipality exhibit the same type of safety risks as illegal growing operations, including mold, electrical hazards, and fire risks.[413] The cities of Chilliwack and Abbottsford in British Columbia have found similar problems during their inspections of medical marijuana growing operations.[414]

261. Robert Boileau provided a rebuttal report to Chief Garis, yet Mr. Boileau agreed with Chief Garis that fire "is one, if not the primary concern with grow operations."[415] He acknowledged that there "is potential for individuals to attempt to skirt these [local] regulations"[416] and that problems occur when electrical work is installed or altered by unqualified individuals.[417]

262. The specific problem of toxic mould in residential marijuana growing operations was addressed by Dr. Miller, an expert on fungal physiology who has published over 300 papers on the impact of fungi and fungal toxins on population health. Dr. Miller noted that each marijuana plant adds as much moisture to a house as approximately seven to ten houseplants.[418] Marijuana plants may overwhelm the ventilation capacity of single-family residences and result in mould damage to the structure, while in multiunit residential buildings Dr. Miller found that the existing data showed that in addition to mould damage

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[411] Garis Transcript, p. 1147
[412] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1560, para. 120
[413] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1559-60, para. 119
[414] Ritchot Aff. JBE Vol. 4, Tab 28, p. 1558-59, paras. 117-118
[415] Boileau Aff, JBE Vol. 13, Tab 66, p. 7062
[416] Boileau Aff, JBE Vol. 13, Tab 66, p. 7061
[417] Boileau AFf, JBE Vol. 13, Tab 66, p. 7053
[418] Miller Aff, JBE Vol. 12, Tab 63, p. 6931

to common walls, the chance of contaminants and odours being transferred from one unit to the other would be quite common.[419]

263. Jason Schut and Eric Nash each provided a rebuttal report to Dr. Miller. They agreed that mould is a serious issue in marijuana growing operations unless proper steps are taken to remove the excess moisture. Mr. Schut, in particular, noted that "if one simply adds plants, of any kind, to such residences without the required equipment to remove or exhaust the moisture, the moisture and humidity levels could be problematic and cause damage and risks to occupants and others."[420] Mr. Schut's report suggests that because of the large number of plants that individuals were authorized to cultivate under the MMAR, the vast majority of these growing operations in Canada either already have toxic mould problems or are at risk of developing them.

264. Mr. Schut, who is a professional remediator, further explained that the remediation of structural mould cannot be undertaken by "[t]he average person or general contractor" because they have "no training or expertise in understanding how to safely remove mould from a structure".[421] Mr. Schut opined that after proper remediation, air quality samples must be taken in order to ensure that the house is safe and suitable for occupancy; without this testing, "there is no proof that the unsafe levels of mould are gone".[422]

265. Larry Dybvig, a professional appraiser, explained the general need for remediation at former residential marijuana growing sites. He testified that these homes usually require bylaw compliance, inspection and remediation to deal with the various problems caused by cultivating marijuana in homes not designed for that purpose.[423]

266. The Plaintiffs' rebuttal witness, Scott Wilkins, explained that in order for owners of homes with medical marijuana growing facilities to obtain insurance, they had to arrange for these homes to be inspected and if necessary, remediated at their own cost, which may run into the thousands of dollars.[424] Mr. Wilkins agreed that there are a number of risks associated with growing marijuana generally and that it is important to mitigate the risks

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[419] Miller Aff. JBE Vol. 12, Tab 63, p. 6932
[420] Schut Aff,, JBE, Vol. 13, Tab 70, p. 7475
[421] Schut Aff, JBE, Vol. 13, Tab 70, p. 7480
[422] *Ibid.*
[423] Dybvig Aff, JBE Vol. 12, Tab 59, p. 6603, pp. 6657-59
[424] Wilkins Transcript, pp. 1405-1410 and 1412-1413.

associated with the residential cultivation of medical marijuana.[425] These risks lead to higher insurance premiums for homes with medical marijuana grows.[426] In fact, Mr. Wilkins noted that most insurance companies in Canada refuse to take on the risk of insuring these homes.[427]

267. The high humidity associated with marijuana cultivation and the subsequent drying of the marijuana bud poses a further health risk because there is a real danger of mould developing on the marijuana itself. Mr. Colasanti explained that it is necessary to dry the marijuana bud after it is harvested from the plant and that during the drying process, the bud will lose about 80% of its weight in water. He testified that if the bud is not dried properly, there is a risk of mould developing on the dried marijuana.[428] He also acknowledged that marijuana is subject to other types of contaminants such as spider mites, aphids and heavy metals.[429]

268. Mr. Nash agreed in cross-examination that mould and other contaminants on the marijuana being used for medical purposes by individuals with various illnesses may pose a health risk to those individuals.[430] As with Mr. Colasanti, Mr. Nash agreed that laboratory testing of the marijuana to ensure that it was free from such contaminants would be ideal.[431]

269. Dr. ElSohly testified as to the comprehensive measures that are required in order to ensure that the marijuana cultivated in his lab is of a stable and consistent quality: "The product to be produced for medicinal use needs to be determined in terms of its chemical composition (i.e. cannabinoids content and ratios of essential cannabinoids) and limits."[432] He also noted that "[e]ach product should have at least a certificate of analysis for each lot which should include the test method, acceptable limits, and the results of the analysis. Each analysis may include the concentration of active constituents (e.g. THC, CBD, etc.), microbial counts, heavy metals, and moisture content."[433] Dr. ElSohly explained that these

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[425] Wilkins Transcript, pp. 1398-1401
[426] Wilkins Transcript, pp. 1422-1423
[427] Wilkins Transcript, pp. 1394-1395
[428] Colasanti Transcript, p. 488
[429] Colasanti Transcript, p. 489
[430] Nash Transcript, p. 1958
[431] Nash Transcript, p. 1959
[432] ElSohly Aff, JBE Vol. 12, Tab 60, pp. 6725
[433] ElSohly Aff, JBE Vol. 12, Tab 60, pp. 6726

procedures are necessary "because the produced marijuana is used as a drug, more like a prescription drug that needs to meet regulatory guidelines for drugs to guarantee the quality of the product, its safety, and its consistency from batch to batch."[434]

270. The Plaintiffs concede that safety risks may also arise because of the monetary value of marijuana. There is a general consensus that the street value of marijuana is approximately $1200-2000 a pound or $5 to $10 per gram.[435] The Plaintiffs acknowledge that the value of marijuana means that all residential marijuana growing operations, including medical marijuana sites, are potential targets for thieves. Mr. Davey and Mr. Alexander, for example, have set up a security system that includes several steel doors, motion sensors, and a monitored alarm presumably because they want to protect their marijuana from theft.[436] Mr. Colasanti agreed that proper security was necessary because even though the price of marijuana has declined over the years, it is still a valuable commodity: "I am aware that thieves can target cannabis production sites much like they target any location that may have valuable items to steal and therefore security precautions need to be taken."[437] He recommended three or more levels of security for growing operations and his own site is fully fenced and gated with security cameras, a monitored alarm system and a panic button.[438]

271. Finally, the evidence demonstrates that residential marijuana growing operations affect the value of these properties. Mr. Dybvig's study on the impact of marijuana cultivation in residential homes found that lenders are reluctant to provide credit secured by mortgages on homes that once contained a growing operation. The report also found that even when these homes are remediated, credit financing is only possible if the debtor pays a higher than average cost.[439] The stigma associated with marijuana growing operations in homes (both medical and illicit) can be substantial and the negative impact can last for a long time.[440] Based on case studies, Mr. Dybvig found that the average home

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[434] ElSohly Aff. JBE Vol. 12, Tab 60, pp. 6730
[435] Holmquist Aff, JBE Vol. 8, Tab 30, p. 4385, para. 43; Colasanti Transcript, p. 496, ll. 17-21; JBE Vol. 11, Tab 55, p. 6240, para. 41
[436] Davey Aff, JBE, Vol. 1, Tab 1Af, p. 82, para. 5; Davey Aff, Vol 1, Tab 1A, p. 22, para. 43; Davey Transcript, p. 73-74; Alexander Transcript, p. 126, ll. 1-21
[437] Colasanti Aff. JBE Vol. 2, Tab 7, p. 559, para. 38
[438] Colasanti Transcript, p. 497
[439] Dybvig Aff, JBE Vol. 12, Tab 59, p. 6603, pp.6661-6662
[440] Dybvig Aff, JBE Vol. 12, Tab 59, p. 6603, pp.6663-6664

used to grow medical marijuana had an appreciation value of only 13.61%, while comparable homes without growing operations appreciated during the same time period by an average of 45.27%.[441]

Potential Criminal Abuses

272. In addition to addressing the health and safety risks associated with the personal cultivation of medical marijuana, the MMPR also intend to eliminate the potential for criminal abuses of personal and designated production licenses. The Plaintiffs acknowledge that some individuals abused their Health Canada licenses by growing more marijuana than they were permitted to grow or by diverting medical marijuana into the illegal market. While they argue that these criminal abuses were "isolated", the Plaintiffs and their experts do not dispute the existence of these abuses or the potential for future criminal abuses.[442]

273. Mr. Colasanti, for example, explained that because the MMAR did not specify the maximum height of marijuana plants, he preferred to grow "extremely large plants" because they "don't need as much attention."[443] He stated that the size and yield of plants can vary dramatically and that he teaches individuals how to maximize their yield.[444] He opined that with the right lighting and physical space, an individual could obtain the same yield from 6 plants as from 600.[445] In his own growing operation, these "monster plants" have grown as high as nine feet and could yield as much as three pounds of marijuana per plant which is far in excess of the yield contemplated by the formula in the MMAR.[446]

274. The overproduction of marijuana, either by growing more plants than is authorized by one's production license or by growing the authorized number of plants as "monster plants" are two examples of the ways in which individuals may abuse their Health Canada licenses. Corporal Shane Holmquist, who is a member of the RCMP's Coordinated Marijuana Enforcement Team, provided numerous examples of these types of abuses in

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[441] Dybvig Aff, JBE Vol. 12, Tab 59, p. 6603, pp. 6665-6667
[442] Nash Aff, JBE Vol. 11, Tab 55, p. 6240, para. 41; Davey Transcript, pp. 52-53, 67
[443] Colasanti Transcript, p. 483
[444] Colasanti Transcript, pp. 500-502
[445] Colasanti Aff. JBE Vol. 2, Tab 7, para. 10; Colasanti Transcript, pp. 506-507
[446] Colasanti Transcript, pp. 507-508

his expert report.[447] Corporal Holmquist reviewed over 18,000 pages of police files from across the country with respect to investigations involving medical marijuana growing operations and found numerous examples of various criminal abuses under the *MMAR*, including overproduction and diversion. While the limitations of police databases across the country did not permit Corporal Holmquist to provide statistical data about these various abuses, his report does provide significant relevant examples to illustrate the genuine risk of criminal abuse.

275. The Plaintiffs acknowledge that some MMAR personal growers diverted their marijuana to the illicit market or "shared" their marijuana with other individuals. Mr. Davey, for example, testified that when he was first authorized by Health Canada to consume marijuana for medical purposes, he became concerned that his designated producer was abusing his license by diverting marijuana to the illicit market.[448] Mr. Davey's second designated grower was not even authorized by Health Canada to produce medical marijuana and, instead, used a production license obtained by his mother.[449] Mr. Colasanti admitted that it is common among users of marijuana for medical purposes to "share" their marijuana. When asked on cross-examination if he was aware that his personal production license did not allow him to share his marijuana with others, he replied: "Well, that is a grey area. If you've seen our community, everybody shares medication."[450] Mr. Allard candidly admitted that other individuals with whom he shared a production site were "sharing" their marijuana with him as it was surplus to the others' needs.[451]

Restriction is Consistent with International Medical Marijuana Regimes

276. Canada's shift to a Licensed Producer regime is consistent with the ways in which medical marijuana is provided to patients in other jurisdictions. The Netherlands and Israel moved to prohibit the home cultivation of marijuana for medical purposes because of similar concerns with respect to diversion and health and safety. Ms. Sandvos testified that the Bureau of Medical Cannabis was established in the Netherlands, in part, to prevent

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[447] Holmquist Aff, JBE, Vol. 8, Tab 30, pp. 4385-4429, paras. 45-122
[448] Davey Transcript, pp. 52-53, ll. 20-28; Davey Aff, JBE, Vol. 1, Tab 1, p. 33, para. 7
[449] Davey Transcript, p. 66, ll.14-20
[450] Colasanti Transcript, p. 484
[451] Allard Aff, JBE Vol 1. Tab 5A, p. 215, para 60; Allard Transcript p. 367, ll.5-20

diversion of marijuana to the "criminal circuit"[452] and to ensure that the marijuana provided to patients was of pharmaceutical quality.[453] Similarly, Dr. Baruch testified that one of the reasons the personal production of medical marijuana has been phased out in Israel in favour of commercial growers is because there was concern over the "trickling" of cannabis (diversion) to the illicit market.[454]

277. In the United States, Professor Mikos of Vanderbilt University explained that his research revealed a recent trend in states permitting the use of marijuana for medical purposes away from home cultivation in favour of providing medical marijuana through commercial producers and distributors. In 2009, the U.S. federal government announced a willingness to respect state marijuana policy decisions which "has enabled states to choose a supply model based on considerations of good public policy rather than one driven largely by fears of a federal crackdown against commercial marijuana suppliers."[455] Professor Mikos further explained in his expert report that it appears states have recently turned to commercial cultivation and away from personal cultivation "due to the belief that commercial cultivation provides a satisfactory – even superior – source of marijuana for many patients and also poses less of a threat of diversion and other safety hazards to the general public."[456]

Restriction is Consistent with Treatment of Other Plant-Based Medicines

278. The Plaintiffs appear to claim that the restriction on home cultivation is arbitrary because the FDA and its regulations do not prohibit the home cultivation of food or other natural health products so long as they are not distributed or sold to the public. They claim that marijuana is unfairly excluded from the permissive regulatory regime that applies to other plants with medicinal properties.

279. Marijuana, however, is not simply a plant with medicinal properties; it is a controlled substance with psychoactive properties that may be used for recreational purposes and is highly subject to diversion. Substances that may alter mental processes and that may produce harm to health and society when diverted or misused are regulated under

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[452] Sandvos Aff. JBE Vol. 11, Tab 53, p. 6060
[453] Sandvos Aff. JBE, Vol. 11, Tab 53, p. 6059, para. 4; Sandvos Transcript, p. 1714
[454] Baruch Transcript, p. 1608
[455] Mikos Aff. JBE Vol. 10, Tab 36, p. 5904, para. 4
[456] Mikos Aff. JBE Vol. 10, Tab 36, p. 5904, para. 4

the CDSA.[457] The *Natural Health Products Regulations* (NHPR) state that natural health products cannot contain a controlled substance. As Jocelyn Kula explained, this provision in the NHPR was specifically included because "it was the Government of Canada's intent to regulate relatively benign substances that occur in nature separately from those that present a higher level of risk to public health and safety."[458] The prohibition on the personal cultivation of marijuana is thus consistent with the regulatory treatment of other drugs, including those derived from plants, that have both psychoactive qualities as well as medical applications.

280. Examples of similarly regulated plants include the opium poppy and coca, which can be used to make a wide range of drugs including heroin, codeine, morphine, oxycodone and cocaine, and are listed in the Schedules to the CDSA and the NCR. They are so listed because, in addition to having legitimate medical uses, they also pose a serious risk to public health and safety. The cultivation of such plants for personal use is prohibited (unlike foods, drugs and natural health products that do not pose such a risk). The MMPR thus seeks to treat marijuana for medical purposes in the same rational way as other psychoactive drugs that have both and medical and non-medical uses.

281. It is also important to note that, to date, the efficacy and safety of dried marijuana has not been demonstrated through the FDA drug approval process.[459] Information on the acute and long-term adverse effects of marijuana use have been obtained mainly from studies of non-medicinal users.[460] Acute adverse effects mainly arise from marijuana's impairment of mental and motor skills and from its ability to precipitate acute psychotic episodes.[461] Adverse effects of chronic use are varied and include significant effects on adolescents. [462]

282. While both Drs. Kalant and Baruch noted that there is no "lethal dose" associated with marijuana, they also stated that deaths from heart attacks have been linked to the use

[457] Kula Aff. JBE Vol. 3, Tab 26, p. 1037, para. 24
[458] Kula Aff. JBE Vol. 3, Tab 26, p. 1037, para. 25
[459] Kalant Aff, JBE Vol. 12, Tab 61, pp. 6808-09
[460] Kalant Aff, JBE Vol. 12, Tab 61, p. 6832
[461] Kalant Aff, JBE Vol. 12, Tab 61, p. 6832
[462] Kalant Aff, JBE Vol. 12, Tab 61, p. 6832-33

of marijuana and that studies on this issue are only recently emerging.[463] Even Dr. Pate agreed that marijuana overdoses can produce side effects that are "extremely unpleasant".[464]

(ii) The Restriction is Not Overly Broad

283. Overbreadth is a principle that is related to, but analytically distinct from, arbitrariness in that it considers whether a law goes too far by sweeping some conduct into its ambit that bears no relation to its objective.[465] The Plaintiffs contend that the restriction on personal cultivation is overly broad because even "good" growers whose growing operations are properly constructed are prohibited from cultivating their own marijuana.

284. The evidence before this Court conclusively demonstrates, however, that growing marijuana in a residential setting poses a whole host of potential negative consequences. While Canada is only required to establish that the personal cultivation of marijuana gives rise to a reasoned apprehension of harm,[466] the evidence of harms set out in the preceding section goes far beyond that standard.

285. Furthermore, the Plaintiffs do not dispute that the personal residential cultivation of medical marijuana entails some inherent risks. They also agree that the extensive health and safety precautions for commercially Licensed Producers under the MMPR are necessary. These concessions, as well as Canada's evidence of the health and safety risks of home cultivation, undermine the Plaintiffs' contention that the restriction on personal cultivation is overly broad.

286. No court has ever established that there is a constitutional right to the personal production of marijuana for medical purposes or a constitutional right to any particular way of accessing medical marijuana. Rather, the jurisprudence has consistently held that Canadians must have reasonable access to medical marijuana and that in providing this access, the government must also protect public health and safety.[467]

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[463] Baruch Transcript, p. 1645; Baruch Aff, JBE Vol. 10, Tab 37, p. 5950; Kalant Aff, JBE Vol. 12, Tab 61, p. 6824
[464] Pate Transcript, pp. 605-606
[465] *Bedford*, para. 112
[466] *Polygamy Reference*, para. 772; *Malmo-Levine*, paras. 78 and 133
[467] See, for example, *Hitzig*, paras. 137-142 and 148

287. Unlike *Carter*, this is not a case in which there is a blanket prohibition on accessing a particular medical treatment.[468] Rather, Canada has implemented a complex regulatory regime whose public health and safety objectives cannot be achieved in the context of home cultivation. It is simply not possible to determine who is a "good" or "bad" grower without an elaborate system of regulatory and inspection requirements. Health Canada has designed and adopted such a system: the MMPR.

288. The Plaintiffs claim a "right" to home cultivation whose viability would require the implementation of an even more expansive and complex regulatory regime. Without such a regime, as the Plaintiffs effectively concede, the inherent risks of home cultivation would persist. The Plaintiffs' demand that the MMAR home cultivation be reinstated is, in effect, a plea for a *de facto* subsidization of personal production. Such positive obligations are not protected by s. 7 of the *Charter*.

289. In *Brown v. British Columbia (Minister of Health)*, the British Columbia Supreme Court held that the *Charter* does not require the government to subsidize access to a particular medical treatment.[469] In *Brown*, the claimants suffered from HIV/AIDS and argued that the failure of the government of British Columbia to cover the cost of purchasing the only effective drug that was available at the time (AZT) violated their rights under s. 7 of the *Charter*. In 1990, when the decision was rendered, a year's worth of AZT cost approximately $2000 per individual. The claimants said they could not afford that cost and requested the government's assistance.

290. In dismissing the claimants' s. 7 *Charter* arguments, the Court in *Brown* observed:

> While the Plaintiffs do not agree, I find that their claim under s. 7 of the *Charter* rests on economic deprivation. I have found that for [the Plaintiffs], and others like them in the same economic situation, to pay $2000 from a limited income, works economic hardship. In order to pay it, they must make sacrifices in their lifestyle. But a reduction in the standard of living is not a deprivation contemplated by s. 7 of the *Charter*.
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> Their position does not differ from the position of any person in this province who must survive on a low income. It is not different from a person in similar economic circumstances who must pay for drugs for heart disease, tuberculosis, diabetes, cystic fibrosis or a host of other serious diseases.[470]

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[468] *Carter v. Canada (Attorney General)*, 2015 SCC 5
[469] *Brown*, p. 467
[470] *Ibid.*

291. In spite of the fact that the Plaintiffs are not requesting the government to directly pay the cost of their medical marijuana, *Brown* is analogous to the present case. Specifically, an extensive and recurring system of inspections and investigations is a necessary prerequisite for mitigating some of the risks that are associated with home cultivation. As in *Brown*, this is akin to a taxpayer-funded benefit that would accrue to individuals who prefer to grow their marijuana at home rather than buy it from Licensed Producers.

292. As set out below, this Court has heard evidence with respect to the extraordinary cost associated with Health Canada's inspection of a handful of these residential growing operations. If the medical marijuana 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 dozens, if not hundreds of inspections, increasing the costs of an inspection regime even further.

293. Health Canada would not be the only government entity faced with significant cost increases if home cultivation was permitted to continue. The Fire Chief of Surrey, as well as other Canadian municipalities, have provided evidence with respect to the cost of inspecting residential marijuana growing operations for compliance with bylaws and other local regulations.[471] While this Court has not heard evidence from law enforcement or utilities providers about the specific dollar amounts associated with responding to complaints and conducting investigations of residential medical marijuana growing operations, there is no question that these entities also expend scarce resources in dealing with these medical marijuana growing operations.

294. The cost of these inspections is borne by the Canadian public in general rather than the individual home cultivator. While the Plaintiffs may be able to produce marijuana at a cost that, for them, would be marginally less than the cost of purchasing from Licensed Producers, the actual cost to Canadian society of attempting to ensure the safety of their

[471] Ritchot Aff, JBE Vol 4, Tab 28, pp. 1558-1560, paras. 116-120 and Ex. "L", pp. 2935-3002; Garis Transcript, p. 1269

production would be obviously be higher than the cost of ensuring the safety of the marijuana produced by Licensed Producers.[472]

295. To a large extent, the MMAR relied upon the goodwill and best efforts of individual growers to adhere to appropriate health and safety protocols. This approach is not a viable means by which a stable, consistent and safe medicine can be produced. The rigorous regular testing that must be conducted in order to determine the levels of active ingredients and to detect the presence of microbial contaminants can only be conducted by trained individuals with costly laboratory equipment. It is not reasonable to expect home cultivators to abide by good production practices or to have the marijuana they grow regularly tested.

296. The fact that Licensed Producers are subject to unannounced inspections further ensures that medical marijuana is produced in a secure and sanitary environment that minimizes the risks associated with its production. It would be impractical and extraordinarily costly to conduct similar types of inspections at the existing tens of thousands of personal production sites across the country. The inspection blitz carried out by Health Canada in 2010 provides a snapshot of the difficulties of conducting such inspections as well as the cost of doing so. Health Canada identified 75 personal production sites in British Columbia and Ontario that were considered to pose less risk to the inspectors. Twenty-seven individuals answered the door and only 15 individuals allowed inspections. Of these 15, nearly half were growing more plants than their licenses allowed.[473]

297. The cost of conducting this very limited compliance inspection initiative was nearly $120,000. The cost per production site that Health Canada was permitted to inspect was $7,980.[474] On December 31, 2013, over 28,000 individuals held personal production licenses. Even assuming that every single licensed grower shared a production site with three other individuals, as was permitted under the MMAR, inspection of more than 7000 sites would amount to over $55 million dollars.[475] In order to be effective, compliance

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[472] *Sfetkopoulous*, para. 14
[473] Ritchot Aff, JBE Vol. 4, Tab 28, p. 1556, para. 108
[474] Ritchot Aff, JBE Vol. 4, Tab 28, p. 1556, para. 109
[475] Ritchot Aff, JBE Vol 4, Tab 28, p. 1557, para. 111

inspections would need to be carried out on a regular basis which would further increase the costs associated with such inspections. The exponential growth pattern of the MMAR and the hundreds of thousands of projected users of marijuana for medical purposes suggest that the costs and logistics of conducting inspections of personal production sites will increase dramatically over the next 10 years.[476]

298. It is also reasonable to expect that the cost of inspecting personal production sites would be even higher if the additional risks associated with home cultivation were addressed by these inspections. Under the MMAR, Health Canada inspectors conducted inspections solely for the purpose of compliance with those particular regulations.[477] Inspections that would address issues such as improper wiring and other fire hazards, structural modifications, mould, contaminants, and so forth would require specialized inspectors such as those employed by municipalities to carry out inspections of personal production sites. Inspectors would also need to regularly return to each growing location in order to ensure that the problems had been properly dealt with and in order to monitor continuing issues such as the quality and safety of the marijuana produced.

299. Even if inspections of tens of thousands of personal growing operations by several different types of inspectors were economically or logistically feasible, there are still privacy issues that may present hurdles to such inspections. Under the MMAR, inspections of growing operations located in dwelling-places required consent of the owner and if consent was not obtained, a warrant pursuant to the CDSA was required.[478] Section 8 of the *Charter* provides that "[e]veryone has the right to be secure against unreasonable search and seizure." Generally speaking, in the regulatory context, so long as the underlying legislation statute expressly authorizes the exercise of inspection powers for the purpose of ensuring compliance with a regulatory regime, s. 8 of the *Charter* will be respected. However, regulatory inspections of dwelling-houses, as opposed to commercial or business premises, must also consider a person's enhanced privacy interest in their home.[479]

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[476] Ritchot Aff, JBE Vol. 4, Tab 28, p. 1533-34 paras. 44-45
[477] Ritchot Aff, JBE Vol, 4, Tab 28, p. 1555, para. 106
[478] MMAR, s. 57(2) in Ritchot Aff, JBE Vol. 4, Tab 28, Ex. "A", p. 1618; CDSA, s. 31(2)
[479] *Silveira*, para. 140, 148

300. The inspection blitz carried out by Health Canada illustrates the likely difficulty of obtaining the consent of owners to enter growing operations located in their homes. Mr. Allard, when asked during cross-examination whether he would consent to an unannounced Health Canada inspection, was candid and forthright in explaining his opposition to this type of inspection. Instead, he would prefer "if somebody called me ahead of time to let me know, to arrange it with me mutually" because he "might want to clean it up a little bit and tidy up, et cetera."[480] However, it is patently obvious that compliance with a regulatory regime cannot be adequately promoted if those who are regulated can be secure in the knowledge that they will not be subject to an inspection without being given prior notice and an opportunity to address deficiencies in advance of an inspection.

301. In contrast to the difficulties of inspecting personal production sites, the regulatory oversight of Licensed Producers is wholly achievable. As the Federal Court (Strayer J.) explained in *Sfetkopoulos*, if fewer growers were permitted to have large client bases, "a host of one-customer designated producers would be made unnecessary and therefore any control and inspection system Health Canada might wish to impose on designated producers would be simpler and cheaper to operate with fewer producers."[481] Mr. Justice Strayer also noted that "with fewer designated producers having larger operations, a system of inspection would be much easier to sustain than in the present plethora of single-customer producers", and that these large-scale operations "could be more secure than the typical home-based self-producer or single-customer designated producer."[482]

302. By removing home cultivation, the Licensed Producer regime, as Mr. Justice Strayer predicted, facilitates regular, on-going inspections by Health Canada. Inspectors may enter a Licensed Producer facility unannounced at any time during their normal business hours and may evaluate all aspects of compliance with the regulations, including reporting requirements.[483] Health Canada conducts four different types of inspections at Licensed Producer facilities: a pre-license inspection; an initial inspection; targeted

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[480] Allard Transcript, p. 356
[481] *Sfetkopolous*, para. 14
[482] *Sfetkopolous*, para. 15
[483] Cain Aff. JBE Vol. 7, Tab 29, p. 4061-62, para. 42

inspections; and regular inspections.[484] Health Canada has already undertaken nearly 200 of these different types of inspections and has suspended certain licensed activities for three of the Licensed Producers because of findings made during their inspections.[485]

(iii) The Restriction is Not Grossly Disproportionate

303. The gross disproportionality analysis considers whether a law's effects on life, liberty or security of the person are so grossly disproportionate to its purposes that they cannot rationally be supported. It only applies in "extreme cases where the seriousness of the deprivation is totally out of sync with the objective of the measure."[486] In *Bedford*, the Supreme Court of Canada provided as an example of a grossly disproportionate law one whose purpose is "keeping the streets clean that imposes a sentence of life imprisonment for spitting on the sidewalk."[487] Gross disproportionality is thus an exceptionally onerous standard to meet and the Plaintiffs have not led evidence capable of substantiating a finding of gross disproportionality.

304. The possibility of incarceration as a deterrent for deliberately growing marijuana is not grossly disproportionate to its purposes, particularly given the lack of a mandatory minimum sentence.[488] In considering whether the possibility of incarceration for possessing, trafficking or producing marijuana for recreational purposes amounts to a grossly disproportionate law, the Supreme Court held the following in *R. v. Malmo-Levine*: "[t]the lack of 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."[489] The Plaintiffs' gross disproportionality argument cannot succeed in light of the Supreme Court of Canada's clear pronouncements in *Malmo-Levine*.

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[484] Cain Aff. JBE Vol. 7, Tab 29, p. 4062, para. 43
[485] Cain Aff. JBE Vol. 7, Tab 29, p. 4066, para. 57
[486] *Bedford*, para 120
[487] *Ibid.*
[488] CDSA, s. 7(2)(b)
[489] *Malmo-Levine*, para. 158

C. RESTRICTING OUTDOOR CULTIVATION COMPLIES WITH S. 7 OF THE *CHARTER*

305. While the Plaintiffs pled that the restriction on outdoor cultivation in the MMPR was unconstitutional, they have not addressed this issue in their Memorandum of Fact and Law nor did they lead any evidence to substantiate this claim. It appears, therefore, that the Plaintiffs have effectively abandoned this aspect of their claim.

D. MEDICAL MARIJUANA POSSESSION LIMITS COMPLY WITH S. 7 OF THE *CHARTER*

306. The Plaintiffs argue that the 150 gram possession limit in the MMPR engages s. 7 because it restricts their freedom of movement and, in particulate, their ability to travel. The Plaintiffs' evidence, however, does not substantiate this claim. Two of the three Plaintiffs, Ms. Beemish and Mr. Davey, do not travel at all and Mr. Allard does so infrequently and only for short periods of time.[490] Further, Mr. Allard claimed that one of the reasons his home cultivation operation is so safe is because he almost always stays at home to tend to his marijuana plants.[491]

307. Even if this Court were to accept that the Plaintiffs might, one day, intend to travel for extended periods of time, the medical necessity of consuming large quantities of marijuana each and every day is questionable. If Mr. Allard and Mr. Davey consumed medically appropriate amounts of marijuana, the 150 gram possession limit would have a minimal impact on any reasonable travel plans they may hypothetically make in the future.

308. In any event, the liberty interest under s. 7 does not protect one's right to travel. The 150 gram possession limit, while a potential inconvenience to the Plaintiffs, does not rise to the level required by the Supreme Court of Canada in order to engage the Plaintiffs' s. 7 liberty interests.[492] While the jurisprudence has recognized that the concept of "liberty" under s. 7 may embrace individual freedom of movement that includes the right to choose where to establish one's home,[493] the MMPR do not restrict the ability to make such a profound choice. Instead, even in the case of a person with a very high authorized amount

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[490] Allard Transcript, p. 343; Beemish Affidavit #1, JBE Vol. 1, Tab 4, p. 169-70, para. 8; Davey Affidavit #2, JBE Vol. 1, Tab 1, p. 17 para. 30
[491] Allard Transcript, pp. 325 and 344; Allard Aff, JBE, Vol. 1, Tab 5, p. 223, para. 17
[492] *Godbout v. Longueuil (City)*, [1997] 3 S.C.R. 844 [**"*Godbout*"**], para. 66
[493] *Godbout*, para. 67

of marijuana, the 150 gram possession cap only restricts the individual's ability to travel (for business or leisure purposes) from their home. The courts have generally rejected arguments that seek to include the right to travel (either for business or leisure) within s. 7 of the Charter.[494]

309. The 150 gram possession limit accords with the principles of fundamental justice because this limit is intended to decrease the risk of diversion to the illicit market and reduce the extent to which individuals possessing marijuana for medical purposes become targets for theft and violence. Furthermore, the potential problems associated with larger possession limits for medical marijuana have been recognized in previous jurisprudence. In *Hitzig*, the Ontario Court of Appeal accepted that Canada has a substantial and compelling interest in ensuring that the amount of medical marijuana possessed by individuals is no greater than necessary "to ensure against diversion of any excess to the illicit drug trade."[495]

310. Common sense dictates that individuals who carry large amounts of marijuana on their person or keep a large amount of marijuana in their homes are at risk of theft or violence because of the value of marijuana on the illicit market. Dr. Baruch testified, for example, that in Israel users of marijuana for medical purposes are not permitted to possess more than a few grams at any one time because of the risk of theft and diversion. Israeli patients who retrieve medical marijuana from a dispensary in amounts over 50 grams must be escorted home by a security guard.[496]

311. The Plaintiffs have not established that the 150 gram possession limit impacts them in any significant way. They may have to purchase their marijuana more frequently than an individual who consumes a medically appropriate dose and they may have to restrict the number of days they travel, but these inconveniences do not outweigh the important objectives behind the 150 gram possession cap.

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[494] *Khadr v Canada (Attorney General)*, 2006 FC 727, at paras. 73-75; *Kamel v. Canada (Attorney General)*, 2011 FC 1061, para. 83, aff'd 2013 FCA 103
[495] *Hitzig*, para. 137
[496] Baruch Transcript, pp. 1662-1663

E. RESTRICTING MEDICAL MARIJUANA TO ITS DRIED FORM COMPLIES WITH S. 7 OF THE CHARTER

312. The Plaintiffs also argue that the MMPR restricts their ability to choose the form of marijuana that is medically appropriate for them. However, the Plaintiffs have led no evidence to demonstrate that they cannot obtain medical relief by using dried marijuana. Instead, they rely upon the British Columbia Court of Appeal's decision in *R. v. Smith*[497] as a precedent for the proposition that their choice to use non-dried forms of marijuana (such as oils, juice, butter, etc.) engages s. 7 of the *Charter* and is inconsistent with the principles of fundamental justice. Canada has appealed the *Smith* decision and the Supreme Court of Canada heard oral submissions on March 20, 2015.

313. As Canada argued in the *Smith* appeal, previous Supreme Court of Canada jurisprudence on the extent to which laws that limit access to medical treatment engage liberty and security of the person interests do not support the Plaintiffs' position. In each of these cases, the law imposed restrictions on access to approved health care services and these restrictions were shown to have significant, discernible consequences for the safety or health of those affected by the law.[498] The same cannot be said of the consequences of using dried marijuana in the present case.

314. What emerges from the jurisprudence is the proposition that where a particular law deprives an individual of access to medical treatment shown to be reasonably necessary in the treatment of a serious or life-threatening medical condition, the individual's s. 7 liberty and security of the person interests are engaged. Not every choice a particular individual seeks to characterize as a question of medical treatment will engage constitutionally protected liberty or security of the person interests.

315. The evidence before this Court does not establish that certain forms of marijuana are required by the Plaintiffs to treat their medical conditions. At best, the evidence suggests that the Plaintiffs periodically prefer to use non-dried cannabis products in addition to dried marijuana. Notably, each of the Plaintiffs consumes marijuana almost exclusively through inhalation and they led no evidence to establish that they would be

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[497] *R. v. Smith*, 2014 BCCA 322

[498] See for example: *R. v. Morgentaler*, [1988] 1 SCR 30, pp. 63 and 90; *Chaoulli*, paras.116, 117, 121, 123; *PHS*, para. 93

incapable of obtaining the medical relief they need if they are limited to consuming dried marijuana. The Plaintiffs' subjectively held beliefs with respect to the medical efficacy of non-dried marijuana are insufficient to establish an infringement of their liberty or security of the person interests.

316. The Plaintiffs rely upon Dr. Pate's theories with respect to the utility of non-dried forms of marijuana but, as Dr. Pate himself notes, these theories have not been published or substantiated by clinical research.[499] This is consistent with Dr. Kalant's statement that he was "unable to find a single scientific study comparing the therapeutic effects of undried versus dried cannabis. Any claims for a special medicinal value of the undried material so far are anecdotal and based purely on conjecture or on the well-known placebo effect."[500]

317. In cross-examination, Dr. Pate admitted that he has never been involved in a clinical trial, has not published a peer reviewed research paper since 2003 and is not affiliated with any academic institution.[501] Dr. Pate also testified that his current knowledge of marijuana for medical purposes is simply based on research he has done at the library and on the internet for his consultancy clients.[502] Dr. Pate's report was prepared more than two years ago for the Plaintiffs in *Smith* and he did not think it was necessary to update it for these proceedings, notwithstanding his claim that the study of cannabis is ongoing and new information is being discovered regularly.[503]

318. The expert opinion evidence thus fails to substantiate the claims of the Plaintiffs that they need access to non-dried forms of marijuana to treat their conditions. As the Nova Scotia Supreme Court found in *R. v. Simpson*, in order to reach a conclusion that the prohibition on non-dried forms of marijuana, such as cannabis oil, engages the Plaintiffs' s. 7 rights, "extensive medical and scientific evidence concerning the medicinal properties of cannabis resin oil would be required."[504] Such evidence has not been led in these proceedings.

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[499] Pate Transcript, p. 596
[500] Kalant Aff, JBE Vol. 12, Tab 61, p. 6819
[501] Pate Transcript, p. 591
[502] Pate Transcript, p. 591
[503] Pate Transcript, pp. 583-584
[504] *Simpson*, para. 58

319. In any event, the MMPR are silent on the modes of ingestion that an individual may use to consume their dried marijuana and does not restrict Licensed Producers from obtaining approval under the FDA and its regulations to sell marijuana products such as edibles and oils.[505] If a Licensed Producer wishes to manufacture and sell a drug product made from marijuana, the Licensed Producer must demonstrate the safety, efficacy and quality of the product in accordance with the FDA and its regulations.[506] This process ensures that there is a legitimate medical and scientific basis to make such products available for therapeutic purposes.

320. The production of non-dried marijuana extracts by individuals in residential settings also raises potential safety concerns. Dr. ElSohly explained that there are two main methods used in the preparation of cannabis extracts: organic solvent extraction and Supercritical Fluid Extraction (SFE).[507] In his expert opinion, each of these methods must follow Good Manufacturing Guidelines in order to ensure that a safe and quality-controlled extract is produced.[508] According to Dr. ElSohly, "[t]hese requirements can only be met by facilities equipped and staffed by qualified personnel and registered with the appropriate regulatory agency that would have oversight over the manufacturing facilities and assure proper procedures to ensure safety of the manufactured product for human use."[509] He also explained that the organic solvent extraction method has two main safety concerns: employee exposure to the inhalation of the vapours of the solvent and the hazard of the solvent causing fire, since all of the organic solvents used for extraction are flammable.[510] The SFE extraction method, according to Dr. ElSohly, does not have these safety concerns, but "requires sophisticated and expensive equipment and highly trained personnel to carry out this process."[511]

321. There is further evidence of the safety concerns with respect to the production of marijuana extracts in the expert report of Corporal Holmquist. He explained that the RCMP

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[505] Ritchot Transcript, p. 876, ll. 27-28 and p. 877., ll. 1-27; Kula Aff. JBE Vol. 3, Tab 26, p. 1042-43, para. 51; Ormsby Aff. JBE Vol. 4, Tab 27, p. 1289-90, para. 23; Ritchot Aff JBE Vol, 4, Tab 28, p. 1568-72, para. 143 and Ex. "BB", JBE Vol. 6, p. 3150
[506] Ormsby Aff. JBE Vol. 4, Tab 27, p. 1296-99, paras. 45-55
[507] ElSohly Aff, JBE Vol. 12, Tab 60, pp. 6731
[508] ElSohly Aff, JBE Vol. 12, Tab 60, pp. 6731
[509] ElSohly Aff, JBE Vol. 12, Tab 60, pp. 6731
[510] ElSohly Aff, JBE Vol. 12, Tab 60, pp. 6731
[511] ElSohly Aff, JBE Vol. 12, Tab 60, pp. 6731

attends and dismantles clandestine laboratories that produce marijuana oil/resin, colloquially known as "Butane Honey Oil" or "Butane Hash Oil".[512] The manufacture of this oil involves passing butane through a filtered container of marijuana in order to strip the trichomes of THC from the marijuana. The butane is evaporated off and the oil that is left behind can be smoked or added to derivatives.[513] As Dr. ElSohly explained, this solvent extraction process may result in fires because of the highly flammable nature of the solvent. Indeed, Corporal Holmquist's report includes several photographs that depict the result of butane explosions caused by the manufacturing of marijuana oil/resin in residential growing operations.[514]

322. Dr. Pate, also agreed that the use of chemical solvents in the extraction process have the potential to cause explosions. On cross-examination, Dr. Pate testified that explosions caused by chemical extractions of cannabis resin/oil may cause serious burns that are akin to "or worse than, using gasoline."[515] He also noted that it was "probable" that by-products of the chemical solvent used to extract the cannabis resin will remain in the extracted resin.[516]

323. Many jurisdictions in the United States that permit the use of medical marijuana also restrict the forms of marijuana that may be consumed. In particular, several states prohibit marijuana oils, resins or concentrates because of safety concerns with the production of the product.[517]

324. Other marijuana products, such as edibles, also pose health and safety risks. These products may, as Dr. Pate testified, look and smell the same as products that do not contain marijuana.[518] It is reasonable to assume that children or other uninformed individuals could mistakenly ingest these edibles and Dr. Pate agreed that there is a risk of unintentional overdosing with edible marijuana products because of the slow onset of effect.[519] He

[512] Holmquist Aff, JBE Vol. 8, Tab 30, p 4442
[513] Holmquist Aff, JBE Vol. 8, Tab 30, p 4443
[514] Holmquist Aff, Annex YY, JBE Vol. 8, Tab 30, p 4724 , and Annex AAA, JBE Vol. 8, Tab 30, p. 4730
[515] Pate Transcript, p. 612
[516] Pate Transcript, p. 613
[517] Mehler Aff. JBE Vol. 12, Tab 62, p. 6908-09, paras. 37-38
[518] Pate Transcript, pp. 600-601
[519] Pate Transcript, pp. 605-606

specifically agreed that there is a risk of children becoming "distressed" from unintentionally consuming marijuana edibles.[520]

325. Dr. Pate also testified that in order to objectively determine how much THC is in an edible would require laboratory analysis.[521] Dr. Baruch explained in cross-examination an additional difficulty encountered in producing marijuana edibles: "Doing cookies is very hard. The distribution of cannabis within the cookie doesn't seem to be all over the cookie and usually goes to one point. [...] We couldn't figure out a dose."[522] Dr. Baruch went on to explain that while in Israel they provide marijuana cookies made with dried marijuana to children they do so only because children could not smoke the marijuana and did not like the aftertaste of the oil.[523] The problem of establishing a "metered dose" remains. In other words, even if there were specific medicinal benefits associated with these marijuana edibles, individuals likely do not know the levels of active ingredients or the "dose" of marijuana that is present in these products.

326. In sum, the fact that only the dried form of marijuana can be possessed and produced pursuant to the MMPR represents a policy choice that is constitutionally sound. There is no constitutional right to medical marijuana in whatever form the Plaintiffs may subjectively prefer.

F. SECTION 1 OF THE *CHARTER*: GENERAL PRINCIPLES

327. Section 1 of the *Charter* provides that:

> 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.

328. While the analysis under s. 7 is similar to the balancing exercise under s. 1, these sections of the *Charter* ask different questions. The question under s. 1 is "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."[524] Under s. 1, the government

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[520] Pate Transcript, p. 608
[521] Pate Transcript, pp. 602-603
[522] Baruch Transcript, pp. 1658-59
[523] Baruch Transcript, p. 1659
[524] *Bedford*, para. 125

bears the burden of showing that a law that breaches an individual's rights can be justified having regard to the government's goal. The Supreme Court of Canada has held that "[d]epending 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."[525]

329. A limit on a *Charter* right must be "reasonable" and "demonstrably justified". The applicable test was originally set out in *R. v. Oakes* and is now well-established:

a. Is the legislative goal pressing and substantial? Ie. is the objective sufficiently important to justify limiting a *Charter* right?

b. Is there proportionality between the objective and the means used to achieve it?[526]

330. The proportionality analysis considers first whether there is a rational, non-arbitrary, non-capricious connection between the objective of the law and the specific aspects of it that have been found to infringe a *Charter* right. Satisfying this element of the analysis is "not particularly onerous."[527] The government must only show that it is reasonable to suppose that the limit "may further the goal, not that it will do so."[528] The Court must then conduct a minimal impairment analysis to consider whether there are other less drastic means of achieving the objective of the MMPR in a real and substantial manner. It is sufficient if the means adopted fall within a range of reasonable alternatives; Parliament cannot be held to a standard of perfection.[529] The Supreme Court of Canada has held that Canada may be better positioned than the courts to choose from a range of alternatives when creating a complex regulatory regime.[530] The final step in the s. 1 analysis requires the Court to engage in a balancing exercise, weighing the salutary and deleterious effects of the legislation.

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[525] *Bedford*, para. 129
[526] *R. v. Oakes*, [1986] 1 SCR 103
[527] *Little Sisters Book and Art Emporium v. Canada (Minister of Justice)*, [2000] 2 SCR 1120, para. 228
[528] *Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 SCR 567 [***Hutterian Brethren***], para. 48
[529] *R. v. Edwards Books and Art Ltd.*, [1986] 2 SCR 713 [***Edward Books***], paras. 147-148, 150
[530] *Hutterian Brethren*, paras. 53-55; *Edwards Books*, paras. 147, 150

G. ANY VIOLATION OF SECTION 7 IS SAVED BY SECTION 1 OF THE *CHARTER*

331. Any violation of the Plaintiffs' s. 7 *Charter* rights with respect to personal cultivation, the availability of strains, outdoor cultivation, the possession limit or the restriction on non-dried forms of marijuana is reasonably justified under s. 1 of the *Charter*.

332. As already discussed at length, the objective of the MMPR is to provide reasonable access to a lawful source of marijuana for those with a demonstrated medical need, while simultaneously addressing the health and public safety risks that are inherent in the personal production of marijuana. The foregoing evidence establishes that this goal is pressing and substantial.

333. The MMPR have shifted the production of marijuana for medical purposes to a commercial Licensed Producer regime subject to stringent standards and government oversight in order to foster the cultivation of safe, quality marijuana. By treating marijuana like other medicines whose consumption and production entail risks both for the consumer and society at large, the MMPR are rationally connected to their objective.

334. As outlined above, there is extensive evidence of the real risks associated with the personal production of marijuana. Canada has established that personal cultivation in residential settings gives rise to a reasoned apprehension of harm that will continue to occur if something less than the MMPR are implemented. Considering the objective and the full range of diverse health and public safety concerns the MMPR are intended to address, and notwithstanding the Plaintiffs' preference for an alternative medical marijuana policy, the MMPR minimally impair the Plaintiffs' s. 7 *Charter* rights.

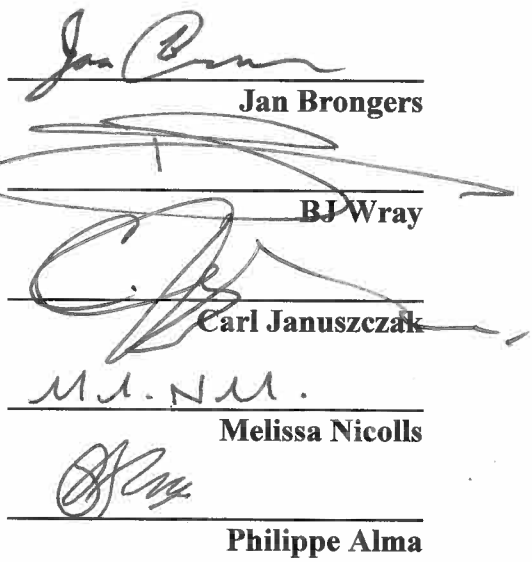
335. Finally, the MMPR are proportionate in their impact on the Plaintiffs' interests. The MMPR ensure that patients with a demonstrated medical need have reasonable access to medically justified dosages of safe, good quality marijuana while concurrently protecting those patients and the Canadian public in general from the very real and serious public health and safety risks that arose under the previous regime.

PART V: ORDER SOUGHT

336. The Defendant Canada requests that this action be dismissed with costs.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.

DATED at the City of Vancouver, this 20th day of April, 2015.



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38.	*Food and Drugs Act*, R.S.C. 1985, c F-27, ss. 1, 2, 8-15 and 30
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