



SUPREME COURT OF CANADA

CITATION: Canada (Attorney General) v. PHS Community Services Society, 2011 SCC 44 **DATE:** 20110930
DOCKET: 33556

BETWEEN:

Attorney General of Canada and Minister of Health for Canada

Appellants / Respondents on cross-appeal

and

**PHS Community Services Society, Dean Edward Wilson, Shelly Tomic
and Attorney General of British Columbia**

Respondents

Vancouver Area Network of Drug Users (VANDU)

Respondent / Appellant on cross-appeal

- and -

**Attorney General of Quebec, Dr. Peter AIDS Foundation,
Vancouver Coastal Health Authority, Canadian Civil Liberties Association,
Canadian HIV/AIDS Legal Network, International Harm Reduction
Association,**

CACTUS Montréal, Canadian Nurses Association,

Registered Nurses' Association of Ontario,

Association of Registered Nurses of British Columbia,

Canadian Public Health Association, Canadian Medical Association,

British Columbia Civil Liberties Association,

British Columbia Nurses' Union and REAL Women of Canada

Interveners

CORAM: McLachlin C.J. and Binnie, LeBel, Deschamps, Fish, Abella, Charron,
Rothstein and Cromwell JJ.

REASONS FOR JUDGMENT:
(paras. 1 to 159)

McLachlin C.J. (Binnie, LeBel, Deschamps, Fish, Abella,
Charron, Rothstein and Cromwell JJ. concurring)

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CANADA (A.G.) v. PHS COMMUNITY SERVICES SOCIETY

**Attorney General of Canada and
Minister of Health for Canada**

Appellants/Respondents on cross-appeal

v.

**PHS Community Services Society,
Dean Edward Wilson, Shelly Tomic and
Attorney General of British Columbia**

Respondents

and

**Vancouver Area Network
of Drug Users (VANDU)**

Respondent/Appellant on cross-appeal

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Dr. Peter AIDS Foundation,
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Registered Nurses' Association of Ontario,
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Canadian Public Health Association,
Canadian Medical Association,
British Columbia Civil Liberties Association,
British Columbia Nurses' Union and REAL Women of Canada**

Interveners

Indexed as: Canada (Attorney General) v. PHS Community Services Society

2011 SCC 44

File No.: 33556.

2011: May 12; 2011: September 30.

Present: McLachlin C.J. and Binnie, LeBel, Deschamps, Fish, Abella, Charron, Rothstein and Cromwell JJ.

ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA

Constitutional Law — Division of Powers — Criminal Law — Safe injection site — Sections 4(1) and 5(1) of Controlled Drugs and Substances Act (“CDSA”) prohibiting possession and trafficking of illegal drugs subject to exemption from federal Minister of Health — Clinic operating safe injection site pursuant to ministerial exemption granted under s. 56 of Act — Minister subsequently revoking exemption — Whether division of powers exempts clinic as health facility from application of CDSA as exercise of federal jurisdiction over criminal law — Controlled Drugs and Substances Act, S.C. 1996, c. 19, ss. 4(1), 5(1), 56 — Constitution Act, 1867, ss. 91(27), 92(7), 92(13), 92(16).

Constitutional Law — Charter of Rights — Right to life, liberty and security of the person — Safe injection site — Sections 4(1) and 5(1) of Controlled

Drugs and Substances Act prohibiting possession and trafficking of illegal drugs subject to exemption from federal Minister of Health — Clinic operating safe injection site pursuant to ministerial exemption granted under s. 56 of Act — Minister subsequently revoking exemption — Whether sections 4(1) and 5(1) of Act contravene claimants' rights to life, liberty and security of the person — Whether decision of Minister to revoke accords with principles of fundamental justice — Controlled Drugs and Substances Act, S.C. 1996, c. 19, ss. 4(1), 5(1), 56 — Charter of Rights and Freedoms, ss. 1, 7.

Constitutional Law — Charter of Rights — Remedies — Safe injection site — Sections 4(1) and 5(1) of Controlled Drugs and Substances Act prohibiting possession and trafficking of illegal drugs subject to exemption from federal Minister of Health granted under s. 56 of Act — Clinic operating safe injection site pursuant to ministerial exemption — Minister subsequently revoking exemption — Appropriate remedy — Charter of Rights and Freedoms, s. 24(1).

In the early 1990s, injection drug use reached crisis levels in Vancouver's downtown eastside ("DTES"). Epidemics of HIV/AIDS and hepatitis C soon followed, and a public health emergency was declared in the DTES in September 1997. Health authorities recognized that creative solutions would be required to address the needs of the population of the DTES, a marginalized population with complex mental, physical, and emotional health issues. After years of research, planning, and intergovernmental cooperation, the authorities proposed a scheme of

care for drug users that would assist them at all points in the treatment of their disease, not simply when they quit drugs for good. The proposed plan included supervised drug consumption facilities which, though controversial in North America, have been used with success to address health issues associated with injection drug use in Europe and Australia.

Operating a supervised injection site required an exemption from the prohibitions of possession and trafficking of controlled substances under s. 56 of the *CDSA*, which provides for exemption at the discretion of the Minister of Health, for medical and scientific purposes. Insite received a conditional exemption in September 2003, and opened its doors days later. North America's first government-sanctioned safe injection facility, it has operated constantly since then. It is a strictly regulated health facility, and its personnel are guided by strict policies and procedures. It does not provide drugs to its clients, who must check in, sign a waiver, and are closely monitored during and after injection. Its clients are provided with health care information, counselling, and referrals to various service providers or an on-site, on demand detox centre. The experiment has proven successful. Insite has saved lives and improved health without increasing the incidence of drug use and crime in the surrounding area. It is supported by the Vancouver police, the city and provincial governments.

In 2008, a formal application for a new exemption was made before the initial one expired. The Minister had granted temporary extensions in 2006 and 2007,

but he indicated that he had decided to deny the application. When the expiry of the extensions loomed, this action was started in an effort to keep Insite open.

The trial judge found that the application of ss. 4(1) and 5(1) of the *CDSA* violated the claimants' rights under s. 7 of the *Charter*. He granted Insite a constitutional exemption, permitting it to continue to operate free from federal drug laws. The Court of Appeal dismissed the appeal and held that the doctrine of interjurisdictional immunity applied.

Held: The appeal and the cross-appeal are dismissed. The Minister of Health is ordered to grant an exemption to Insite under s. 56 of the *CDSA* forthwith.

The criminal prohibitions on possession and trafficking in the *CDSA* are constitutionally valid and applicable to Insite under the division of powers. First, the impugned provisions of the *CDSA* are, in pith and substance, valid exercises of the federal criminal law power. The fact that they have the incidental effect of regulating provincial health institutions does not mean that they are constitutionally invalid. Second, provincial programmes designed to advance the public interest are not, by virtue of their public interest status, exempt from the operation of criminal laws unless the law is expressly or impliedly so limited. The *CDSA* does not contain such a limit. Third, the doctrine of interjurisdictional immunity does not apply. Decisions about what treatment may be offered in provincial health facilities do not constitute a protected core of the provincial power over health care and are not, therefore, immune from federal interference. In addition, the doctrine of interjurisdictional

immunity is narrow, and its premise of fixed watertight cores is in tension with the evolution of Canadian constitutional interpretation towards the more flexible concepts of double aspect and cooperative federalism. To apply it here would disturb settled competencies and introduce uncertainties for new ones. Finally, as it is common ground that, absent a constitutional immunity, the federal law constrains operations at Insite and trumps any provincial legislation or policies that conflict with it, it is unnecessary to inquire into whether the doctrine of paramountcy applies.

The claimants' lack of success on the division of powers issue does not doom their claim that the law deprives them of a *s. 7 Charter* right. There is no conflict between saying that a federal law is validly adopted under s. 91 of the *Constitution Act, 1867*, and that the same law, in purpose of effect, deprives individuals of rights guaranteed by the *Charter*.

Section 4(1) of the *CDSA* engages the *s. 7 Charter* rights of the individual claimants and others like them, but, because the Minister has the power to grant exemptions from s. 4(1), it does so in accordance with the principles of fundamental justice. Section 4(1) directly engages the liberty interests of the health professionals who provide the supervised services at Insite because of the availability of a penalty of imprisonment in ss. 4(3) to 4(6) of the *CDSA*. It also directly engages the rights to life, liberty and security of the person of the clients of Insite. In order to make use of the lifesaving and health-protecting services offered at Insite, clients must be allowed to be in possession of drugs on the premises. Prohibiting possession at large engages

drug users' liberty interests; prohibiting possession at Insite engages their rights to life and to security of the person. However, because s. 56 gives the Minister a broad discretion to grant exemptions from the application of the *CDSA* if, "in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest", s. 4(1) does not violate s. 7. The exemption acts as a safety valve that prevents the *CDSA* from applying where it would be arbitrary, overbroad or grossly disproportionate in its effects.

On the facts, the prohibition on trafficking in s. 5(1) of the *CDSA* does not constitute a limitation of the claimants' s. 7 rights because trafficking charges would not apply to the activities of Insite staff.

The discretion vested in the Minister of Health is not absolute: as with all exercises of discretion, the Minister's decisions must conform to the *Charter*. If the Minister's decision results in an application of the *CDSA* that limits the s. 7 rights of individuals in a manner that is not in accordance with the *Charter*, then the Minister's discretion has been exercised unconstitutionally. In the special circumstances of this case, the Court should go on to consider whether the Minister's decision violated the claimants' *Charter* rights. The issue is properly before the Court and justice requires that it be considered.

There is no reason to conclude that the deprivation the claimants would suffer was due to personal choice rather than government action. The ability to make some choices does not negate the trial judge's findings that addiction is a disease in

which the central feature is impaired control over the use of the addictive substance. Additionally, the morality of the activity the law regulates is irrelevant at the initial stage of determining whether the law engages a s. 7 right. Finally, the issue of illegal drug use and addiction is a complex one which attracts a variety of social, political, scientific and moral reactions. While it is for the relevant governments to make criminal and health policy, when a policy is translated into law or state action, those laws and actions are subject to scrutiny under the *Charter*. The issue is not whether harm reduction or abstinence-based programmes are the best approach to resolving illegal drug use, but whether Canada has limited the rights of the claimants in a manner that does not comply with *Charter*.

The Minister's failure to grant a s. 56 exemption to Insite engaged the claimants' s. 7 rights and contravened the principles of fundamental justice. The Minister of Health must be regarded as having made a decision whether to grant an exemption, since he considered the application before him and decided not to grant it. The Minister's decision, but for the trial judge's interim order, would have prevented injection drug users from accessing the health services offered by Insite, threatening their health and indeed their lives. It thus engages the claimants' s. 7 interests and constitutes a limit on their s. 7 rights. Based on the information available to the Minister, this limit is not in accordance with the principles of fundamental justice. It is arbitrary regardless of which test for arbitrariness is used because it undermines the very purposes of the *CDSA* — the protection of health and public safety. It is also grossly disproportionate: during its eight years of operation, Insite has been proven to

save lives with no discernable negative impact on the public safety and health objectives of Canada. The effect of denying the services of Insite to the population it serves and the correlative increase in the risk of death and disease to injection drug users is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics.

If a s. 1 analysis were required, a point not argued, no s. 1 justification could succeed. The goals of the *CDSA* are the maintenance and promotion of public health and safety. The Minister's decision to refuse the exemption bears no relation to these objectives, therefore they cannot justify the infringement of the complainants' s. 7 rights.

As the infringement is ongoing, and the concern is a governmental decision, s. 24(1) allows the court to fashion an appropriate remedy. In the special circumstances of this case, an order in the nature of mandamus is warranted. The Minister is ordered to grant an exemption to Insite under s. 56 of the *CDSA* forthwith. A declaration that the Minister erred in refusing the exemption would be inadequate, given the seriousness of the infringement and the grave consequences that might result from a lapse in Insite's current constitutional exemption, and for various reasons, granting a permanent constitutional exemption would be inappropriate.

On future applications, the Minister must exercise that discretion within the constraints imposed by the law and the *Charter*, aiming to strike the appropriate balance between achieving public health and public safety. In accordance with the

Charter, the Minister must consider whether denying an exemption would cause deprivations of life and security of the person that are not in accordance with the principles of fundamental justice. Where, as here, a supervised injection site will decrease the risk of death and disease, and there is little or no evidence that it will have a negative impact on public safety, the Minister should generally grant an exemption.

VANDU's cross-appeal, which challenges the application of the prohibition on possession to all addicted persons, lacks an adequate basis in the record.

Cases Cited

Distinguished: *R. v. Parker* (2000), 188 D.L.R. (4th) 385; **referred to:** *Canadian Western Bank v. Alberta*, 2007 SCC 22, [2007] 2 S.C.R. 3; *Global Securities Corp. v. British Columbia (Securities Commission)*, 2000 SCC 21, [2000] 1 S.C.R. 494; *R. v. Malmo-Levine*, 2003 SCC 74, [2003] 3 S.C.R. 571; *Attorney General of Canada v. Law Society of British Columbia*, [1982] 2 S.C.R. 307; *Garland v. Consumers' Gas Co.*, 2004 SCC 25, [2004] 1 S.C.R. 629; *Bell Canada v. Quebec (Commission de la santé et de la sécurité du travail)*, [1988] 1 S.C.R. 749; *Quebec (Attorney General) v. Canadian Owners and Pilots Association*, 2010 SCC 39, [2010] 2 S.C.R. 536; *Derrickson v. Derrickson*, [1986] 1 S.C.R. 285; *Natural Parents v. Superintendent of Child Welfare*, [1976] 2 S.C.R. 751; *R. v. Morgentaler*, [1988] 1 S.C.R. 30; *Morgentaler v. The Queen*, [1976] 1 S.C.R. 616; *R. v. Morgentaler*, [1993]

3 S.C.R. 463; *New Brunswick Broadcasting Co. v. Nova Scotia (Speaker of the House of Assembly)*, [1993] 1 S.C.R. 319; *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791; *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519; *R. v. York*, 2005 BCCA 74, 193 C.C.C. (3d) 331; *R. v. Spooner* (1954), 109 C.C.C. 57; *R. v. Hess (No. 1)* (1948), 94 C.C.C. 48; *R. v. Ormerod*, [1969] 4 C.C.C. 3; *Suresh v. Canada (Minister of Citizenship and Immigration)*, 2002 SCC 1, [2002] 1 S.C.R. 3; *Doucet-Boudreau v. Nova Scotia (Minister of Education)*, 2003 SCC 62, [2003] 3 S.C.R. 3; *R. v. 974649 Ontario Inc.*, 2001 SCC 81, [2001] 3 S.C.R. 575; *Mills v. The Queen*, [1986] 1 S.C.R. 863; *R. v. Ferguson*, 2008 SCC 6, [2008] 1 S.C.R. 96.

Statutes and Regulations Cited

Canadian Charter of Rights and Freedoms, ss. 1, 7, 24(1).

Combines Investigation Act, R.S.C. 1970, c. C-23, s. 32.

Constitution Act, 1867, ss. 91, 92.

Constitution Act, 1982, s. 52.

Controlled Drugs and Substances Act, S.C. 1996, c. 19, ss. 4(1), (3) to (6), 5(1), 10(1), 55, 56.

Criminal Code, R.S.C. 1985, c. C-46, s. 4(3).

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Canada. Health Canada. *Vancouver's INSITE service and other Supervised injection sites: What has been learned from research? — Final report of the Expert*

Advisory Committee, March 31, 2008 (online: http://www.hc-sc.gc.ca/ahc-asc/pubs/_sites-lieux/insite/index-eng.php).

Canada. House of Commons. *Evidence of the Standing Committee on Health*, No. 032, 2nd Sess., 39th Parl., May 29, 2008 (online: <http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=3529880&Language=E&Mode=1&Parl=39&Ses=2>).

APPEAL and CROSS-APPEAL from a judgment of the British Columbia Court of Appeal (Rowles, Huddart and D. Smith JJ.A.), 2010 BCCA 15, 100 B.C.L.R. (4th) 269, 314 D.L.R. (4th) 209, 250 C.C.C. (3d) 443, 207 C.R.R. (2d) 232, [2010] 2 W.W.R. 575, 281 B.C.A.C. 161, 475 W.A.C. 161, [2010] B.C.J. No. 57 (QL), 2010 CarswellBC 50, affirming the decisions of Pitfield J., 2008 BCSC 661, 85 B.C.L.R. (4th) 89, 293 D.L.R. (4th) 392, 173 C.R.R. (2d) 82, [2009] 3 W.W.R. 450, [2008] B.C.J. No. 951 (QL), 2008 CarswellBC 1043, and 2008 BCSC 1453, 91 B.C.L.R. (4th) 389, 302 D.L.R. (4th) 740, [2009] 3 W.W.R. 494, [2008] B.C.J. No. 2057 (QL), 2008 CarswellBC 2300. Appeal and cross-appeal dismissed.

Robert J. Frater and *W. Paul Riley*, for the appellants/respondents on cross-appeal.

Joseph J. Arvay, Q.C., Monique Pongracic-Speier, Scott E. Bernstein and *Jeffrey W. Beedell*, for the respondents PHS Community Services Society, Dean Edward Wilson and Shelly Tomic.

Craig E. Jones and *Karrie Wolfe*, for the respondent the Attorney General of British Columbia.

John W. Conroy, Q.C., and Stephen J. Mulhall, Q.C., for the respondent/appellant on cross-appeal.

Hugo Jean, for the intervener the Attorney General of Quebec.

Andrew I. Nathanson and Brook Greenberg, for the intervener the Dr. Peter AIDS Foundation.

Sheila M. Tucker, for the intervener the Vancouver Coastal Health Authority.

Paul F. Monahan and Antonio Di Domenico, for the intervener the Canadian Civil Liberties Association.

Michael A. Feder, Angela M. Juba and Louis Letellier de St-Just, for the interveners the Canadian HIV/AIDS Legal Network, International Harm Reduction Association and CACTUS Montréal.

Rahool P. Agarwal, John M. Picone and Michael Kotrly, for the interveners the Canadian Nurses Association, the Registered Nurses' Association of Ontario and the Association of Registered Nurses of British Columbia.

Owen M. Rees and Fredrick Schumann, for the intervener the Canadian Public Health Association.

Guy J. Pratte, Nadia Effendi and Jean Nelson, for the intervener the Canadian Medical Association.

Ryan D. W. Dalziel and Thomas J. Moran, for the intervener the British Columbia Civil Liberties Association.

Marjorie Brown, for the intervener the British Columbia Nurses' Union.

Michael A. Chambers, for the intervener REAL Women of Canada.

The judgment of the Court was delivered by

THE CHIEF JUSTICE —

[1] Since 2003, the Insite safe injection facility has provided medical services to intravenous drug users in the Downtown Eastside of Vancouver (“DTES”). Local, provincial and federal authorities came together to create a legal framework for a safe injection facility in which clients could inject drugs under medical supervision without fear of arrest and prosecution. Insite was widely hailed as an effective response to the catastrophic spread of infectious diseases such as HIV/AIDS and hepatitis C, and the high rate of deaths from drug overdoses in the DTES.

[2] In 2008, the federal government failed to extend Insite’s exemption from the operation of criminal laws in the *Controlled Drugs and Substances Act*, S.C.

1996, c. 19 (“*CDSA*”). Faced with the threat that Insite would have to stop offering services, the claimants brought an action for declarations that the *CDSA* is inapplicable to Insite and that its application to Insite resulted in a violation of the claimants’ s. 7 rights under the *Canadian Charter of Rights and Freedoms*, or, in the alternative, that the federal Minister of Health, in refusing to grant an extension of Insite’s exemption, had violated the claimants’ s. 7 rights.

[3] The question in this appeal is whether Insite is exempt from the federal criminal laws that prohibit the possession and trafficking of controlled substances, either because Insite is a health facility within the exclusive jurisdiction of the Province, or because the application of the criminal law would violate the *Charter*. For the reasons that follow, we conclude that the *CDSA* is applicable to Insite, and that the scheme of the *CDSA* conforms to the *Charter*. However, the actions of the federal Minister of Health in refusing to extend Insite’s exemption under s. 56 of the *CDSA* are in violation of s. 7 of the *Charter*, and cannot be justified under s. 1. Accordingly, we order the Minister to grant Insite an extended exemption, and dismiss the appeal.

I. Introduction and Background

[4] The DTES is home to some of the poorest and most vulnerable people in Canada. Its population includes 4,600 intravenous drug users, which is almost half of the intravenous drug users in the city as a whole. This number belies the size of the

DTES. It is in fact a very small area, stretching for a few blocks in each direction from its heart at the intersection of Main and Hastings.

[5] There is no single reason for the concentration of intravenous drug users in this urban neighbourhood. Contributing factors include the presence of several single room occupancy hotels, the de-institutionalization of the mentally ill, the effect of drug enforcement policies over the years, and the availability of illicit narcotics at street level.

[6] The injection drug use problem of the DTES is not hidden. At any given time of day drug transactions can be witnessed in the open air on the very steps of the historic Carnegie Community Centre at Main and Hastings. In alleys steps away, addicts tie rubber bands around their arms to find veins in which to inject heroin and cocaine, or smoke crack from glass pipes.

[7] The residents of the DTES who are intravenous drug users have diverse origins and personal histories, yet familiar themes emerge. Many have histories of physical and sexual abuse as children, family histories of drug abuse, early exposure to serious drug use, and mental illness. Many injection drug users in the DTES have been addicted to heroin for decades, and have been in and out of treatment programmes for years. Many use multiple substances, and suffer from alcoholism. Some engage in street-level survival sex work in order to support their addictions. It should be clear from the above that these people are not engaged in recreational drug

use: they are addicted. Injection drug use is both an effect and a cause of a life that is a struggle on a day to day basis.

[8] While some affordable housing is available in the DTES, living conditions there would shock many Canadians. The DTES is one of the few places where Vancouver's poorest people, crippled by disability and addiction, can afford to live. Twenty percent of its population is homeless. Of those who are not homeless, many live in squalid conditions in single-room occupancy hotels. Residents of single-room occupancy hotels live with little in the way of security, privacy or hygienic facilities. The residents of one building often have to share a single bathroom. Single-room occupancy hotels are commonly infested with bedbugs and rats. Existence is bleak.

[9] A survey of approximately 1,000 drug users living in the DTES was presented to the federal Minister of Health in a 2008 report, and summarized by the trial judge at para. 16 of his reasons (2008 BCSC 661, 85 B.C.L.R. (4th) 89). Generally, he found that:

- those surveyed had been injecting drugs for an average of 15 years;
- the majority (51%) inject heroin and 32% inject cocaine;
- 87% are infected with hepatitis C virus (HCV) and 17% with human immunodeficiency virus (HIV);

- 18% are Aboriginal;
- 20% are homeless and many more live in single resident rooms;
- 80% have been incarcerated;
- 38% are involved in the sex trade;
- 21% are using methadone; and
- 59% reported a non-fatal overdose in their lifetime.

[10] For injection drug users, the nature of addiction makes for a desperate and dangerous existence. Aside from the dangers of the drugs themselves, addicts are vulnerable to a host of other life-threatening practices. Although many users are educated about safe practices, the need for an immediate fix or the fear of police discovering and confiscating drugs can override even ingrained safety habits. Addicts share needles, inject hurriedly in alleyways and dissolve heroin in dirty puddle water before injecting it into their veins. In these back alleyways, users who overdose are often alone and far from medical help. Shared needles transmit HIV and hepatitis C. Unsanitary conditions result in infections. Missing a vein in the rush to inject can mean the development of abscesses. Not taking adequate time to prepare can result in mistakes in measuring proper amounts of the substance being injected. It is not uncommon for injection drug users to develop dangerous infections or endocarditis. These dangers are exacerbated by the fact that injection drug users are a historically marginalized population that has been difficult to bring within the reach of health care providers.

[11] Although injection drug use is by no means a new problem in Vancouver, or for that matter in the rest of the country, in the early 1990s it reached crisis levels in the DTES. In just six years, the number of annual deaths from overdose in Vancouver increased exponentially, from 16 in 1987 to 200 in 1993. In 1996, Vancouver's medical health officer reported an increase in infectious diseases in the DTES, including HIV/AIDS, hepatitis A, B and C, skin and blood-borne infections, endocarditis and septicaemia, as well as fatal and non-fatal overdoses. All were related to injection drug use. The same year, the British Columbia Centre for Excellence in HIV/AIDS reported an HIV/AIDS epidemic in the neighbourhood. The following year, an epidemic of hepatitis C was reported. A public health emergency was declared in the DTES in September 1997.

[12] The decision to implement a supervised safe injection site was the result of years of research, planning, and intergovernmental cooperation. The process of research and planning is described in the affidavit of Heather Hay, the Director of Addictions, HIV/AIDS and Aboriginal Health Services for the Vancouver Coastal Health Authority ("VCHA"). In her affidavit, Ms. Hay describes the response of the various government agencies to the crisis in the DTES. From the beginning, health authorities recognized that creative solutions would be required to address the needs of the difficult-to-reach population of the DTES.

[13] In 1997, the Vancouver/Richmond Health Board adopted the "Vancouver Downtown Eastside HIV/AIDS Action Plan", which introduced harm reduction

strategies such as the creation of the Vancouver Area Network of Drug Users (VANDU) (“VANDU”) to provide peer outreach and support, and the establishment of needle exchanges. In 1999, VCHA issued a report identifying injection drug use as the root of the health concerns in the DTES, and recommended an integrated health approach that had as its focus harm reduction: expansion of primary care services, the development of creative interventions to address communicable disease, the development of a scheme of drug and alcohol services including harm reduction strategies, and improved access to stable housing. In accordance with this plan, new low threshold health clinics were opened in the DTES, needle exchange services were expanded, methadone service was increased, and access to antiretroviral drugs was improved.

[14] In April 2002, the Province transferred responsibility for adult alcohol and drug services to the regional health authorities, allowing VCHA to integrate its approach to addictions treatment. In September 2002, the VCHA proposed a new addictions plan for Vancouver that adopted harm reduction strategies and moved away from traditional abstinence-based programmes. The plan envisioned a scheme of care for drug users that would assist them at all points in the treatment of their disease, not simply at the exit point when they quit drugs for good. The proposed plan included supervised drug consumption facilities.

[15] The notion of a supervised injection facility, although politically contentious in North America, has precedent elsewhere. Supervised injection sites

have been used with success to address health issues associated with injection drug use in other parts of the world. Safe injection sites operate in 70 cities in six European countries, and in Sydney, Australia. These sites are evidence that health authorities are increasingly recognizing that health care for injection drug users cannot amount to a stark choice between abstinence and forgoing health services. Successful treatment requires acknowledgment of the difficulties of reaching a marginalized population with complex mental, physical, and emotional health issues.

[16] Ms. Hay prepared a proposal for a supervised injection site, which received the approval of the Board of the VCHA in March 2003. In May 2003, the proposal was submitted to Health Canada for consideration. Federal approval was required in order to obtain an exemption from the prohibitions on possession and trafficking of controlled substances in the *CDSA*. The scheme of the *CDSA* provides for such exemptions, at the discretion of the Minister of Health, under s. 56. Health Canada gave final approval for conditional exemption of the facility from possession and trafficking laws as a pilot research project under s. 56 of the *CDSA* on September 12, 2003.

[17] Insite opened its doors on September 21, 2003. It was North America's first government-sanctioned safe injection facility. It has operated constantly since then, seven days a week, 18 hours a day. Its operations are described at paras. 71-77 of the trial judge's reasons:

Insite is located on East Hastings Street between Carrall and Main Streets. It is open daily from 10:00 a.m. to 4:00 a.m. the following day. The facility is known to DTES residents. Police refer addicts to it. Insite operates under an extensive and detailed operating protocol approved by Health Canada. It is staffed by a combination of PHS, Health Authority and community workers.

Users must be 16 years of age or over, must sign a user agreement, release and consent form, must agree to adhere to a code of conduct, and cannot be accompanied by children. Users must register at each visit to the site and each is asked to identify the substance that will be injected. No substances are provided by staff. It goes without saying that the substances brought to Insite by users have been obtained from a trafficker in an illegal transaction. Users are obviously in possession of their substance en route to Insite. Approximately 60% of the drugs injected are opioids, of which two-thirds are heroin and one-third morphine or hydromorphone. Approximately 40% of injected drugs are stimulants, approximately 90% of which are cocaine and 10%, methamphetamine.

Insite has 12 injection bays. Users are provided with clean injection equipment which is the only equipment that can be used at the site. Users are monitored by staff during injection. Nurses and paramedical staff provide treatment in the event of overdose and contact a physician and the ambulance service as necessary. Overdoses vary in severity and treatment.

The protocol permits pregnant women to use Insite. They are required to undergo a more intensive assessment than others before being allowed access to the injection room. Those women are also referred to a clinic and child daycare facilities directly managed by the Health Authority, which provides pre- and post-natal care to pregnant women who are actively using illegal substances.

Users who have completed an injection are assessed by staff. They may be discharged to the "chill-out" lounge or treated by a nurse in the treatment room for injection-related conditions. Users requiring extensive or ongoing care are referred to the closest primary care facility, either the Downtown Community Health Centre or the Pender Clinic.

Staff and support workers interact with users at Insite on a one-to-one basis. Users are provided with health care information, counselling and referrals to Health Authority and other service providers. Records indicate that in 2005, 2006 and 2007, staff made 2,270, 1,828, and 2,269 referrals, respectively, to community clinic, hospital

emergency, outpatient medical mental health, emergency shelter and community services; and to addiction counselling, housing, withdrawal, methadone treatment, drug recovery, and miscellaneous other services.

Since the fall of 2007, the staff has also been able to refer users to “Onsite”, a detox centre located above Insite which permits Insite to provide detox on demand. Onsite is a drug free environment supported by physicians who are addiction specialists and general practitioners, nurses and peers. Users may also be referred to residential detox and additional treatment services.

[18] This passage describes a strictly regulated health facility. It operates under the authority of the Vancouver Coastal Health Authority, and its personnel are guided by strict policies and procedures. It does not provide drugs to its clients, who must check in, must sign a waiver, and are closely monitored during and after injection. There are guidelines for staff to follow in the disposal of used injection equipment and the containment of leftover drugs.

[19] Insite was the product of cooperative federalism. Local, provincial and federal authorities combined their efforts to create it. It was launched as an experiment. The experiment has proven successful. Insite has saved lives and improved health. And it did those things without increasing the incidence of drug use and crime in the surrounding area. The Vancouver police support Insite. The city and provincial government want it to stay open. But continuing the Insite project will be impossible without a federal government exemption from the laws criminalizing possession of prohibited substances at Insite.

[20] The federal *CDSA* is the federal government's response to the problem of illegal drug use across Canada. By way of the *CDSA*, the federal government has chosen an approach that favours a blanket prohibition on possession and trafficking in illegal drugs. At the same time, Parliament has recognized that there are good reasons to allow the use of illegal substances in certain circumstances. The federal Minister of Health can issue exemptions for medical and scientific purposes under s. 56 of the *CDSA*. Section 55 of the *CDSA* allows for the Governor in Council to make regulations for the medical, scientific and industrial use of illegal substances. In this manner, Parliament has attempted to balance the two competing interests of public safety and public health. In 2008, the federal exemption for Insite from the operation of the criminal drug laws expired. This action was started in an effort to keep Insite open.

II. Procedural History

[21] This action was brought by Dean Edward Wilson, Shelly Tomic, PHS Community Services ("PHS"), and VANDU. PHS is a non-profit organization that oversees the operation of Insite. VANDU is a non-profit society that advocates on behalf of drug users.

[22] The individual claimants, Mr. Wilson and Ms. Tomic, are residents of the DTES and are (or have been) clients of Insite. Mr. Wilson is 55 years old and has been injecting heroin since he was 13. He has been injecting cocaine for almost as long. His drug use has had serious health consequences: he is hepatitis C positive,

and is frequently ill. He has tried to stop or reduce his drug use many times, but has been unable to go completely clean. Mr. Wilson has translated his own experiences into a positive role in helping to educate and improve the health situation of other drug users in the community. He was the first person to use Insite's facilities, and continues to go back when he relapses into heroin use. He considers Insite to be an important resource for injection drug users in the DTES, and believes that he has reduced his own risk of serious overdose by injecting there. Most importantly, he says, "Insite has given dignity to people who have to struggle to have their humanity recognized" (A.R. vol. II, at p. 44).

[23] Ms Tomic is 43 years old, and was born addicted to speed. She began injecting cocaine when she was 19 or 20, heroin when she was 26 or 27. She has turned to sex work at times to support her addiction. Like Mr. Wilson, she is hepatitis C positive. She is treating her addiction with methadone, but occasionally relapses and uses heroin. Ms Tomic started injecting at Insite as soon as it opened in 2003, and immediately noticed that she stopped getting abscesses when she injected there. She also credits Insite with getting her started on methadone treatment. Like Mr. Wilson, she attests to the psychological and emotional support that Insite and its staff provide, and its role in keeping her on the path to recovery.

[24] Ms Tomic, Mr. Wilson and PHS seek a declaration that ss. 4(1) and 5(1) of the *CDSA* are constitutionally inapplicable to Insite, because as a health facility it is under exclusive provincial control, making an exemption under s. 56 unnecessary.

They also allege that the application of the criminal prohibitions in the *CDSA* to Insite violates their constitutional rights under s. 7 of the *Charter*, and to this extent are invalid under s. 52 of the *Constitution Act, 1982*. In the alternative, they seek a declaration that any decision of the federal Minister of Health to refuse to grant or extend the exemption constitutes a violation of the individual plaintiffs' s. 7 *Charter* rights.

[25] At this Court, VANDU supports the submissions of Tomic, Wilson and PHS and seeks a declaration that the offence of possession of all addictive drugs violates s. 7 of the *Charter*.

A. *British Columbia Supreme Court, 2008 BCSC 661, 85 B.C.L.R. (4th) 89*

[26] The action was brought by way of a summary trial before Pitfield J. at the British Columbia Supreme Court in May 2008, shortly before the federal exemption was set to expire. The evidence was presented in affidavit form.

[27] Justice Pitfield recognized that there are competing approaches to dealing with addiction, and limited his findings of fact to what was necessary to decide the matter before him. His factual findings are key to this appeal. He summarized those findings at paras. 87-89 of his reasons:

. . . all of the evidence adduced by PHS, VANDU and Canada supports some incontrovertible conclusions:

1. Addiction is an illness. One aspect of the illness is the continuing need or craving to consume the substance to which the addiction relates.
2. Controlled substances such as heroin and cocaine that are introduced into the bloodstream by injection do not cause Hepatitis C or HIV/AIDS. Rather, the use of unsanitary equipment, techniques, and procedures for injection permits the transmission of those infections, illnesses or diseases from one individual to another; and
3. The risk of morbidity and mortality associated with addiction and injection is ameliorated by injection in the presence of qualified health professionals.

What is less certain and more controversial are the root causes of addiction. The evidence adduced in these proceeding regarding the character of the DTES, many of its inhabitants, and the nature of addiction leads me to the following assessment.

Residents of the DTES who are addicted to heroin, cocaine, and other controlled substances are not engaged in recreation. Their addiction is an illness frequently, if not invariably, accompanied by serious infections and the real risk of overdose that compromise their physical health and the health of other members of the public. I do not assign or apportion blame, but I conclude that their situation results from a complicated combination of personal, governmental and legal factors: a mixture of genetic, psychological, sociological and familial problems; the inability, despite serious and prolonged efforts, of municipal, provincial and federal governments, as well as numerous non-profit organizations, to provide meaningful and effective support and solutions; and the failure of the criminal law to prevent the trafficking of controlled substances in the DTES as evidenced by the continuing prevalence of addiction in the area.

[28] With respect to outcomes, Pitfield J. accepted the findings of the Expert Advisory Committee's report to the federal Minister of Health with respect to Insite (para. 85). In its report, the Expert Advisory Committee concluded, *inter alia*, that:

- observations in the period shortly before and after the opening of Insite indicated a reduction in the number of people injecting in public;
- there was no evidence of increases in drug-related loitering, drug dealing or petty crime in the area around Insite;
- the local Chinese Business Association reported reductions in crime in the Chinese business district outside the DTES;
- police data showed no changes in rates of crime recorded in the DTES;
- there was no evidence that Insite increased the relapse rate among injection drug users; and
- the cost/benefit analysis was favourable.

[29] Pitfield J. rejected VANDU's application for a declaration that the activities of the staff of Insite did not amount to possession or trafficking. The question of whether an individual has committed either offence is fact-dependent and not amenable to a judicial declaration "in the air" (para. 98).

[30] Pitfield J. also rejected the claim that Insite was shielded from the application of ss. 4(1) and 5(1) of the *CDSA* by the operation of the doctrine of interjurisdictional immunity. He noted this Court's ambivalence towards the doctrine in recent years and its view that interjurisdictional immunity should only be employed sparingly (para. 118). In cases of "double aspect" where both levels of government

may regulate the same subject matter, Pitfield J. held that the courts “must strive to give legitimacy to both legislative initiatives” (para. 119). The federal and provincial legislation conflicted, with the result that the federal scheme prevailed to the extent of the conflict by virtue of the doctrine of federal paramountcy.

[31] With respect to the *Charter* claim, Pitfield J. found that the s. 7 rights of life, liberty, and security of the person were all engaged by the application of ss. 4(1) and 5(1) of the *CDSA* to Insite. Applied to Insite, the impugned provisions of the *CDSA* did not accord with the principles of fundamental justice because they arbitrarily prohibited the management of addiction and its associated risks. The arbitrariness of the scheme was not cured by s. 56 of the *CDSA*, because the Minister’s discretion to grant exemptions was unfettered. Pitfield J. went on to hold that the violation of s. 7 could not be saved under s. 1 of the *Charter*. Accordingly, he declared ss. 4(1) and 5(1) of the *CDSA* unconstitutional and of no force and effect. He suspended the declaration of constitutional invalidity and granted Insite a constitutional exemption, permitting it to continue to operate free from federal drug laws.

B. British Columbia Court of Appeal, 2010 BCCA 15, 100 B.C.L.R. (4th) 269

[32] The British Columbia Court of Appeal upheld the trial judge’s conclusion that Insite should continue to operate free from federal drug prohibitions. Rowles J.A., writing for herself and concurring with Huddart J.A., upheld the trial judge’s decision with respect to the *Charter* claim, although she would have found the law

overbroad, rather than arbitrary. She agreed with Pitfield J. that the application of the *CDSA* to the activities at Insite would have a grossly disproportionate effect on its clients by denying them access to necessary health care, with no corresponding benefit either to themselves or to society at large.

[33] Rowles J.A. also concurred in the reasons of Huddart J.A., holding that the federal drug laws were inapplicable to Insite by virtue of the doctrine of interjurisdictional immunity. Insite, Huddart J.A. held, is a provincial undertaking created under the provincial power over hospitals. The determination of the nature of services to be provided by a hospital, she held, is at the core of the purpose of the provincial health power, and cannot be undercut by conflicting federal laws. At para. 162, she wrote:

If the federal executive, in exercising or failing to exercise authority granted to it by Parliament, can effectively prohibit a form of health care vital to the delivery of a provincial health care program, that means Parliament has an effective veto over provincial health care services, to the extent its use of the criminal power can be justified by the potential for harm to public health or safety. That is just the sort of intrusion into a provincial domain that constituted an impermissible intrusion into the federal domain in *Bell Canada [v. Quebec (Commission de la santé et de la sécurité du travail)]*, [1988] 1 S.C.R. 749. [pp. 797-98]

The immunity created, Huddart J.A. held, “would apply only to exempt a health care service considered essential by a provincial agency with the authority to make that decision under provincial legislation” (para. 167). She concluded that “[i]f interjurisdictional immunity is not available to a provincial undertaking on the facts

of this case, then it may well be said the doctrine is not reciprocal and can never be applied to protect exclusive provincial powers” (para. 176).

[34] D. Smith J.A. dissented on both the *Charter* and the division of powers issues. With respect to the *Charter*, she held that although a deprivation of s. 7 rights had been made out, the claimants had not established that the deprivation was not in accordance with the principles of fundamental justice. With respect to arbitrariness, she found that “there was no evidence presented to show that the blanket prohibition of possession of illegal drugs is not rationally connected to or is inconsistent with the overall state interest in health and public safety” (para. 291). Similar conclusions were reached with respect to disproportionality and overbreadth. The claimants “provided no evidence to show that Parliament could prevent increased drug use, addiction, and associated crime by something other than a blanket prohibition” (para. 297). The claimants had provided no evidence upon which the court could conclude that Parliament could have achieved its goals of protecting the health and safety of all Canadians from dangerous and addictive drugs by alternative and narrower legislative means (para. 303).

[35] On the division of powers issue, D. Smith J.A. essentially agreed with the trial judge. She reviewed the recent jurisprudence of this Court on interjurisdictional immunity, and concluded that the doctrine was limited to circumstances in which previous case law had identified an area of exclusive legislative authority (para. 225).

Accordingly, she concluded that the doctrine of interjurisdictional immunity should not apply to the provincial power over health care services and hospitals.

III. Questions on Appeal

[36] The Attorney General of Canada asks this Court to overturn the Court of Appeal's holdings on the division of powers and the *Charter*. These questions are considered separately below. The first question is whether ss. 4(1) and 5(1) of the *CDSA* are constitutionally inapplicable to the activities of the staff and clients at Insite by virtue of the division of powers. The second question is whether ss. 4(1) and 5(1) infringe the rights guaranteed by s. 7 of the *Charter*, and if so, whether the infringement is justified under s. 1 of the *Charter*.

IV. Statutory and Constitutional Provisions

A. *The CDSA*

[37] The federal government, exercising its criminal law power, has enacted the *CDSA*. The *CDSA* makes it a crime to possess or traffic in illegal drugs across Canada. The *CDSA* regulates drug possession and trafficking in two complementary ways.

[38] First, the *CDSA* prohibits possession and trafficking in ss. 4(1) and 5(1):

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

5. (1) No person shall traffic in a substance included in Schedule I, II, III or IV or in any substance represented or held out by that person to be such a substance.

[39] Second, the *CDSA* empowers the Minister of Health to issue exemptions for medical or scientific reasons, or for any purpose the Minister deems to be in the public interest:

56. The Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.

[40] Section 55 complements the s. 56 exemption power by giving the Governor in Council the power to make regulations concerning the use and distribution of controlled substances in their permitted applications.

[41] The mechanisms embodied in the *CDSA* — general prohibitions subject to targeted ministerial exemptions — reflect the dual purpose of the *CDSA*: the protection of both public safety and public health. This dual purpose is also reflected in the sentencing provision of the *CDSA*, s. 10(1), which directs that “the fundamental purpose of any sentence for an offence under this Part is to contribute to the respect for the law and the maintenance of a just, peaceful and safe society while encouraging

rehabilitation, and treatment in appropriate circumstances, of offenders and acknowledging the harm done to victims and to the community”.

B. The Constitutional Provisions

[42] Canada has asserted jurisdiction to prohibit the possession and trafficking of illicit drugs by virtue of its power to enact criminal laws under s. 91(27) of the *Constitution Act, 1867*:

91. . . . it is hereby declared that (notwithstanding anything in this Act) the exclusive Legislative Authority of the Parliament of Canada extends to all Matters coming within the Classes of Subjects next herein after enumerated; that is to say, —

. . .

27. The Criminal Law, except the Constitution of Courts of Criminal Jurisdiction, but including the Procedure in Criminal Matters.

[43] The claimants and the Attorney General of British Columbia submit that Insite is exempt from the prohibitions in the federal *CDSA* because decisions about health facilities fall within provincial jurisdiction over health under ss. 92(7), (13) and (16) of the *Constitution Act, 1867*:

92. In each Province the Legislature may exclusively make Laws in relation to Matters coming within the Classes of Subjects next herein after enumerated; that is to say, —

7. The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals.

...

13. Property and Civil Rights in the Province.

...

16. Generally all Matters of a merely local or private Nature in the Province.

The Province, exercising these powers, has delegated them to the VCHA, which in turn established Insite.

[44] The claimants also invoke ss. 1 and 7 of the *Charter*:

1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

...

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

V. Division of Powers Arguments

[45] All the parties accept that apart from its application to provincial health facilities, the *CDSA* is valid legislation, pursuant to Parliament's criminal law power, s. 91(27). The issue before the Court is whether, as a result of the division of powers between the federal government and the provinces, Insite is not bound by the valid criminal laws that prohibit the possession and trafficking of controlled substances. The parties and interveners have advanced three arguments in support of this position.

[46] First, the Attorney General of Quebec argues that the impugned provisions of the *CDSA* are *ultra vires* insofar as Insite is concerned because the federal criminal law power cannot interfere with the regulation of provincial health facilities.

[47] Second, the Attorney General of British Columbia argues that the *CDSA* should be read as avoiding interfering with the Province's jurisdiction over health policy. When the *CDSA* is interpreted in this way, British Columbia argues that any institution that a province identifies as serving the public interest must be exempted from the criminal prohibitions of possession and trafficking.

[48] Third, the Attorney General of British Columbia, Wilson, Tomic and PHS argue that the doctrine of interjurisdictional immunity should apply to shield provincial decisions about medical treatments from interference by the federal government.

[49] I consider each of these arguments below.

A. Are the Impugned Provisions of the CDSA Ultra Vires?

[50] The Attorney General of Quebec submits that ss. 4(1) and 5(1) of the *CDSA* are partially invalid because they exceed Parliament's jurisdiction to enact criminal laws under s. 91(27) of the *Constitution Act, 1867*. Quebec argues that while the federal government is permitted to criminalize the possession and trafficking of

illicit drugs in many contexts, prohibiting these drugs in a medical context is *ultra vires* the federal government. Quebec acknowledges that its approach might appear novel.

[51] This argument appears to confuse the constitutional validity of a law with the applicability of a valid law. When determining whether a law is valid under the division of powers, the Court looks to the dominant purpose of the law. The fact that the law at issue in this case has the incidental effect of regulating provincial health institutions does not mean that it is constitutionally invalid. A valid federal law may have incidental impacts on provincial matters: *Canadian Western Bank v. Alberta*, 2007 SCC 22, [2007] 2 S.C.R. 3, at para. 28; *Global Securities Corp. v. British Columbia (Securities Commission)*, 2000 SCC 21, [2000] 1 S.C.R. 494, at para. 23. It is therefore untenable to argue, as I understand Quebec to do, that a valid federal law becomes invalid if it affects a provincial subject, in this case health.

[52] In pith and substance, the impugned provisions of the *CDSA* are valid exercises of the federal criminal law power. At trial, PHS conceded that ss. 4(1) and 5(1) of the *CDSA* were “concerned with suppressing the availability of drugs that have harmful effects on human health” (para. 112). The protection of public health and safety from the effects of addictive drugs is a valid criminal law purpose: *R. v. Malmo-Levine*, 2003 SCC 74, [2003] 3 S.C.R. 571, at paras. 77-78. Additionally, the prohibitions in ss. 4(1) and 5(1) are backed by penalties. Since none of the parties

have argued that the impugned provisions colourably intrude on provincial jurisdiction, I conclude that they are valid exercises of the criminal law power.

B. *Should Sections 4(1) and 5(1) Be Read as Not Applying to Insite?*

[53] The Attorney General of British Columbia argues that ss. 4(1) and 5(1) of the *CDSA* should be read as not applying to Insite. Relying on this Court's decision in *Attorney General of Canada v. Law Society of British Columbia*, [1982] 2 S.C.R. 307 ("*Jabour*"), British Columbia argues that federal criminal laws are "implicitly constrained to operate consistently with the public interest" (AGBC factum, at para. 47). It argues that once a province establishes that a particular activity (in this case the provision of health services through Insite) serves the public interest, that activity is exempt from the operation of federal criminal laws. Since the Province has authorized the operation of Insite in the public interest, the prohibitions in ss. 4(1) and 5(1) of the *CDSA* do not apply to it.

[54] *Jabour* does not establish that federal criminal laws cease to apply if their application is inconsistent with the public interest, as defined by a province. The issue before the Court in *Jabour* was whether s. 32 of the *Combines Investigation Act*, R.S.C. 1970, c. C-23, which only prohibited activities that harmed the public interest, interfered with the operation of a provincial law society. The Court, *per* Estey J., held that "[w]hen a federal statute can be properly interpreted so as not to interfere with a provincial statute, such an interpretation is to be applied in preference to

another applicable construction which would bring about a conflict between the two statutes” (p. 356).

[55] The decision in *Jabour* rested on the fact that the prohibition in the *Combines Investigation Act* extended only to activities that harmed the public interest. *Jabour* was about interpreting the federal statute. It did not establish a general rule that provincial programmes designed to advance the public interest are always exempt from the operation of the criminal law. The Court made this point in *Garland v. Consumers’ Gas Co.*, 2004 SCC 25, [2004] 1 S.C.R. 629, *per* Iacobucci J., who wrote that the principle of interpretation adopted in *Jabour* would only apply where Parliament has “expressly or by necessary implication . . . granted leeway to those acting pursuant to a valid provincial regulatory scheme” (para. 77).

[56] The wording of s. 56 of the *CDSA* makes clear that the federal government did not grant any leeway to the provinces. Section 56 establishes that the federal Minister may grant exemptions “on such terms and conditions as the Minister deems necessary . . . if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest” (emphasis added). The federal Minister alone has the power to determine if an activity should be exempt from the prohibitions in the *CDSA*. Action by provincial authorities is neither contemplated nor authorized by the *CDSA*. To put it another way, the *CDSA* grants no leeway to the provinces, and cannot be interpreted as exempting the provinces from its provisions.

C. *Interjurisdictional Immunity*

[57] British Columbia, Mr. Wilson, Ms Tomic and PHS argue that Insite is shielded from the operation of the *CDSA* by virtue of the doctrine of interjurisdictional immunity. The argument, accepted by the majority of the Court of Appeal, is that decisions about what treatment may be offered in provincial health facilities lie at the core of the provincial jurisdiction in the area of health care, and are therefore protected from federal intrusions by the doctrine of interjurisdictional immunity. Accordingly, they say that ss. 4(1) and 5(1) of the *CDSA* are of no force or effect to the extent that they impair the Province's ability to make decisions about health care services.

[58] The doctrine of interjurisdictional immunity is premised on the idea that there is a "basic, minimum and unassailable content" to the heads of powers in ss. 91 and 92 of the *Constitution Act, 1867* that must be protected from impairment by the other level of government: *Bell Canada v. Quebec (Commission de la santé et de la sécurité du travail)*, [1988] 1 S.C.R. 749, at p. 839. In cases where interjurisdictional immunity is found to apply, the law enacted by the other level of government remains valid, but has no application with regard to the identified "core".

[59] It is not necessary to show that there is a conflict between the laws adopted by the two levels of government for interjurisdictional immunity to apply: *Quebec (Attorney General) v. Canadian Owners and Pilots Association*, 2010 SCC 39, [2010] 2 S.C.R. 536, at para. 52 ("*COPA*"). Indeed, it is not even necessary for

the government benefiting from the immunity to be exercising its exclusive authority:
Canadian Western Bank, at para. 34.

[60] The doctrine of interjurisdictional immunity has been applied to circumscribed areas of activity referred to in the cases as undertakings. These include aviation, ports, interprovincial rail and federal communications works. The doctrine has also been applied to federal things like Aboriginal land, and federally regulated persons such as Aboriginal peoples: *Derrickson v. Derrickson*, [1986] 1 S.C.R. 285; *Natural Parents v. Superintendent of Child Welfare*, [1976] 2 S.C.R. 751; see also *Canadian Western Bank*, at para. 41. It has never been applied to a broad and amorphous area of jurisdiction.

[61] Recent jurisprudence has tended to confine the doctrine of interjurisdictional immunity. In *Canadian Western Bank*, the majority stated that “although the doctrine of interjurisdictional immunity has a proper part to play in appropriate circumstances, we intend now to make it clear that the Court does not favour an intensive reliance on the doctrine, nor should we accept the invitation of the appellants to turn it into a doctrine of first recourse in a division of powers dispute” (para. 47). More recently, in *COPA*, the majority held that the doctrine “has not been removed from the federalism analysis”, but rather remains “in a form constrained by principle and precedent” (para. 58).

[62] This caution reflects three related concerns. First, the doctrine of interjurisdictional immunity is in tension with the dominant approach that permits

concurrent federal and provincial legislation with respect to a matter, provided the legislation is directed at a legitimate federal or provincial aspect, as the case may be. This model of federalism recognizes that in practice there is significant overlap between the federal and provincial areas of jurisdiction, and provides that both governments should be permitted to legislate for their own valid purposes in these areas of overlap.

[63] Second, the doctrine is in tension with the emergent practice of cooperative federalism, which increasingly features interlocking federal and provincial legislative schemes. In the spirit of cooperative federalism, courts “should avoid blocking the application of measures which are taken to be enacted in furtherance of the public interest”: *Canadian Western Bank*, at para. 37. Where possible, courts should allow both levels of government to jointly regulate areas that fall within their jurisdiction: *Canadian Western Bank*, at para 37.

[64] Third, the doctrine of interjurisdictional immunity may overshoot the federal or provincial power in which it is grounded and create legislative “no go” zones where neither level of government regulates. Since it is not necessary for the government benefiting from the immunity to actually regulate in the field in question, extension of the doctrine of interjurisdictional immunity risks creating “legal vacuums”: *Canadian Western Bank*, at para. 44.

[65] While the doctrine of interjurisdictional immunity has been narrowed, it has not been abolished. Predictability, important to the proper functioning of the

division of powers, requires recognition of previously established exclusive cores of power: *Canadian Western Bank*, at paras. 23-24. Nor, in principle, is the doctrine confined to federal powers: *Canadian Western Bank*. However, in areas of overlapping jurisdiction, the modern trend is to strike a balance between the federal and provincial governments, through the application of pith and substance analysis and a restrained application of federal paramountcy. Therefore, before applying the doctrine of interjurisdictional immunity in a new area, courts should ask whether the constitutional issue can be resolved on some other basis.

[66] The question in this case is whether the delivery of health care services constitutes a protected core of the provincial power over health care in ss. 92(7), (13) and (16) of the *Constitution Act, 1867*, and is therefore immune from federal interference. I conclude that it is not, for three related reasons.

[67] First, the proposed core of the provincial power over health has never been recognized in the jurisprudence. This is not determinative since new areas of exclusive jurisdiction could in theory be identified in the future. However, as noted above, courts are reluctant to identify new areas where interjurisdictional immunity applies.

[68] Second, and more importantly, the claimants in this case have failed to identify a delineated “core” of an exclusively provincial power. The provincial health power is broad and extensive. It extends to thousands of activities and to a host of different venues. Such a vast core would sit ill with the restrained application of the

doctrine called for by the jurisprudence. To complicate the matter, Parliament has power to legislate with respect to federal matters, notably criminal law, that touch on health. For instance, it has historic jurisdiction to prohibit medical treatments that are dangerous, or that it perceives as “socially undesirable” behaviour: *R. v. Morgentaler*, [1988] 1 S.C.R. 30; *Morgentaler v. The Queen*, [1976] 1 S.C.R. 616; *R. v. Morgentaler*, [1993] 3 S.C.R. 463. The federal role in the domain of health makes it impossible to precisely define what falls in or out of the proposed provincial “core”. Overlapping federal jurisdiction and the sheer size and diversity of provincial health power render daunting the task of drawing a bright line around a protected provincial core of health where federal legislation may not tread.

[69] Third, application of interjurisdictional immunity to a protected core of the provincial health power has the potential to create legal vacuums. Excluding the federal criminal law power from a protected provincial core power would mean that Parliament could not legislate on controversial medical procedures, such as human cloning or euthanasia. The provinces might choose not to legislate in these areas, and indeed might not have the power to do so. The result might be a legislative vacuum, inimical to the very concept of the division of powers.

[70] In summary, the doctrine of interjurisdictional immunity is narrow. Its premise of fixed watertight cores is in tension with the evolution of Canadian constitutional interpretation towards the more flexible concepts of double aspect and cooperative federalism. To apply it here would disturb settled competencies and

introduce uncertainties for new ones. Quite simply, the doctrine is neither necessary nor helpful in the resolution of the contest here between the federal government and the provincial government.

D. *Paramountcy*

[71] In the case of a conflict between a federal law and a provincial law, the doctrine of paramountcy means that the federal law prevails to the extent of the inconsistency: *Canadian Western Bank*, at para. 69. While the Attorney General of Canada did not rely on this principle, it merits mention. The doctrine of federal paramountcy applies when there is operational conflict between a federal and provincial law, or when a provincial law would frustrate the purpose of a federal law.

[72] It can be argued that, absent an exemption, the Insite program involves an operational conflict with the federal prohibition on possession of illegal drugs under the *CDSA*. A detailed analysis of paramountcy is unnecessary in this case, however. The complainants concede that if interjurisdictional immunity does not apply, the federal prohibitions on drugs in the *CDSA* apply to Insite, whether by operation of paramountcy or by the requirement that the VCHA exercise its delegated authority within the limits of the criminal law. Indeed, the claimants' *Charter* arguments are premised on the proposition that these prohibitions, absent an exemption, effectively prevent them from operating Insite. It is common ground that absent a constitutional immunity, the federal law constrains operation at Insite and trumps any provincial legislation or policies that conflict with it. It is therefore unnecessary to inquire into

whether the conditions for the application of the doctrine of paramountcy and ouster of the provincial scheme are present.

E. Conclusion on Division of Powers

[73] None of the arguments raised against the constitutional validity or applicability of the *CDSA* withstand scrutiny. I conclude that the criminal prohibitions on possession and trafficking in the *CDSA* are constitutionally valid and applicable to Insite under the division of powers.

VI. Charter Claims

[74] Three *Charter* claims fall for consideration.

[75] Ms Tomic, Mr. Wilson and PHS argue that ss. 4(1) and 5(1) of the *CDSA*, which prohibit possession and trafficking respectively, are invalid because they limit the claimants' s. 7 rights to life, liberty and security of the person and are not in accordance with the principles of fundamental justice.

[76] In the alternative, they assert that their s. 7 rights have been infringed by the Minister's refusal to extend the exemption for Insite from the application of the federal drug laws.

[77] Finally, VANDU submits that the *CDSA*'s prohibition on possession of drugs limits the s. 7 *Charter* rights of all addicted drug users everywhere, not just at Insite.

[78] Before addressing these arguments, it is necessary to consider Canada's preliminary submission that if the claimants' division of powers arguments fail, their *Charter* arguments must also fail.

A. Relationship Between the Division of Powers Claim and the Charter Claims

[79] Canada submits that if this Court concludes that the *CDSA* is valid and applies to Insite under the division of powers, the *Charter* arguments must also fail.

[80] Canada asserts that if the *CDSA* is valid federal legislation, then the Province has no legal jurisdiction to operate Insite without federal approval. The idea appears to be that absent a federal exemption, the provincial government does not have the legal authority to provide the safe injection service. It is that constitutional inability, not the *CDSA*, that threatens Insite's delivery of health services. Therefore, the *CDSA* cannot be said to deprive the claimants of any right. Canada also supports its preliminary objection as "a novel variation on the rule that 'one part of the Constitution cannot be abrogated or diminished by another part of the Constitution'", A.F., at para. 93, citing *New Brunswick Broadcasting Co. v. Nova Scotia (Speaker of the House of Assembly)*, [1993] 1 S.C.R. 319, at p. 373. The idea here seems to be

that if the *CDSA* is valid and applicable, upholding *Charter* claims would amount to an internal contradiction within the Constitution.

[81] The answer to the first part of this argument is that the Province does in fact have the constitutional power to establish Insite without federal approval. No one argues that the provision of the health services offered by Insite is not within the provincial health power. The claimants seek a federal exemption from operation of the *CDSA*, not because this is necessary to validate the Province's decision to operate Insite as a health service, but because it is necessary as a practical matter to implement the decision. Insite cannot operate without a federal exemption, not for lack of constitutional powers in the Province, but for the practical reason that neither workers nor clients will come to the facility, making it effectively impossible to offer the proposed health services. Thus the premise of Canada's argument — that the Province has no legal jurisdiction to operate Insite without federal approval — fails.

[82] More broadly, the principle that one part of the Constitution cannot be abrogated or diminished by another part of the Constitution is of no assistance in dealing with division of powers issues on the one hand, and *Charter* issues on the other. There is no conflict between saying a federal law is validly adopted under s. 91 of the *Constitution Act, 1867*, and asserting that the same law, in purpose or effect, deprives individuals of rights guaranteed by the *Charter*. The *Charter* applies to all valid federal and provincial laws. Indeed, if the *CDSA* were *ultra vires* the federal

government, there would be no law to which the *Charter* could apply. Laws must conform to the constitutional division of powers and to the *Charter*.

[83] I conclude that the claimants' lack of success on the division of powers issues does not doom their claim that the law deprives them of a s. 7 *Charter* right. Any deprivation of s. 7 rights arises, not because the province is constitutionally unable to establish Insite, but because of the application of ss. 4(1) and 5(1) of the *CDSA* to Insite.

B. *Challenge to Sections 4(1) and 5(1) of the CDSA*

[84] The inquiry into the validity of legislation under s. 7 of the *Charter* requires us to ask: (1) whether ss. 4(1) or 5(1) of the *CDSA* limit the right of the claimants to life, liberty or security of the person (i.e. the “deprivation” or “engagement” issue); and (2) if so, whether that limitation is in accordance with the principles of fundamental justice: *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791, at para. 109, *per* McLachlin C.J. and Major J., *R. v. Malmo-Levine*, at para. 83.

(1) Are the Claimants' Section 7 Interests Engaged by the Prohibition on Possession of Drugs in Section 4(1) of the CDSA?

[85] Section 7 of the *Charter* states that everyone “has the right to life, liberty and security of the person”. A law that interferes with any of these rights may be said to “engage” s. 7 of the *Charter* or constitute a “deprivation” under s. 7.

[86] I begin with the offence of possession of prohibited drugs under s. 4(1) of the *CDSA*. The question is whether it engages or limits the s. 7 rights of Insite staff and/or clients.

[87] I turn first to the argument that s. 7 is engaged because of the impact of s. 4(1) of the *CDSA* on staff. The argument is that the prohibition on possession of proscribed drugs on Insite's premises engages the liberty interests of the staff of Insite, because it exposes them to the threat of being imprisoned for carrying out their duties. This constitutes a direct limit on the s. 7 rights of staff.

[88] The actions of the staff at Insite could be construed as the offence of possession. The definition of possession of prohibited drugs under the *CDSA* is broad enough to encompass the activities of staff at Insite. "Possession" in the *CDSA* is defined with reference to s. 4(3) of the *Criminal Code*, R.S.C. 1985, c. C-46, which provides:

(3) For the purposes of this Act,

(a) a person has anything in possession when he has it in his personal possession or knowingly

(i) has it in the actual possession or custody of another person, or
(ii) has it in any place, whether or not that place belongs to or is occupied by him, for the use or benefit of himself or of another person;
and

(b) where one of two or more persons, with the knowledge and consent of the rest, has anything in his custody or possession, it shall be deemed to be in the custody and possession of each and all of them.

[89] I conclude that, without a s. 56 exemption, s. 4(1) applies to the staff of Insite because, by operating the premises — opening the doors and welcoming prohibited drugs inside — the staff responsible for the centre may be “in possession” of drugs brought in by clients. They have knowledge of the presence of drugs, and consent to their presence in the facility over which they have control.

[90] The evidence is clear that staff do not buy drugs or assist with their injection. Yet their minimal involvement with clients’ drugs may bring them within the legal concept of illegal possession of drugs, contrary to s. 4(1) of the *CDSA*. As such, the availability of a penalty of imprisonment in ss. 4(3) to 4(6) of the *CDSA* engages the liberty interests of staff: *Malmö-Levine*, at para. 84. The threat to the liberty of the staff in turn impacts on the s. 7 rights of clients who seek the health services provided by Insite.

[91] The record supports the conclusion that, without an exemption from the application of the *CDSA*, the health professionals who provide the supervised services at Insite will be unable to offer medical supervision and counselling to Insite’s clients. This deprives the clients of Insite of potentially lifesaving medical care, thus engaging their rights to life and security of the person. The result is that the limits on the s. 7 rights of staff will in turn result in limits on the s. 7 rights of clients.

[92] The application of s. 4(1) to the clients of Insite also directly engages their s. 7 interests. In order to make use of the lifesaving and health-protecting services offered at Insite, clients must be allowed to be in possession of drugs on the

premises. To prohibit possession by drug users *anywhere* engages their liberty interests; to prohibit possession at Insite engages their rights to life and to security of the person.

[93] The trial judge made crucial findings of fact that support the conclusion that denial of access to the health services provided at Insite violates its clients' s. 7 rights to life, liberty and security of the person. He found that many of the health risks of injection drug use are caused by unsanitary practices and equipment, and not by the drugs themselves. He also found that "[t]he risk of morbidity and mortality associated with addiction and injection is ameliorated by injection in the presence of qualified health professionals": para. 87. Where a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out: *R. v. Morgentaler* (1988), at p. 59, *per* Dickson C.J., and pp. 105-106, *per* Beetz J.; *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, at p. 589, *per* Sopinka J.; *Chaoulli*, at para. 43, *per* Deschamps J., and, at paras. 118-19, *per* McLachlin C.J. and Major J.; *R. v. Parker* (2000), 188 D.L.R. (4th) 385 (Ont. C.A.). Where the law creates a risk not just to the health but also to the lives of the claimants, the deprivation is even clearer.

[94] I conclude that s. 4(1) of the *CDSA* limits the s. 7 rights of staff and clients of Insite.

[95] However, I am unable to conclude that the claimants have shown that the prohibition on trafficking in s. 5(1) of the *CDSA* constitutes a limitation of their s. 7

rights to life and security of the person, on the record before us. The clients of Insite are not involved in trafficking. They do not obtain their drugs at the facility, and are not permitted to engage in activities that could be construed as trafficking while they are on the premises.

[96] Nor are the staff of Insite involved in trafficking. Canada concedes that trafficking charges would not lie against the staff of Insite for their legitimate activities on the premises. Staff members do not handle drugs at Insite, except to safely remove and hand over to the police any substances left behind by clients. Delivering leftover drugs to the police does not constitute possession, let alone trafficking: *R. v. York*, 2005 BCCA 74, 193 C.C.C. (3d) 331; *R. v. Spooner* (1954), 109 C.C.C. 57 (B.C.C.A.); *R. v. Hess (No. 1)* (1948), 94 C.C.C. 48 (B.C.C.A.); *R. v. Ormerod*, [1969] 4 C.C.C. 3 (Ont. C.A.).

(2) Canada's Argument on Choice

[97] Canada argues that any negative health risks drug users may suffer if Insite is unable to provide them with health services, are not caused by the *CDSA's* prohibition on possession of illegal drugs, but rather are the consequence of the drug users' decision to use illegal drugs.

[98] Canada's position, deconstructed, reveals three distinct strands.

[99] The first strand is that from a factual perspective, personal choice, not the law, is the cause of the death and disease Insite prevents. Canada's difficulty is that this assertion contradicts the uncontested factual findings of the trial judge. The trial judge found that addiction is an illness, characterized by a loss of control over the need to consume the substance to which the addiction relates: para. 87.

[100] This does not negate the fact that some addicts may retain some power of choice. Insite is premised on the assumption that at least some addicts will be capable of making the choice to consume drugs in the safety of the facility and under the supervision of its staff. The range of services offered at the facility, from peer counselling to detox, assume at least a limited capacity on the part of some people to choose not to consume drugs.

[101] The ability to make some choices, whether with the aid of Insite or otherwise, does not negate the trial judge's findings on the record before him that addiction is a disease in which the central feature is impaired control over the use of the addictive substance: para. 142. At trial, Pitfield J. adopted the definition of addiction developed by the Canadian Society of Addiction Medicine:

A primary, chronic disease, characterized by impaired control over the use of a psychoactive substance and/or behaviour. Clinically, the manifestations occur along biological, psychological, sociological and spiritual dimensions. Common features are change in mood, relief from negative emotions, provision of pleasure, pre-occupation with the use of substance(s) or ritualistic behaviour(s); and continued use of the substance(s) and/or engagement in behaviour(s) despite adverse physical, psychological and/or social consequences. Like other chronic diseases, it can be progressive, relapsing and fatal. [para. 48]

That finding was not challenged here. Indeed, Canada conceded at trial that addiction is an illness.

[102] The second strand of Canada's choice argument is a moral argument that those who commit crimes should be made to suffer the consequences. On this point it suffices to say that whether a law limits a *Charter* right is simply a matter of the purpose and effect of the law that is challenged, not whether the law is right or wrong. The morality of the activity the law regulates is irrelevant at the initial stage of determining whether the law engages a s. 7 right.

[103] The third way to view Canada's choice argument is as a matter of government policy. Canada argues that the decision to allow supervised injection is a policy question, and thus immune from *Charter* review.

[104] The answer, once again, is that policy is not relevant at the stage of determining whether a law or state action limits a *Charter* right. The place for such arguments is when considering the principles of fundamental justice or at the s. 1 stage of justification if a *Charter* breach has been established.

[105] The issue of illegal drug use and addiction is a complex one which attracts a variety of social, political, scientific and moral reactions. There is room for disagreement between reasonable people concerning how addiction should be treated. It is for the relevant governments, not the Court, to make criminal and health policy. However, when a policy is translated into law or state action, those laws and actions

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

[106] I conclude that, whatever form it takes, Canada's assertion that choice rather than state conduct is the cause of the health hazards Insite seeks to address and the claimants' resultant deprivation must be rejected.

(3) Is the Deprivation in Accordance with the Principles of Fundamental Justice?

[107] For the reasons just discussed, I conclude that the prohibition on possession in s. 4(1) of the *CDSA* limits the s. 7 interests of the claimants and others like them. The next question is whether this limitation is in accordance with the principles of fundamental justice.

[108] The claimants argue that the prohibition on possession of illegal drugs in s. 4(1) of the *CDSA* is not in accordance with the principles of fundamental justice because it is arbitrary, disproportionate in its effects, and overbroad. They say it is arbitrary because, when applied to Insite, it is not only inconsistent with the goals of the *CDSA*, but undermines them. They submit that it is disproportionate in its effects, as it causes significant harm to the clients of Insite and those like them, while

providing no commensurate benefit. And they assert that it is overbroad because its application to Insite is unnecessary to meet the state's objectives.

[109] The difficulty with this submission is that it considers s. 4(1) in isolation, rather than in the context of other provisions of the *CDSA*, notably s. 56. If the Act consisted solely of blanket prohibitions with no provision for exemptions for necessary medical or scientific use of drugs, the assertions that it is arbitrary, overbroad and disproportionate in its effects might gain some traction. However, the Act contains not only a prohibition on possession of illegal drugs, but a provision, s. 56, that empowers the Minister to grant exemptions from the prohibition to health service providers like Insite. The constitutional validity of s. 4(1) of the Act cannot be determined without considering the provisions in the Act designed to relieve against unconstitutional or unjust applications of that prohibition

[110] The scheme of the *CDSA* reveals that it has two purposes: the protection of public health and the maintenance of public safety. The public safety purpose of the Act is achieved by the prohibition on possession and trafficking in listed substances. The public health purpose of the statute is achieved not only by the prohibitions in ss. 4(1) and 5(1), which seek to avert the use of dangerous substances, but also by the provision of regulations guiding exemptions for and the use of listed substances for medical and scientific purposes in ss. 55 and 56 of the Act.

[111] Section 55(1) provides that “[t]he Governor in Council may make regulations for carrying out the purposes and provisions of this Act, including the

regulation of the medical, scientific and industrial applications and distribution of controlled substances”. There follows a lengthy non-exhaustive list of matters in respect of which regulations may be made, including regulations exempting a person or class of person from the application of the Act: s. 55(1)(z).

[112] Section 56 gives the Minister of Health a broad discretion to grant exemptions from the application of the Act “if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest”.

[113] The availability of exemptions acts as a safety valve that prevents the *CDSA* from applying where such application would be arbitrary, overbroad or grossly disproportionate in its effects.

[114] I conclude that while s. 4(1) of the *CDSA* engages the s. 7 *Charter* rights of the individual claimants and others like them, it does not violate s. 7. This is because the *CDSA* confers on the Minister the power to grant exemptions from s. 4(1) on the basis, *inter alia*, of health. Indeed, if one were to set out to draft a law that combats drug abuse while respecting *Charter* rights, one might well adopt just this type of scheme — a prohibition combined with the power to grant exemptions. If there is a *Charter* problem, it lies not in the statute but in the Minister’s exercise of the power the statute gives him to grant appropriate exemptions.

[115] The claimants’ s. 7 challenge to the *CDSA* accordingly fails.

C. Has the Minister's Decision Violated the Claimants' Section 7 Rights?

[116] The main issue, as the appeal was argued, was the constitutionality of the *CDSA* itself. I have concluded that, properly interpreted, the statute is valid. This leaves the question of the Minister's decision to refuse an exemption. A preliminary issue arises whether the Court should consider this issue. In the special circumstances of this case, I conclude that it should. The claimants pleaded in the alternative that, if the *CDSA* were valid, the Minister's decision violated their *Charter* rights. The issue was raised at the hearing and the parties afforded an opportunity to address it. It is therefore properly before us and the Attorney General of Canada cannot complain that it would be unfair to deal with it. Most importantly, justice requires us to consider this issue. The claimants have established that their s. 7 rights are at stake. They should not be denied a remedy and sent back for another trial on this point simply because it is the Minister's decision and not the statute that causes the breach when the matter has been pleaded and no unfairness arises.

[117] The discretion vested in the Minister of Health is not absolute: as with all exercises of discretion, the Minister's decisions must conform to the *Charter*: *Suresh v. Canada (Minister of Citizenship and Immigration)*, 2002 SCC 1, [2002] 1 S.C.R. 3. If the Minister's decision results in an application of the *CDSA* that limits the s. 7 rights of individuals in a manner that is not in accordance with the *Charter*, then the Minister's discretion has been exercised unconstitutionally.

[118] I note that this case is different from *Parker*, where the Ontario Court of Appeal held that the general prohibition on possession of marihuana was not saved by the availability of an exemption for possession for medical purposes under s. 56. No decision of the Minister was at stake in *Parker*, and the Court's conclusion rested on findings of the trial judge that, at that time, "the availability of the exemption was illusory" (para. 174).

(1) Has the Minister Made a Decision?

[119] The Attorney General of Canada argues that the Minister has not violated s. 7 because the Minister has not yet made a decision whether to grant a s. 56 exemption to Insite. He also submits that the decision of the British Columbia Courts that ss. 4(1) and 5(1) of the *CDSA* are unconstitutional prevents the Minister from exercising his powers to grant an exemption under s. 56. Although the declaration of unconstitutionality has been suspended and a temporary constitutional exemption granted to Insite by judicial order, the Minister says it would be improper for him to exercise his s. 56 discretion until the constitutionality of the *CDSA* has been finally resolved by this Court.

[120] In my view, the record establishes that the Minister *has* made a decision on the request for an exemption for Insite, and that that decision was to refuse the exemption.

[121] The essential facts are as follows. The first exemption for Insite, which lasted three years, was effective as of September 12, 2003. The Minister granted a temporary extension on September 11, 2006, to expire December 31, 2007. On October 2, 2007, the exemption was extended for another six months to June 30, 2008. In his letters to Vancouver Coastal Health granting the exemption, the Minister stated that the extensions were to be for the purpose of allowing time for additional research on the impact of Insite on prevention, treatment and crime. In the course of the summary trial, on May 2, 2008, Vancouver Coastal Health sent an application to Health Canada formally requesting an extension of the exemption for another three years. The application was supported by the provincial Minister of Health. Health Canada responded on December 19, 2008, after the trial judge had rendered his judgment. It stated that, in view of the result at trial, an exemption was not required at that time.

[122] However, before December 2008, the Minister indicated that he had decided not to grant the exemption. The then federal Minister of Health, Tony Clement, spoke to the Standing Committee on Health on May 29, 2008. He had at that point received the report of the Expert Advisory Committee, a formal application for a continued exemption, and a statement of support for Insite from the provincial Minister of Health. The federal Minister's comments can be summarized briefly: he approved of the other services Insite was providing, but not supervised injection. He felt that the scientific evidence with respect to its effectiveness was mixed, but that the "public policy is clear", and that "the site itself represents a failure of public

policy” (12:40 (online)). He disagreed with the experts who saw Insite as a public health success, and stated he intended to appeal the trial judge’s decision. These comments, coupled with the failure to accord an exemption, amount to an effective refusal of the application.

[123] The Attorney General of Canada draws our attention to this statement by the Minister near the end of his presentation to the Committee:

Indeed, I want to state for the record, if I might, that should another exemption application come forward, I have a duty to once again look at all the evidence and once again turn my mind to it in a way that gives due process. So I’m not resigning from that obligation that I have as a health minister. [13:20 (online)]

This statement can be interpreted only in one way. The Minister was rejecting the formal application that was then before him, while asserting he would consider any new application “in a way that gives due process”.

[124] To recap, the Minister had before him a formal application dated May 2, 2008. He was obliged, as he conceded, to consider all applications. The Minister treated the application before him as denied; it was spent, and a duty to reconsider could only be triggered by a new application. The only rational conclusion is that the Minister had considered the application for an exemption that was then before him, and had decided not to grant it.

[125] More broadly, Canada's submission that there has been no decision to refuse the s. 56 application is in tension with its argument that this case is essentially about conflicting policy choices. Implicit in this is the concession that the federal government, through the Minister of Health, has made a policy choice to deny exemption under s. 56 of the *CDSA*.

(2) Are the Claimants' Section 7 Rights Engaged by the Minister's Decision?

[126] The last ministerial exemption expired on June 30, 2008. Absent the judicial exemption granted by Justice Pitfield and extended by the Court of Appeal, the prohibition contained in s. 4(1) of the *CDSA* would apply to Insite. For the reasons discussed above, the application of s. 4(1) to the staff engages the staff's liberty interests, and engages the security of the person and life interests of the clients of Insite. I conclude that the Minister's rejection of the application for a s. 56 exemption likewise engages the s. 7 rights of the claimants. The only reason Insite users have continued to receive its health services is because of a temporary remedial order made by the trial judge, pending completion of these proceedings. A judicial order directed at preserving the *status quo* pending resolution of a dispute does not prevent the claimants from asserting their s. 7 rights.

(3) Does the Minister's Refusal to Grant an Exemption to Insite Accord with the Principles of Fundamental Justice?

[127] The next question is whether the Minister's decision that the *CDSA* applies to Insite is in accordance with the principles of fundamental justice. On the

basis of the facts established at trial, which are consistent with the evidence available to the Minister at the relevant time, I conclude that the Minister's refusal to grant Insite a s. 56 exemption was arbitrary and grossly disproportionate in its effects, and hence not in accordance with the principles of fundamental justice.

[128] As noted above, the Minister, when exercising his discretion under s. 56, must respect the rights guaranteed by the *Charter*. This means that, where s. 7 rights are at stake, any limitations imposed by ministerial decision must be in accordance with the principles of fundamental justice. The Minister cannot simply deny an application for a s. 56 exemption on the basis of policy *simpliciter*; insofar as it affects *Charter* rights, his decision must accord with the principles of fundamental justice.

(a) *Arbitrariness*

[129] When considering whether a law's application is arbitrary, the first step is to identify the law's objectives. Decisions of the Minister under s. 56 of the *CDSA* must target the purpose of the Act. The legitimate state objectives of the *CDSA* (then the *Narcotic Control Act*, R.S.C. 1986, c. N-1) were identified by this Court in *Malmo-Levine* as the protection of health and public safety.

[130] The second step is to identify the relationship between the state interest and the impugned law, or, in this case, the impugned decision of the Minister. The

relationship between the general prohibition on possession in the *CDSA* and the state objective was recognized in *Malmo-Levine* with respect to marihuana:

The criminalization of possession is a statement of society's collective disapproval of the use of a psychoactive drug such as marihuana ..., and, through Parliament, the continuing view that its use should be deterred. The prohibition is not arbitrary but is rationally connected to a reasonable apprehension of harm. In particular, criminalization seeks to take marihuana out of the hands of users and potential users, so as to prevent the associated harm and to eliminate the market for traffickers. [para. 136]

The question is whether the decision that the *CDSA* apply to the activities at Insite bears the same relationship to the state objective. As noted above, the burden is on the claimants to establish that the limit imposed by the law is not in accordance with the principles of fundamental justice.

[131] The trial judge's key findings in this regard are consistent with the information available to the Minister, and are those on which successive federal Ministers have relied in granting exemption orders over almost five years, including the facts that: (1) traditional criminal law prohibitions have done little to reduce drug use in the DTES; (2) the risk to injection drug users of death and disease is reduced when they inject under the supervision of a health professional; and (3) the presence of Insite did not contribute to increased crime rates, increased incidents of public injection, or relapse rates in injection drug users. On the contrary, Insite was perceived favourably or neutrally by the public; a local business association reported a reduction in crime during the period Insite was operating; the facility encouraged

clients to seek counselling, detoxification and treatment. Most importantly, the staff of Insite had intervened in 336 overdoses since 2006, and no overdose deaths had occurred at the facility. (See trial judgment, at paras. 85 and 87-88.) These findings suggest not only that exempting Insite from the application of the possession prohibition does not undermine the objectives of public health and safety, but furthers them.

[132] The jurisprudence on arbitrariness is not entirely settled. In *Chaoulli*, three justices (*per* McLachlin C.J. and Major J.) preferred an approach that asked whether a limit was “necessary” to further the state objective: paras. 131-32. Conversely, three other justices (*per* Binnie and LeBel JJ.), preferred to avoid the language of necessity and instead approved of the prior articulation of arbitrariness as where “[a] deprivation of a right . . . bears no relation to, or is inconsistent with, the state interest that lies behind the legislation”: para. 232. It is unnecessary to determine which approach should prevail, because the government action at issue in this case qualifies as arbitrary under both definitions.

(b) *Gross Disproportionality*

[133] The application of the possession prohibition to Insite is also grossly disproportionate in its effects. Gross disproportionality describes state actions or legislative responses to a problem that are so extreme as to be disproportionate to any legitimate government interest: *Malmo-Levine*, at para. 143. Insite saves lives. Its benefits have been proven. There has been no discernable negative impact on the

public safety and health objectives of Canada during its eight years of operation. The effect of denying the services of Insite to the population it serves is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics.

(c) *Overbreadth*

[134] Having found the Minister's decision arbitrary and its effects grossly disproportionate, I need not consider this aspect of the argument.

[135] I conclude that, on the basis of the factual findings of the trial judge, the claimants have met the evidentiary burden of showing that the failure of the Minister to grant a s. 56 exemption to Insite is not in accordance with the principles of fundamental justice.

(4) Conclusion on the Challenge to Minister's Decision

[136] The Minister made a decision not to extend the exemption from the application of the federal drug laws to Insite. The effect of that decision, but for the trial judge's interim order, would have been to prevent injection drug users from accessing the health services offered by Insite, threatening the health and indeed the lives of the potential clients. The Minister's decision thus engages the claimants' s. 7 interests and constitutes a limit on their s. 7 rights. Based on the information

available to the Minister, this limit is not in accordance with the principles of fundamental justice. It is arbitrary, undermining the very purposes of the *CDSA*, which include public health and safety. It is also grossly disproportionate: the potential denial of health services and the correlative increase in the risk of death and disease to injection drug users outweigh any benefit that might be derived from maintaining an absolute prohibition on possession of illegal drugs on Insite's premises.

D. *Section 1*

[137] If a s. 1 analysis were required, a point not argued, no s. 1 justification could succeed. The goals of the *CDSA*, as I have stated, are the maintenance and promotion of public health and safety. The Minister's decision to refuse the exemption bears no relation to these objectives; therefore they cannot justify the infringement of the complainants' s. 7 rights. However one views the matter, the Minister's decision was arbitrary and unsustainable. See *Chaoulli*, at para. 155, *per* McLachlin C.J. and Major J.

[138] Before leaving s. 1, I turn to the Minister's argument that granting a s. 56 exemption to Insite would undermine the rule of law and that denying an exemption is therefore justified.

[139] Canada submits that exempting Insite from the prohibitions in the *CDSA* "would effectively turn the rule of law on its head by dictating that where a particular

individual breaks the law with such frequency and persistence that he or she becomes unable to comply with it, it is unconstitutional to apply the law to that person” (A.F., at para. 101). Canada raises the spectre of a host of exempt sites, where the country’s drug laws would be flouted with impunity.

[140] The conclusion that the Minister has not exercised his discretion in accordance with the *Charter* in this case, is not a licence for injection drug users to possess drugs wherever and whenever they wish. Nor is it an invitation for anyone who so chooses to open a facility for drug use under the banner of a “safe injection facility”. The result in this case rests on the trial judge’s conclusions that Insite is effective in reducing the risk of death and disease and has had no negative impact on the legitimate criminal law objectives of the federal government. Neither s. 56 of the *CDSA* nor s. 7 of the *Charter* require condonation of crime. They demand only that, in administering the criminal law, the state not deprive individuals of their s. 7 rights to life, liberty and security of the person in a manner that violates the principles of fundamental justice.

VII. Remedy

[141] Having found that the Minister’s refusal to grant an exemption to Insite violates s. 7 in a manner that cannot be justified under s. 1, we must find the appropriate remedy.

[142] What is required is a remedy that vindicates the respondents' *Charter* rights in a responsive and effective manner: *Doucet-Boudreau v. Nova-Scotia (Minister of Education)*, 2003 SCC 62, [2003] 3 S.C.R. 3, at para. 25.

[143] The infringement of the claimants' s. 7 rights is ongoing. The federal exemption for Insite expired on June 30, 2008. The application of the federal drug laws to Insite has been suspended in the interim only by judicial intervention.

[144] The claimants asked for a declaration that the impugned provisions be struck down. Given my conclusion that s. 4(1) of the *CDSA*, considered with s. 56, is constitutionally valid, no remedy lies under s. 52 of the *Constitution Act, 1982*. Where, as here, the concern is a government decision that is inconsistent with the *Charter*, s. 24(1) applies and allows the court to fashion an appropriate remedy: *R. v. 974649 Ontario Inc.*, 2001 SCC 81, [2001] 3 S.C.R. 575, at para. 14 ("*Dunedin*").

[145] Section 24(1) confers a broad discretion on the Court to craft an appropriate remedy that is responsive to the violation of the respondents' *Charter* rights. As the Court said in *Dunedin*:

Section 24(1)'s interpretation necessarily resonates across all *Charter* rights, since a right, no matter how expansive in theory, is only as meaningful as the remedy provided for its breach. From the outset, this Court has characterized the purpose of s. 24(1) as the provision of a "direct remedy" (*Mills, [v. the Queen]*, [1986] 1 S.C.R. 863], p. 953, *per* McIntyre J.). As Lamer J. stated in *Mills*, "[a] remedy must be easily available and constitutional rights should not be 'smothered in procedural delays and difficulties'" (p. 882). Anything less would undermine the role of s. 24(1) as a cornerstone upon which the rights and freedoms

guaranteed by the *Charter* are founded, and a critical means by which they are realized and preserved. [Emphasis in original, para. 20.]

[146] One option would be to issue a declaration that the Minister erred in refusing to grant a further exemption to Insite in May 2008, and return the matter to the Minister to reconsider the matter and make a decision that respects the claimants' *Charter* rights.

[147] However, this remedy would be inadequate.

[148] The infringement at stake is serious; it threatens the health, indeed the lives, of the claimants and others like them. The grave consequences that might result from a lapse in the current constitutional exemption for Insite cannot be ignored. These claimants would be cast back into the application process they have tried and failed at, and made to await the Minister's decision based on a reconsideration of the same facts. Litigation might break out anew. A bare declaration is not an acceptable remedy in this case.

[149] Nor is the granting of a permanent constitutional exemption appropriate where the remedy is for a state action, not a law. In any event, such exemptions are to be avoided: *R. v. Ferguson*, 2008 SCC 6, [2008] 1 S.C.R. 96. Moreover, the Minister should not be precluded from withdrawing an exemption to Insite should changed circumstances at Insite so require. The flexibility contemplated by s. 56 of the *CDSA* would be lost.

[150] In the special circumstances of this case, an order in the nature of mandamus is warranted. I would therefore order the Minister to grant an exemption to Insite under s. 56 of the *CDSA* forthwith. (This of course would not affect the Minister's power to withdraw the exemption should the operation of Insite change such that the exemption would no longer be appropriate.) On the trial judge's findings of fact, the only constitutional response to the application for a s. 56 exemption was to grant it. The Minister is bound to exercise his discretion under s. 56 in accordance with the *Charter*. On the facts as found here, there can be only one response: to grant the exemption. There is therefore nothing to be gained (and much to be risked) in sending the matter back to the Minister for reconsideration.

[151] This does not fetter the Minister's discretion with respect to future applications for exemptions, whether for other premises, or for Insite. As always, the Minister must exercise that discretion within the constraints imposed by the law and the *Charter*.

[152] The dual purposes of the *CDSA* — public health and public safety — provide some guidance for the Minister. Where the Minister is considering an application for an exemption for a supervised injection facility, he or she will aim to strike the appropriate balance between achieving the public health and public safety goals. Where, as here, the evidence indicates that a supervised injection site will decrease the risk of death and disease, and there is little or no evidence that it will

have a negative impact on public safety, the Minister should generally grant an exemption.

[153] The *CDSA* grants the Minister discretion in determining whether to grant exemptions. That discretion must be exercised in accordance with the *Charter*. This requires the Minister to consider whether denying an exemption would cause deprivations of life and security of the person that are not in accordance with the principles of fundamental justice. The factors considered in making the decision on an exemption must include evidence, if any, on the impact of such a facility on crime rates, the local conditions indicating a need for such a supervised injection site, the regulatory structure in place to support the facility, the resources available to support its maintenance, and expressions of community support or opposition.

VIII. VANDU's Cross-Appeal

[154] VANDU, in its cross-appeal, brings a much broader challenge to s. 4(1) of the *CDSA*. VANDU challenges the application of the prohibition on possession to all addicted persons, not only those who are seeking treatment at supervised injection sites. The argument is that because addicted persons have no control over the urge to consume addictive substances, they are forced by fear of arrest and prosecution to procure and consume drugs in a manner that threatens their lives and health, and which causes them a high level of psychological stress. This is a very different argument than that advanced by Tomic, Wilson and PHS.

[155] VANDU's contention lacks an adequate basis in the record. The evidence at trial and the factual findings of the trial judge related to the nature of addiction and its attendant dangers, and how Insite responds to those dangers. There is nothing in Pitfield J.'s reasons which would permit this Court to conclude that there is a causal connection between the prohibition on possession and the deprivation of all addicts' s. 7 rights.

IX. Disposition

[156] The *CDSA* is constitutionally valid and applies to the activities at Insite. However, the Minister of Health's actions in refusing to exempt Insite from the operation of the *CDSA* are in violation of the respondents' s. 7 *Charter* rights. The Minister is ordered to grant an exemption for Insite under s. 56 of the *CDSA*.

[157] Canada's appeal is dismissed, as is VANDU's cross-appeal. I would answer the constitutional questions as follows:

1. Are ss. 4(1) and 5(1) of the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19, constitutionally inapplicable to the activities of staff and users at Insite, a health care undertaking in the Province of British Columbia?

No.

2. Does s. 4(1) of the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19, infringe the rights guaranteed by s. 7 of the *Canadian Charter of Rights and Freedoms*?

No.

3. If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the *Canadian Charter of Rights and Freedoms*?

It is not necessary to answer this question.

4. Does s. 5(1) of the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19, infringe the rights guaranteed by s. 7 of the *Canadian Charter of Rights and Freedoms*?

No.

5. If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the *Canadian Charter of Rights and Freedoms*?

It is not necessary to answer this question.

X. Costs

[158] The trial judge awarded special costs in favour of the claimants: 2008 BCSC 1453, 91 B.C.L.R. (4th) 389. Such an order was within his discretion, and in my view there is no reason to disturb it.

[159] The respondents will also have their costs on this appeal. There will be no costs on the cross-appeal.

Appeal dismissed with costs. Cross-appeal dismissed without costs.

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Solicitor for the intervener the Attorney General of Quebec: Attorney General of Quebec, Ste-Foy.

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Solicitors for the intervener the Vancouver Coastal Health Authority: Davis, Vancouver.

Solicitors for the intervener the Canadian Civil Liberties Association: Fasken Martineau DuMoulin, Toronto.

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