



**CITY OF LODI  
COUNCIL COMMUNICATION**

**AGENDA TITLE:** Adopt Uncodified Urgency Interim Ordinance to Establish a Moratorium on the Establishment and Operation of Medical Marijuana Dispensaries.

**MEETING DATE:** April 15, 2009

**PREPARED BY:** Deputy City Attorney

**RECOMMENDED ACTION:** Adopt Uncodified Urgency Interim Ordinance to Establish a Moratorium on the Establishment and Operation of Medical Marijuana Dispensaries.

**BACKGROUND INFORMATION:** The City has recently received a number of inquiries from members of the public about the regulations and process for opening medical marijuana dispensaries within the City. However, the City's Municipal Code does not address the issue, which given undecided questions over the conflict between California and Federal marijuana laws may (or may not) mean that such dispensaries are a prohibited use within the City of Lodi.

Staff recommends that provisions should be added to the City's Municipal Code that either regulate medical marijuana dispensaries or prohibit such uses if that is the desire of the Council. To do so, however, Staff will need adequate time to study the current status of State and Federal law governing the distribution of medical marijuana, to review the City's General Plan and the zoning ordinances, and to make recommendations for the Council's consideration.

Under the U.S. Controlled Substances Act (CSA), marijuana is classified as a Schedule 1 drug, meaning that it has no accepted medical use. Further, the Federal government has historically interpreted the CSA to mean that all marijuana is illegal regardless of state laws to the contrary. In 2005, the U.S. Supreme Court in *Raich v. Gonzales* held that the CSA's ban on possession and cultivation of marijuana did not exceed the federal government's constitutional authority under the interstate commerce clause even in an instance of private, personal use of marijuana by patients under medical care.

In contrast, California voters passed Proposition 215 known as the Compassionate Use Act of 1996, which permits persons who are in need of marijuana for medical reasons to obtain and use marijuana under limited, specified circumstances. In 2003, the State legislature enacted Senate Bill 240 to clarify the scope of Proposition 215 by allowing local governments to adopt and enforce rules and regulations consistent with SB 240. SB 240 expanded the scope of Proposition 215 to authorize caregivers who provide marijuana to patients to be compensated for the costs of their services, on a not-for-profit basis and allows patients to form collective, cooperative cultivation projects. However, neither Proposition 215 nor **SB 240** explicitly allow "dispensaries".

Adding another dimension to the apparent conflict and tension between State and Federal law, is that many cities in California have enacted ordinances aimed at regulating facilities through zoning, city issued permits or the prohibition of medical marijuana dispensaries. Of 147 surveyed cities, 28 regulate medical marijuana dispensaries (either by zoning or a permitting process), 49 prohibit such dispensaries

outright and 70 cities have adopted moratoriums (although some have expired), on the establishment of dispensaries pending further analysis by staff or further clarification of existing State and Federal laws.

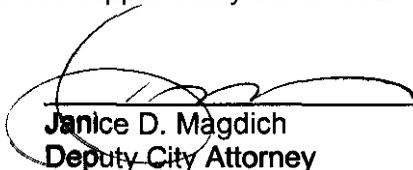
In addition to giving the City Attorney's Office time to thoroughly analyze State and Federal law on this issue, the requested moratorium will also permit the Community Development Department and the Police Department to analyze the potential impacts and effects on the public health, safety and welfare if medical marijuana dispensaries were allowed to operate within the City. Some negative effects that may be created include increased criminal activity, loitering, disturbing the peace, and property damage. (See, pp. 8-13 of the attached July 25, 2008 letter from the U.S. Department of Justice, Office of Legislative Affairs to The Honorable John Conyers, Jr., Chairman of the Committee on the Judiciary, U.S. House of Representatives.) If the Council was inclined to permit dispensaries within the City, Staff would require time to draft regulations to mitigate, if not eliminate, such negative impacts. In addition, the Community Development Department will require time to review and analyze whether dispensaries would be in conflict with the General Plan currently being contemplated by the City as well as the City's existing zoning laws.

Pursuant to Government Code 565858, the Council, with a minimum four-fifths (4/5) vote, may, to protect the public safety, health, and welfare of the community, "adopt as an urgency measure an interim ordinance prohibiting any uses that may be in conflict with a contemplated general plan, specific plan, or zoning proposal that the legislative body is considering or studying or intends to study within a reasonable time". Such an interim ordinance is only effective for 45-days from adoption, though as discussed below it can then be extended on a vote of the Council.

As proposed, the recommended urgency interim ordinance would place a 45-day moratorium on the issuance of use permits, variances, building permits, business licenses, or any other entitlement for the establishment or operation of medical marijuana dispensaries. Staff anticipates that 45-days may be inadequate to conduct a thorough review and analysis of the laws governing medical marijuana and the mitigation necessary to counter the potential negative impacts of having dispensaries operate within the City, as well as impacts on City zoning laws and the General Plan now under consideration. Although Staff will do its best to prepare its analysis in that time, Staff may ultimately bring forward an ordinance to extend the proposed moratorium for consideration at the Council's meeting on May 20, 2009. Any proposed ordinance would be noticed as a public hearing pursuant to Government Code 565090.

Without the proposed 45-day moratorium, the City could receive an application for a medical marijuana dispensary or a dispensary could open on its own, and the City would be without any local regulations to enforce and protect the public health, safety and welfare of the community. Accordingly, the findings required to pass the proposed urgency ordinance are supported by the record.

**FUNDING:** None.

  
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**Janice D. Magdich**  
**Deputy City Attorney**

**Attachments – U.S. Dept. of Justice letter dated 7/25/08**  
**Proposed Urgency Interim Ordinance**

**cc: Rad Bartlam, community Development Director**  
**David Main, Police Chief**

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**APPROVED:**   
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**Blair King, City Manager**

## **Staff Report**

### **Secondary Impacts and Concerns Related to Medical Marijuana Dispensaries**

**By: David J. Main, Chief of Police**

The purpose of this staff report is to provide a brief summary of background information regarding the proposed temporary moratorium ordinance for Medical Marijuana Dispensaries. Police department staff believes it is important to identify the potential secondary impacts on public safety that the operation of this type of establishment in the City of Lodi could create.

#### **ANALYSIS OF OTHER LAW ENFORCEMENT AGENCIES EXPERIENCES**

Research conducted by many law enforcement agencies concludes that the establishment of Medical Marijuana Dispensaries can have adverse secondary effects such as increased crime. Local agencies in cities where dispensaries exist have reported an increase of illegal drug activity, illegal drug sales, robberies of persons leaving dispensaries, loitering around dispensaries, falsely obtained identification cards, and increases in other types of criminal activity. There is also concern that the operation of a medical marijuana dispensary within the city of Lodi would result in an increased demand for police response, thereby negatively impacting the Lodi Police Department's ability to respond to other calls for service. This type of establishment would also require additional patrols, during a period when the department is already below staffing levels placing an additional burden on the department's already limited resources.

Below is a brief summary representing some of the agencies in California that have Medical Marijuana Dispensaries within their jurisdiction and their experiences. This is a very cursory research attempt representing secondary impacts dating back to 2004. In fact, most of the research and analysis available seems to have been generated between the years of 2004 to 2006. A more detailed and updated analysis might be beneficial but could not be included at this time due to time constraints.

#### **Los Angeles Police Department**

The Los Angeles Police Department experienced a 200% increase in robberies, 52% increase in Burglaries, 57% increase in aggravated assaults and 130% increase in auto burglaries at locations near Cannabis Clubs. During this same time period the city of Los Angeles noted reductions in part one crime in most other areas of their city.

The Narcotics Division of L.A.P.D. has conducted surveillance of many of these dispensaries and has observed young healthy individuals entering these locations and purchasing marijuana.

In San Pedro the owner of a dispensary, armed with an assault rifle and handgun tried to prevent L.A. Fire from entering the establishment for the purpose of inspection.

### **San Francisco Police Department**

The San Francisco Police Department reported that during a one-year period, crimes at or near 23 of the 29 medical marijuana dispensaries showed a significant increase of violent crimes and property crimes.

### **Redding Police Department**

In 2005 a medical marijuana dispensary opened in the city of Redding. The Redding Police Department initiated a criminal investigation for the unlawful sales of marijuana. Utilizing undercover agents, they were able to obtain a prescription from a local physician without any physical examination, only verbal questioning, and then purchase marijuana from the dispensary. Consequently, six individuals were arrested, including the manager and owner for possession of marijuana for sale. This dispensary has since closed and a new one has apparently opened at a different location under the same management.

### **Modesto Police Department**

The city of Modesto had one dispensary operating in their jurisdiction. The owner was arrested for being in possession of concealed weapon and possession of a loaded firearm. Illegal drug transactions have occurred in the parking lot. Additionally, a local high school student was found to be in possession of 74 rocks of cocaine. A search warrant of the students house revealed scales, baggies, money and marijuana packaged from the Medical Marijuana Dispensary. Modesto reports a variety of other criminal related activity connected with the establishment.

### **Arcata Police Department**

Arcata reports numerous instances of persons purchasing marijuana at the dispensary and then selling it at a nearby park. It has also been brought to their attention that a physician comes to the dispensary for a fee and provides a medical marijuana recommendation for just about anyone who has a medical complaint.

## **Roseville Police Department**

Roseville reports street level dealers trying to sell to those entering the dispensary at a lower price and persons smoking marijuana in public around the facility. They also report people coming from nearby cities and from out of state to purchase marijuana. The dispensary in Roseville has since closed.

## **Oakland Police Department**

As of 2004 the city Oakland limits the number of dispensaries by ordinance. They report a large degree of criminal element loitering in and around the dispensary location. Marijuana dealers who have a doctor's recommendation have purchased from the dispensary and then conduct illegal street sales. Street criminals in search of drugs have robbed medical marijuana patients. Increased reports of thefts and robberies in the area of the dispensary.

## **Hayward Police Department**

The Hayward police department had a number of dispensaries around 2004. They experienced robberies outside of these locations. They also noticed a great deal of loitering around this location. They experienced problems with there being no standard practice for the issuance of recommendation cards from physicians and that most anyone could obtain them. The department received complaints that other illegal drugs were sold inside the dispensary. The Police Chief at the time felt that dispensaries are reluctant to report crimes around their establishments because they did not want police to respond.

## **Conclusion**

As police chief I am concerned with the following potential of secondary impacts:

- Potential for criminal activity in and around dispensaries
- Lack of staffing to monitor activities and or enforce regulatory standards, since it is an integral part of our job is to enforce all controlled substance laws, bring violators to justice and to reduce the availability of controlled substances.
- The potential increase in calls for service.
- Potential for abuse under the guise of medical use.
- Lack of regulations and standards for physician referrals (ripe for abuse).

- Other illegal drugs being sold at the dispensaries.
- Who would conduct background checks on the owner, manager and or employees?
- Who enforces standards?
- The message it sends to the youth in our community
- Close proximity to schools, churches, activity centers etc.
- Dispensaries obtaining marijuana illegally
- Street level dealers selling to those going to the dispensary at a lower price
- Public marijuana smoking around the dispensary and at nearby parks.
- Other businesses in the area impacted
- Minors purchasing marijuana

The illegal sale of marijuana in California is very serious and extremely lucrative. These crimes have been made easier due to medical marijuana dispensaries and the lack of regulations associated with these types of establishments. Problems have been compounded by physicians who have been known to frivolously issue recommendations with the intent of financial gain. As Police Chief, I strongly endorse an Interim Ordinance to establish a Moratorium on the establishment and operation of Medical marijuana Dispensaries within the city of Lodi. Based on the experiences of other cities, I am extremely concerned with the impact medical marijuana dispensaries will likely have on the safety, public health and the welfare of our citizens.



U.S. Department of Justice  
Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

July 25, 2008

The Honorable John Conyers, Jr.  
Chairman  
Committee on the Judiciary  
U.S. House of Representatives  
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter, dated April 29, 2008, inquiring about the efforts of the Drug Enforcement Administration (DEA) to enforce federal law with respect to marijuana traffickers in California. We appreciate your interest in this issue. As you are aware, there has been a significant amount of misleading information circulating about DEA's activities, and we welcome the opportunity to share with you how the Department of Justice (DOJ) and DEA are meeting our obligations under federal law, and how the unlawful trafficking in marijuana taking place in California under the guise of "medicine" is detrimental to the public health and safety.

As you know, marijuana is a schedule I controlled substance under the Controlled Substances Act (CSA).<sup>1</sup> Marijuana remains in schedule I consistent with the fact that the drug has never been approved by the Food and Drug Administration (FDA) for marketing in the United States because scientific studies have never established that marijuana can be used safely and effectively for the treatment of any disease or condition.<sup>2</sup> Marijuana's placement in schedule I of the CSA results in the following legal consequences: marijuana may not be dispensed for medical use in the United States; it is illegal to manufacture, distribute, or possess marijuana for any purpose (other than Government-approved research); and there is no "medical necessity" defense to the CSA prohibitions relating to marijuana.<sup>3</sup>

Marijuana also is a schedule I controlled substance under California law,<sup>4</sup> but pursuant to a 1996 voter referendum, California decriminalized the cultivation and possession of marijuana by any person who has obtained from a physician a "recommendation" that marijuana would benefit that person's health. Nonetheless, as the Supreme Court's decisions in *United States v. Oakland Cannabis Buyers' Cooperative*

<sup>1</sup> 21 U.S.C. § 812(c), Schedule I(c)(10).

<sup>2</sup> See 66 Fed. Reg. 20038, 20050-52 (2001) (DEA denial of petition to remove marijuana from schedule I based on FDA scientific and medical evaluation), *pet. for review dismissed*, *Gettman v. DEA*, 290 F.3d 430 (D.C. Cir. 2002).

<sup>3</sup> *United States v. Oakland Cannabis Buyers' Cooperative* 532 U.S. 483, 491, 494 & n.7 (2001).

<sup>4</sup> Ca. Health & Safety Code § 11054.

(*OCBC*)<sup>5</sup> and *Gonzales v. Raich*<sup>6</sup> make clear, regardless of the California marijuana legalization law, it remains illegal under the CSA for any person to cultivate, distribute, or possess marijuana for claimed “medical reasons.”

Please also note that the effectiveness of **CSA** depends on maintaining the integrity of the “closed system” of distribution of controlled substances established by the Act.<sup>7</sup> Through this closed system, the **CSA** “provides for control of problems related to drug abuse through registration of manufacturers, wholesalers, retailers, and all others in the legitimate distribution chain, and makes transactions outside the legitimate distribution chain illegal.”<sup>8</sup> One of the central elements of this closed system is that all transactions in controlled substances undertaken by **DEA** registrants involve strict record-keeping requirements to ensure proper accounting and prevent diversion.<sup>9</sup> Those who engage in illicit manufacturing and distribution of marijuana (such as the California “cannabis clubs”) obviously act wholly outside the closed system mandated by the CSA.

Under federal law, marijuana has been classified as a schedule I substance since Congress enacted the **CSA** in 1970. However, as with any controlled substance, marijuana may be rescheduled if new evidence so dictates. The **CSA** provides a statutory procedure that allows any drug to be rescheduled in light of changes in the factors relevant to scheduling, such as new patterns of abuse and increased understanding about the drug’s pharmacological effects. Under the CSA, any person who believes that new evidence warrants the rescheduling of a particular drug may petition **DEA** to initiate rescheduling proceedings. Before initiating such proceedings, **DEA** must obtain from the **FDA** a scientific and medical evaluation and scheduling recommendation. If the **FDA** evaluation and other relevant data constitute substantial evidence that the drug should be rescheduled, **DEA** must initiate rulemaking proceedings to reschedule the drug accordingly.<sup>10</sup>

To date, there are no data from adequate and well-controlled clinical trials to support any of the claimed therapeutic uses for smoked marijuana. In 2001, **DEA** published in the Federal Register the agency’s response to a petition seeking to initiate rulemaking proceedings to reschedule marijuana.” The **FDA** and **DEA** thoroughly analyzed the relevant medical, scientific, and abuse data and concluded that marijuana continues to meet the criteria for placement in schedule I. The complete **FDA** and **DEA** analyses were published in the Federal Register along with the denial of the petition. With respect to whether marijuana can be used safely and effectively as medicine, the **FDA** noted that “there have been no studies that have scientifically assessed the efficacy

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<sup>5</sup> 532 U.S. 483 (2001).

<sup>6</sup> 545 U.S. 1 (2005).

<sup>7</sup> H.R. Rep. No. 91-1444 at 6 (1970).

<sup>8</sup> *United States v. Moore*, 423 U.S. 122, 135 (1975)(quoting *id.* at 3).

<sup>9</sup> 21 U.S.C. § 827.

<sup>10</sup> 21 U.S.C. § 811; 21 C.F.R. § 1308.43 see *Gettman v. DEA*, 290 F.3d 430, 432 (D.C. Cir. 2002) (explaining CSA rescheduling procedures).

<sup>11</sup> 66 Fed. Reg. 20038 (2001).

of marijuana for any (emphasis added) medical condition” and that “[t]here are no FDA-approved marijuana products.” The FDA concluded:

Marijuana does not have a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions. As discussed earlier, the known risks of marijuana use are not outweighed by any potential benefits. In addition, the agency cannot conclude that marijuana has an acceptable level of safety without assurance of a consistent and predictable potency and without proof that the substance is free of contamination. If marijuana is to be investigated more widely for medical use, information and data regarding the chemistry, manufacturing and specifications of marijuana must be developed. Therefore, FDA concludes that, even under medical supervision, marijuana has not been shown to have an acceptable level of safety.

FDA therefore recommends that marijuana be maintained in schedule I of the CSA.<sup>12</sup>

FDA has recently reiterated this determination, stating that “there is currently sound evidence that smoked marijuana is harmful,” and “that no sound scientific studies supported medical use of marijuana for treatment in the United States, and no animal or human data supported the safety or efficacy of marijuana for general medical use.”<sup>13</sup>

As the foregoing indicates, the CSA criteria for determining whether a controlled substance may be transferred out of schedule I overlap substantially With the medical and scientific considerations involved in the FDA drug approval process under the Food, Drug, and Cosmetic Act (FDCA).<sup>14</sup> It is therefore not mere coincidence that all schedule I controlled substances, including marijuana, lack FDA approval. The FDA approval process has protected the public for decades, and serves as the model for all nations. For the United States to remain the safest country in which to purchase medicine, adherence to the rigorous scientific criteria required by the federal drug approval laws must remain mandatory and not be allowed to be superseded or circumvented by state law or referendum.

The impact of marijuana on young persons warrants additional consideration. The Director of the National Institute for Drug Abuse, Nora Volkow, M.D., has stated that, “Although the overall number of young people using marijuana has declined in recent years, there is still reason for great concern, particularly since roughly 60 percent

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<sup>12</sup> 66 Fed. Reg. at 20052.

<sup>13</sup> “Inter-Agency Advisory Regarding Claim That Smoked Marijuana Is a Medicine.” U.S. Food and Drug Administration, April 20, 2006), *available at* <http://www.fda.gov/bbs/topics/NEWS/2006/NEW01362.html>.

<sup>14</sup> See 57 FR 10499 (1992) (setting forth criteria for determining whether a controlled substance has a currently accepted medical use within the meaning of the CSA), *pet. for review dismissed, Alliance for Cannabis Therapeutics v. DEA*, 15 F.3d 1131 (D.C. Cir. 1994).

of first-time marijuana users are under 18 years old. During adolescence and into young adulthood, the brain continues to develop and may be vulnerable to marijuana's deleterious effects. Science has shown marijuana can produce adverse physical, mental, emotional and behavioral changes, and . . . it can be **addictive**."<sup>15</sup>

These conclusions are not unique to the federal government. In 1999, the Institute of Medicine (IOM), a component of the National Academy of Sciences, conducted a review of the scientific evidence regarding the potential health benefits and risks of marijuana and its constituent cannabinoids. The IOM report stated, among other things: "Defined substances, such as purified cannabinoid compounds, are preferable to plant products, which are of variable and uncertain composition. Use of defined cannabinoids permits a more precise evaluation of their effects, whether in combination or alone."<sup>16</sup> With respect to this issue, the IOM reached the following conclusion: "Scientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation; smoked marijuana, however, is a crude THC delivery system that also delivers harmful **substances**."<sup>17</sup> The report further stated:

The therapeutic effects of cannabinoids are most well established for THC, which is the primary psychoactive ingredient of marijuana. But it does not follow from this that smoking marijuana is good medicine.

Although marijuana smoke delivers THC and other cannabinoids to the body, it also delivers harmful substances, including most of those found in tobacco smoke. In addition, plants contain a variable mixture of biologically active compounds and cannot be expected to provide a precisely defined drug effect. For those reasons there **is** little future in smoked marijuana as a medically approved medication. If there is any future in cannabinoid drugs, it lies with agents of more certain, not less certain, composition."<sup>18</sup>

Of note, both the IOM and the FDA support research into the possible medical utility of *individual chemical components* of marijuana, **as** distinguished from research into the medical utility of smoked marijuana. Marijuana contains at least 483 different chemicals, the effects of which are either uncertain or likely to be highly detrimental to humans, **as** the FDA and the IOM have indicated. While there have been some preliminary clinical trials conducted toward the goal of investigating the possible medical utility of smoked marijuana, preliminary phases of clinical research must be distinguished

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<sup>15</sup> Press Release, Office of National Drug Control Policy, Study Finds Highest Levels of THC in U.S. Marijuana To Date: 20 Year Analysis of Marijuana Seizures Reveals a Doubling In Pot Potency Since Mid-80's (April 25, 2007), available at [http://www.whitehousedrugpolicy.gov/news/press07/042507\\_2.html](http://www.whitehousedrugpolicy.gov/news/press07/042507_2.html).

<sup>16</sup> Institute of Medicine, *Marijuana and Medicine: Assessing the Science* Base 4 (J. Janet E. Joy et al. eds. 1999).

<sup>17</sup> *Id.*

<sup>18</sup> *Id.* at 177-178.

from later phases of research.<sup>19</sup> Preliminary scientific trials are not designed to – and cannot, as a scientific fact – demonstrate that a drug can be used safely and effectively as medicine.

Many medical organizations have issued statements regarding marijuana that are consistent with the federal government’s position. A few of these notable organizations include:

- **The American Medical Association**, which rejected pleas to endorse marijuana as medicine and instead urged that it remain a prohibited, schedule I controlled substance, at least until more research is done.<sup>20</sup>
- **The American Cancer Society**, which “does not advocate inhaling smoke, nor the legalization of marijuana, although the organization does support carefully controlled clinical studies for alternative delivery methods, specifically a THC patch.”<sup>21</sup>
- **The American Academy of Pediatrics**, which expressed the view that any change in the legal status of marijuana, even if limited to adults, could affect the prevalence of use among adolescents, and while it supports scientific research on the possible medical use of cannabinoids as opposed to smoke marijuana, it opposes the legalization of marijuana.<sup>22</sup>
- **The National Multiple Sclerosis Society**, which stated that it could not recommend that medical marijuana be made widely available for people with multiple sclerosis (MS) for symptom management, explaining: “This decision was not only based on existing legal barriers to its use but, even more importantly, because studies to date do not demonstrate a clear benefit compared to existing symptomatic therapies and because issues of side effects, systemic effects, and long-term effects are not yet clear,”<sup>23</sup> and

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<sup>19</sup> Clinical trials generally proceed in three phases involving successively larger groups of patients: 20 to 80 subjects in phase I; no more than several hundred subjects in phase II; and several hundred to several thousand subjects in phase III. 21 CFR 312.21. After completing the clinical trials, the sponsor files a new drug application containing, among other things, “full reports of investigations” showing whether the “drug is safe for use and ... effective”; the drug’s composition; a description of the drug’s manufacturing, processing, and packaging; and the proposed labeling for the drug. 21 U.S.C. § 355(b)(1).

<sup>20</sup> “Policy H-95.952 ‘Medical marijuana.’ American Medical Association.

<sup>21</sup> “Experts: Pot Smoking Is Not Best Choice to Treat Chemo Side-Effects.” American Cancer Society. May 22, 2001, available at

[http://www.cancer.org/docroot/NWS/content/update/NWS\\_11xU\\_Experts\\_Pot\\_Smoking\\_Is\\_Not\\_Best\\_Choice\\_to\\_Treat\\_Chemo\\_Side\\_Effects.asp](http://www.cancer.org/docroot/NWS/content/update/NWS_11xU_Experts_Pot_Smoking_Is_Not_Best_Choice_to_Treat_Chemo_Side_Effects.asp).

<sup>22</sup> Committee on Substance Abuse and Committee on Adolescence. “Legalization of Marijuana: Potential Impact on youth.” *Pediatrics* Vol. 113, No. 6 (June 6, 2004): 1825-1826. See also, Joffe, Alain, MD, MPH, and Yancy, Samuel, MD. “Legalization of Marijuana: Potential Impact on Youth.” *Pediatrics* Vol. 113, No. 6 (June 6, 2004): e632-e638h. Recommendations Regarding the Use of Cannabis in Multiple Sclerosis

<sup>23</sup> *Recommendations Regarding the Use of Cannabis in Multiple Sclerosis*, National Clinical Advisory Board of the National Multiple Sclerosis Society, April 2, 2008.

- **The British Medical Association**, which voiced extreme concern that downgrading the criminal status of marijuana would mislead the public into believing that the drug is **safe**.<sup>24</sup>

Unfortunately, the British Government did not heed their Medical Association's warning and downgraded cannabis from Class B to a Class C drug in 2004. This resulted in **an** increase of crime and various health problems, which later prompted a reversal, according to United Kingdom's Home Office.<sup>25</sup> **As** a result, on May 8, 2008, the Home Office announced that cannabis will be reclassified as a Class B drug.<sup>26</sup> Home Secretary Jacqui Smith addressed the need to update their public policies to match recent scientific evidence about the serious harms of marijuana use when she said, "The enforcement response must reflect the danger that the drug poses to individuals, and in turn to communities."<sup>27</sup>

The United States has also signed various international treaties to control illegal drug activity.<sup>28</sup> The International Narcotics Control Board (INCB) of the United Nations is charged with monitoring compliance with the drug control treaties. In its 1998 annual report, the INCB pointed out that the state marijuana initiatives recently passed in the United States are contrary to United States federal law. The report called on the United States to "vigorously enforce its federal law" in the face of these initiatives. The report further stated: "The decision of whether a substance should be authorized for medical use has always been taken, and should continue to be taken, in all countries by the bodies designated to regulate and register medicines [which, in the United States, are the FDA and **DEA**]. Such decisions should have a sound medical and scientific basis and should not be made in accordance with referendums organized by interest groups."<sup>29</sup>

The recitation of the forgoing information should not be interpreted **as** implying that DOJ *or* **DEA** opposes efforts to conduct research into the possible therapeutic effects of marijuana or its cannabinoid constituents. To the contrary, the CSA provides for, and **DEA** supports, all bona fide research involving schedule I controlled substances (including marijuana) conducted by researchers who have submitted research protocols that have been deemed scientifically meritorious by the Department **of** Health and Human

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<sup>24</sup> *Doctors' Fears at Cannabis Change*, BBC News, January 21, 2004, available at <http://news.bbc.co.uk/1/hi/health/3414285.stm>.

<sup>25</sup> Press Release, UK Home Office, Government crackdown on cannabis (May 7 2008), available at <http://www.homeoffice.gov.uk/press-releases/government-crackdown-cannabis>.

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

<sup>28</sup> The **main** drug control treaties currently in force to which the United States is a party are: the Single Convention on Narcotic Drugs, 1954, 18 U.S.T. 1407; the Convention on Psychotropic Substances, 1971, 32 U.S.T. 543; and the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, 28 I.L.M. 493. Among the United States obligations pursuant to these treaties are: (i) to enact and carry out legislation disallowing the use of schedule I **drugs** outside of authorized research; (ii) to **make** it a criminal offense, subject to imprisonment, to traffic in illicit drugs **or** to aid and abet such trafficking; and (iii) to prohibit the cultivation of marijuana except by persons licensed by, and under the direct supervision of, the federal Government.

<sup>29</sup> U.N. International Narcotics Control Board, United Nations. *Report 1998* at par. 259, U.N. Sales No. E.99.XI.1, available at [http://www.incb.org/incb/en/annualreport\\_1998.html](http://www.incb.org/incb/en/annualreport_1998.html).

Services (HHS).<sup>30</sup> As of June 2008, there were over one hundred researchers registered with DEA to perform studies with marijuana, marijuana extracts, and non-tetrahydrocannabinol marijuana derivatives that exist in the plant, such as cannabidiol and cannabitol. Studies include evaluation of abuse potential, physical/psychological effects, adverse effects, therapeutic potential, and detection, DEA has registered all researchers of marijuana whose research protocols have been approved by HHS. Nineteen of the researchers were approved to conduct research with smoked marijuana on human subjects.

In addition, beginning in 1999, HHS instituted new procedures to make research-grade marijuana more readily available to privately funded researchers. Pursuant to this new program, the California Center for Medical Cannabis Research has sponsored at least seventeen pre-clinical or clinical studies of marijuana, all of which were deemed meritorious by HHS and granted DEA registrations to conduct the research. In sum, DEA's position on marijuana is not based on a lack of compassion for those who are seriously ill, but on the fundamental principles that science must dictate whether we allow drugs to be sold to the American people as medicine and that FDA regulations must be adhered to when conducting clinical research involving marijuana to protect the safety of the human subjects.

As you are well aware, DEA was established to be the lead federal drug enforcement agency when it was created in 1973. Since its creation, the DEA **has** had primary responsibility for the enforcement of the CSA. The DEA is therefore the agency responsible for fulfilling the Executive Branch's constitutional obligation to "take care that the laws be faithfully executed" with respect to the CSA.

It is the mission of the DEA to enforce all the controlled substance laws and regulations of the United States and bring to the criminal and civil justice system of the United States, or any other competent jurisdiction, those organizations and principal members of organizations, involved in the trafficking of controlled substances appearing in, or destined for, the United States. It is also the agency's responsibility to recommend and support nonenforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets. It would it be detrimental to the public health and welfare for DEA to abandon these responsibilities when it comes to marijuana.

The authority of the DEA to investigate those growing, selling, and possessing marijuana, irrespective of state law has been reaffirmed by recent rulings by the Supreme Court. In rejecting the notion marijuana activities purportedly taking place in compliance with California law and supposedly on a "wholly intrastate" basis are beyond the reach of Congress' commerce clause authority, the Supreme Court stated in *Raich*:

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<sup>30</sup> See 21 U.S.C. § 823(f) (providing that DEA may **only** issue a registration for research involving a schedule I controlled substance where **HHS has** found the researcher to **be** qualified and the research protocol meritorious).

The CSA designates marijuana as contraband for *any* purpose; in fact, by characterizing marijuana **as** a Schedule I drug, Congress expressly found that the drug has no acceptable medical uses. Moreover, the CSA is a comprehensive regulatory regime specifically designed to regulate which controlled substances can be utilized for medicinal purposes, and in what manner. . . . Thus, even **if** respondents are correct that marijuana does have accepted medical uses and thus should be re-designated **as** a lesser schedule drug, the CSA would still impose controls beyond what is required by California law. The CSA requires manufacturers, physicians, pharmacies, and other handlers of controlled substances to comply with statutory and regulatory provisions mandating registration with the DEA, compliance with specific production quotas, security controls to **guard** against diversion, recordkeeping and reporting obligations, and prescription requirements. *See* 21 U.S.C. §§ 821-830; 21 C.F.R. § 1301 *et seq.* (2004). Furthermore, the dispensing of new drugs, even when doctors approve their use, must await federal **approval**.<sup>31</sup>

The Court also provided the following explanation for rejecting the marijuana trafficker's commerce clause argument in *Raich*:

Given the enforcement difficulties that attend distinguishing between marijuana cultivated locally and marijuana grown elsewhere, 21 U.S.C. § 801(5), and concerns about diversion into illicit channels, we have no difficulty concluding that Congress had a rational basis for believing that failure to regulate the intrastate manufacture and possession of marijuana would leave a gaping hole in the CSA.<sup>32</sup>

In addition, as noted above, the Supreme Court's decision in *OCBC* makes clear that the marijuana activities of a California "cannabis club" are illegal under the CSA. In sum, the Supreme Court rulings indicate unequivocally that the CSA prohibitions on manufacturing, distributing, and possessing marijuana apply regardless of whether the person engaging in such activity claims to have a "medical necessity," claims to be acting in accordance with state law, or claims to be acting in a wholly intrastate manner. Thus, the DEA is constitutionally obligated to enforce the CSA in all circumstances. Accordingly, DEA is obligated to take all appropriate law enforcement actions, using all of the tools at our disposal, and to investigate any organization, including marijuana distribution facilities (sometimes referred to by their operators **as** "cannabis clubs") that are engaged in the unlawful manufacture and distribution of controlled substances.

**DEA** investigations of cannabis clubs are typically initiated as a result of one or several of the following factors: a community complaint made to DEA or other law enforcement agency;<sup>33</sup> a request for assistance from local law enforcement and/or city

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<sup>31</sup> 545 U.S. at 27-28.

<sup>32</sup> 545 U.S. at 22 (footnote omitted).

<sup>33</sup> Occasional news articles have reported on community complaints about the presence of cannabis clubs, which are very similar to the complaints made to the **DEA**. An example of such articles include: Eric

government(s);<sup>34</sup> or a tip that was generated as a result of its association with a collateral drug trafficking/money laundering investigation. **DEA** does not investigate or target individual “patients” who use cannabis, but instead the Drug Trafficking Organizations (DTOs) involved in marijuana trafficking. A sample list of the complaints that DEA has received include:

- a people smoking marijuana outside the distribution facility,
- a an increase in pedestrian and automobile traffic clogging the streets,
- a illegal parking,
- a public safety concerns,
- a loss of customers and business in a once quiet neighborhood,
- an influx of criminal elements into the neighborhoods,
- a noise, litter, loitering, property damage,
- a the pungent smell of marijuana seeping into neighboring businesses,
- a the smell of marijuana making people ill,
- a secondary smoking risks,
- a public urination,
- a threats and harassment,
- display of firearms by owners or customers,
- a verbal altercations,
- a selling items that look like candy that small children could confuse and ingest,
- a violations of residential zoning laws,
- a marijuana distributors operating in school zones or close to schools or parks,
- marijuana distributors operating in or near buildings that house drug treatment facilities,
- fire hazards from makeshift electrical systems for indoor grows,
- a a decrease in business and revenue for legitimate neighborhood stores,
- a decrease in tourist revenues and tourist traffic,
- a a decrease in property values,
- a juveniles under the age of 18 are able to purchase marijuana from cannabis clubs under the guise of parental consent,
- a the majority of the customers seen in these clubs are young and do not appear to have any illness, and
- adults have been buying marijuana from the cannabis clubs and re-selling marijuana to juveniles.

**DEA** has always focused its attention on those cannabis club operators who are major drug traffickers. Again, the agency does not target individual users who are engaged in “simple possession” of the drug – even though they too are violating federal

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Bailey, “Reefer Sadness and Untended Consequences,” *Los Angeles Times*, December 27, 2006; Paul Payne, “Pot Club Triggers Furor in Forestville” *The Press Democrat*, November 9, 2005; and Phillip Matier and Andrew Ross, “Pot Clubs May be Taking Root Near Your Own Backyard,” *San Francisco Chronicle*, December 1, 2004.

<sup>34</sup> For an example of such a request, please see an October 2006 letter from the California Police Chiefs Association, Inc., to former **DEA** Administrator Karen Tandy. A copy is provided as Attachment 2.

law and entitled to no immunity.<sup>35</sup> In fact, **DEA** has not charged anyone associated with a cannabis club with simple possession, including anyone encountered in the 106 enforcement actions listed in the attachment to your letter.<sup>36</sup> Rather, the **DEA** has targeted drug dealers and suppliers.

For example, since 2004, **DEA** has initiated over **87** investigations involving cannabis clubs. In the 130 enforcement actions taken to date as part of these investigations, 365 people were arrested on both federal and state charges. None of those arrested were charged with simple possession, nor were any of the individuals arrested simply customers of the cannabis clubs. **An** overall breakdown of arrests during these cases is as follows:

- **28%** of the arrests were of retail dealers,
- 15% of the arrests were of lab (marijuana grow) operators,
- **9%** of the arrests were of domestic suppliers,
- 11% of the arrests were of facilitators,
- 13% of the arrests were of organization lieutenants,
- 8% of the arrests were of organizational heads,
- 1% of the arrests were of transporters,
- 1% of the arrests were of couriers,
- 1% of the arrests were for money laundering , and
- 11% of the arrests were for other related charges (e.g., conspiracy to cultivate marijuana, weapons offenses).<sup>37</sup>

In addition, there were a wide variety of state charges also filed by state prosecutors as a result of these enforcement actions, showing that in addition to violating federal law, these marijuana traffickers often are in violation of state law as well.

Moreover, the amassed profits and assets attributed to these marijuana traffickers who **DEA** have investigated show the true nature of these criminal organizations. These organizations also take steps to hide their profits. **DEA** investigations have shown that many of these individuals use bank accounts to launder their illegal proceeds and structure transactions (in violation of state and federal law) to attempt to avoid detection of the source of the funds. In addition, they use proceeds from the illegal sales and cultivation of marijuana to buy and lease conveyances (vehicles), investments and personal property, and pay expenses. For example, in a recent investigation, **DEA** found that Larry Kristich, the owner of several dispensaries in the Los Angeles area, purchased several luxury and exotic vehicles, including a new Land Rover, Ferrari F-430 sports car and a Bentley, and owned a \$3 million estate. On January 31, 2008, Kristich pled guilty to one count of maintaining drug-involved premises and one count of money laundering. Kristich admitted he was responsible for distributing over 15,000 pounds of marijuana,

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<sup>35</sup> Unlawful possession of a controlled substance, as set forth in 21 U.S.C. § 844 (sometimes referred to as “simple possession”), is a misdemeanor. In contrast, possession of a controlled substance with intent to manufacture, distribute, or dispense is a felony, as set forth in 21 U.S.C. § 841.

<sup>36</sup> Please see Attachment I for additional information on these enforcement actions.

<sup>37</sup> Percentages are approximate due to rounding.

sold \$95 million worth of marijuana and THC-laced products, and laundered over \$50 million in marijuana proceeds. As part of his plea, Kristich also agreed to the forfeiture of over \$1.2 million. In 2004, there were approximately ten marijuana distribution clubs in the Los Angeles area. But by 2007, that number had escalated to over 400.

Given that marijuana remains illegal under federal and state law, it is not surprising that there is no regulatory oversight whatsoever – federal or state – of the quality of marijuana products sold at these facilities. There are no warning labels, standard dosages, or reporting requirements for those who sell marijuana products – whether those products are intended to be smoked or eaten. Cannabis clubs take advantage of this by marketing marijuana as food products, including baked goods, candy, soda, liquids, peanut butter, cereal, soup, and ice cream.<sup>38</sup> The food products are typically labeled, "3X," "6X," "9X" and "10X," which describes the potency of THC in the food product, although there is no standard against which this can be measured. Again, there are no standards at all for these products; they are not inspected by anyone prior to selling them; there are no expiration dates; no list of ingredients; and no danger warnings on the packaging. Some of the marijuana food and beverage products have been packaged in wrappers and labels made to purposely resemble legitimate food items,<sup>39</sup>

The illegal activity generated by these cannabis clubs is not limited to selling marijuana. According to a complaint filed with the **DEA** in Los Angeles in August 2006, a high school coach provided his "medical marijuana" recommendation to high school students to enable them to purchase marijuana for recreational use. The 16 and 17 year olds then went to a dispensary in Sherman Oaks, California and purchased marijuana. In a separate case, a Van Nuys area patrol officer was dispatched to Grant High School to investigate an assault. While walking across campus, the officer observed a card placed on several vehicles in the school parking lot that advertised medical marijuana recommendations at JT Medical Group, Inc., in North Hollywood (approximately ½ mile from the school). The card stated, "Yes, in the state of California, it is still legal to own, grow, and smoke medical marijuana as long as you do it properly. Qualifying is simple and our experienced physicians are more than happy to help you." The card also stated, "If you do not qualify for a recommendation your visit is free."<sup>40</sup>

In addition, there have been many recorded incidents of violence and property crimes at or near dispensaries around the state. These violent crimes have included robberies, burglaries, aggravated assaults, and burglary from autos. For example, the Los Angeles Police Department (LAPD) reported a 200% increase in robberies, **52.2%** increase in burglaries, 57.1% rise in aggravated assaults, and 130.8% rise in burglaries from autos near cannabis clubs in Los Angeles.

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<sup>38</sup> Please see Attachment 3 for photographs of such products.

<sup>39</sup> In addition to violating the CSA and FDCA, marketing products in such a manner raises potential trademark infringement issues.

<sup>40</sup> Please see Attachment 4 for a copy of this flyer.

Similarly, an analysis of one-year's data provided by the San Francisco Police Department (SFPD) of the crimes committed at or near **23** of the city's 29 cannabis clubs in the city of San Francisco between January 1, 2006, and February 1, 2007, shows a significant concentration of violent crimes and property crimes. Violent crimes include: murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault. Violent crimes that occurred at, or in close proximity to, San Francisco's cannabis clubs during the last year included:

- 98 aggravated assaults,
- **144** incidents of battery,
- 7 incidents of battery of a police officer,
- 1 attempted rape – bodily force,
- 1 forcible rape – bodily force,
- 3 sexual batteries,
- 2 attempted homicides,
- 3 homicides with a gun,
- 21 deaths (causes unknown),
- 6 possession of a loaded firearm,
- 1 exhibiting deadly weapon,
- 27 attempted robberies, and
- 57 robberies.

Property crimes include burglary, larceny-theft, and motor vehicle theft. Property crimes that occurred at, or in close proximity to, **San** Francisco's cannabis clubs during the last year included:

- 20 attempted thefts,
- 294 grand thefts,
- **23** credit card thefts,
- 139 petty thefts,
- 2 attempted burglaries, and
- 198 burglaries.

These reports from individual police departments are supported by a July 2006 report by the California Police Chiefs Association (CPCA) on the secondary effects of marijuana distribution clubs. This report compiled data from state and local law enforcement agencies and media coverage, showed that between 2005 and 2006 there were at least 5 homicides, 35 robberies, and several fires at cannabis clubs. These are just a small sample of the crimes. Often crimes involving dispensaries are underreported, if reported at all, due to the fear of arrest and **prosecution.**<sup>41</sup>

Investigations have shown that individuals operating dispensaries consider themselves to be a “covert industry” trusting no one. There is no requirement for

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<sup>41</sup> “Medical Marijuana Dispensaries and Associated Issues Presented to the California Chiefs of Police Association.” El Cerrito, CA Police Department, **September** to December **2007**. See: [www.californiapolicechiefs.org/nav\\_files/marijuana\\_files/Oct Dec 07 final report.pdf](http://www.californiapolicechiefs.org/nav_files/marijuana_files/Oct%20Dec%2007_final_report.pdf).

background verifications of persons who open, operate, or work at dispensaries. Operators and owners include convicted drug traffickers, persons on probation for serious crimes, and street gang members. Many of the owners/operators and employees of the marijuana dispensaries have extensive criminal histories. In January 2007, DEA executed 11 search warrants and identified 17 owners and/or operators in the Los Angeles area. Of these 17 owners and/or operators, 14 had prior criminal histories, seven had weapons charges, eight had prior drug charges, and two had murder/attempted murder charges.

As with all medicines containing controlled substances, and approved by the FDA, only those who are registered with DEA and licensed in accordance with state laws can legally manufacture, possess, or dispense these substances. In addition to this registration process, registrants are required to maintain certain records, report theft and losses of these substances, and report suspicious transactions involving these substances. All of these requirements are circumvented in cases involving cannabis clubs. Furthermore, individuals operating these clubs do not have necessary training commensurate with that of a pharmacist. For example, pharmacists, through their training and experience, help identify and prevent situations where taking one drug in combination with another, wittingly or unwittingly, may cause harm to the patient. These protections are clearly nonexistent with the dispensation of marijuana at these cannabis clubs.

Your letter also asked how DEA uses the legal authorities and resources that we have been provided to enforce the CSA. In particular, your letter questioned DEA's "use of civil forfeiture" as a tactic when conducting marijuana trafficking investigations in California. DEA's use of civil asset forfeiture stems from the authorities granted to law enforcement by the Civil Asset Forfeiture Reform Act of 2000 (CAFRA).<sup>42</sup>

CAFRA requires that all real property be forfeited pursuant to a federal judicial action. Any search warrant, seizure warrant or Complaint for Forfeiture *In Rem*, involving real property, ~~must~~ be presented to the United States Attorney's Office in the applicable judicial district for review. Only a federal court proceeding may authorize a seizure warrant, search warrant, or the forfeiture of real property.

These protections and judicial review assist in ensuring that the use of asset forfeiture remains a valuable law enforcement tool. Civil asset forfeiture is provided for in the CSA. Specifically, 21 U.S.C. § 881(a) provides that certain property "shall be subject to forfeiture to the United States and no property right shall exist in them." This includes "[a]ll real property, including any right, title and interest (including any

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<sup>42</sup> See 18 U.S.C. § 983 *et. seq.* The CAFRA legislation increased protections for property owners, while respecting the interests of law enforcement. Among other provisions, the bill placed the burden of proof in civil forfeiture cases on the government throughout the proceeding; placed reasonable time limits on the government in civil forfeiture actions; awards attorney fees and costs to property owners who prevail against the government in civil forfeiture cases; authorizes the court to release property pending trial in appropriate circumstances; eliminates the cost bond; and provides a uniform innocent owner defense to all federal civil forfeitures affected by the bill.

leasehold interest) in the whole of any lot or tract of land ... which is used, or intended to be used, in any manner or **part**, to commit, or to facilitate the commission of, a violation of this subchapter punishable by more than one year's imprisonment."<sup>43</sup> CAFRA governs how these authorities can be exercised, and struck an important balance between law enforcement objectives and the rights of innocent owners by codifying a uniform innocent owner defense.<sup>44</sup>

In addition, it is important to keep in mind that CAFRA also codifies that real property may not be seized – except in exigent circumstances – without prior notice and an opportunity to be heard. In particular, sections § 983(d) and § 985 detail how an individual could protect themselves against forfeiture by acting as a “reasonable person.” **DEA**'s use of any civil forfeiture action must, and does, comply with this law. In addition, civil asset forfeiture serves as a valuable deterrent for individuals who need financial consequences to understand the costs of breaking the law.

You also asked about **DEA**'s allocation of resources to investigate marijuana dispensaries in California. **DEA** appreciates the Committee's concern that we may not have adequate resources to work against the drug cartels in Mexico, Colombia, and elsewhere. Accordingly, we want to reassure you that **DEA** routinely assesses the drug threat and drug-related crimes when we are making allocation decisions. To address the changes in the drug threat, or drug flow, **DEA** regularly conducts workload analyses and 'right sizing' reviews to ensure that the most urgent needs are being met with the limited resources we have available. Other factors that are taken into consideration include information on drug-related crimes from state, local, and federal entities; statistical data from drug use surveys, such as the Monitoring the Future study or the National Survey on Drug Use and Health; current investigative information about significant drug traffickers and organizations; agent investigative work hours; and the advice of **DEA** Special Agents in Charge. Working with the resources we have, **DEA** believes our current deployment is well-balanced to confront all of the threats we face. **DEA** personnel and resources are well-positioned to accomplish the tasks and responsibilities of this agency in fulfilling our mission.

You also raised a concern about whether the loss of state tax revenue was a consideration in **DEA**'s decision to enforce the **CSA**. You may know that this is a question that some jurisdictions in California have raised directly with the Department of Justice, and to which the Department has responded. In *summary*, we have explained that income derived from the sale of marijuana, whether in California or not, represents proceeds of illegal drug trafficking, and as such is forfeitable under federal law. The State of California is neither an innocent owner nor a lien holder in regards to collecting illegal drug proceeds.<sup>45</sup> All right, title, and interest in property subject to forfeiture under the **CSA** – including all money and other proceeds of illegal drug sales – shall vest in the United States upon commission of the illegal act giving rise to the forfeiture.<sup>46</sup> Under the

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<sup>43</sup> See 21 U.S.C. § 881 (a)(7).

<sup>44</sup> See 18 U.S.C. § 983 (d).

<sup>45</sup> See 21 U.S.C. § 881.

<sup>46</sup> 21 U.S.C. § 811(h).

supremacy clause of the United States Constitution, a state may not impose a sales tax, or any other tax, on the property of the United States.<sup>47</sup>

Nonetheless, if a state entity wishes to assert a legal claim to any seized funds, CAFRA provides a mechanism for it to do so, which begins by submitting a claim in a timely manner and in the appropriate legal proceeding. In evaluating whether to maintain a legal claim please consider that general creditors lack standing to contest the federal forfeiture of property.<sup>48</sup> Thus, if a state or local entity asserts that it is a general creditor based upon unreported and/or unpaid sales taxes, it might look to those entities whose property was seized, rather than the federal government, for relief

If, instead, the state or local entity claims some specific interest in the seized funds – funds which were derived from the distribution of a schedule I controlled substance – then such an interest would have to be evaluated according to principles of federal forfeiture law.<sup>49</sup> To date, no state or local entity has made such claims.

With respect to what the research to date has demonstrated regarding the potential therapeutic value of marijuana, and what role scientific data plays in DEA actions, please note the following. As indicated above, scientific data is of paramount consideration under both the CSA scheduling process and the FDA approval process. In particular, "[t]here must be adequate, well-controlled, well-designed, well-conducted and well-documented studies, including clinical investigations, by experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs, on the basis of which it could fairly and responsibly be concluded by such experts that the substance will have the intended effect in treating a specific, recognized disorder."<sup>50</sup> It is therefore crucial to bear in mind that the FDA, the Substance Abuse and Mental Health Services (SAMHSA), and the National Institute for Drug Abuse (NIDA) have all "concluded that no sound scientific studies supported medical use of marijuana for treatment in the United States, and no animal or human data supported the safety or efficacy of marijuana for general medical use."<sup>51</sup> Absent a scientific basis for concluding that marijuana should be removed from schedule I, there is no legal basis for DOJ to treat it as anything other than a schedule I controlled substance.

Nonetheless, we are aware that some supporters of the marijuana legalization laws continue to contend that persons suffering from terminal illnesses should be allowed to use whatever substances they believe will help them, regardless of whether such substances have been proven to be safe and effective. Such a contention was once made with respect to the drug Laetrile, which many touted in the 1970s as a cure for cancer. Laetrile was sold in Mexico but was banned in the United States due to its lack of FDA

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<sup>47</sup> See *McCullough v. Maryland*, 17 U.S. 316 (1819); see also *U.S. v. California State Bd. of Equalization*, 650 F.2d 1127 (9th Cir. 1981), *aff'd*, 456 U.S. 901 (1982), *reh'g denied*, 456 U.S. 985 (1982).

<sup>48</sup> See, e.g., *United States v. \$20,193.39 U.S. Currency*, 16 F.3d 344,346 (9th Cir. 1994).

<sup>49</sup> See, e.g., 18 U.S.C. § 983(d)(3) and 21 U.S.C. § 853(n)(6)(B).

<sup>50</sup> 57 FR at 10505.

<sup>51</sup> Press Release, FDA, Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine (April 20, 2006) (available at <http://fda.gov/bbs/topics/NEWS/2006/NEW01362.html>).

approval. Several terminally ill cancer patients who believed they needed the drug to survive sued the United States to stop the **FDA** from enforcing the Food, Drug, and Cosmetic Act (**FDCA**) with respect to their use of Laetrile. The case was decided by the United States Supreme Court in *United States v. Rutherford*.<sup>52</sup> The Supreme Court ruled that the **FDCA** drug approval process must be followed – even in the case of terminally ill patients. Writing for a unanimous Court, Justice Thurgood Marshall emphasized the dangers of abandoning the **FDCA** approval process:

To accept the proposition that the safety and efficacy standards of the **[FDCA]** have no relevance for terminal patients is to deny the **[FDA]** Commissioner's authority over all drugs, however toxic or ineffectual, for such individuals. If history is any guide, this new market would not be long overlooked. Since the turn of the century, resourceful entrepreneurs have advertised a wide variety of purportedly simple and painless cures for cancer, including liniments of turpentine, mustard, oil, eggs, and ammonia; peat moss; arrangements of colored floodlamps; pastes made from glycerin and limburger cheese; mineral tablets; and "Fountain of Youth" mixtures of spices, oil, and suet. In citing these examples, we do not, of course, intend to deprecate the sincerity of Laetrile's current proponents, or to imply any opinion on whether that drug may ultimately prove safe and effective for cancer treatment. But this historical experience does suggest why Congress could reasonably have determined to protect the terminally ill, no less than other patients, from the vast range of self-styled panaceas that inventive minds can devise.<sup>53</sup>

State actions that circumvent these protections by permitting the manufacturing, possession, distribution, and use of a schedule I controlled substance undermine the effectiveness of the **CSA**. **DEA's** efforts to enforce federal law with respect to trafficking in, and possession of, marijuana have been hampered by the passage of laws in several states which inhibit state and local law enforcement from acting against individuals and organizations selling marijuana under the guise of "medicine".

In these states, law enforcement has seen a growing list of ailments used by dealers, patients and physicians to justify smoking marijuana. That list includes attention deficit disorder, headaches, arthritis, premenstrual syndrome, irritable bowel syndrome, hepatitis, renal failure, hypertension, anxiety, depression, post-traumatic stress disorder, insomnia, paranoia, bipolar affective disorder, alcoholism, cocaine and amphetamine addiction, epilepsy, bronchitis, emphysema, osteoporosis, degenerative disc disease, polio, ulcers, stuttering, seizures, color blindness and various types of pain. It has become so exhaustive that anyone could claim "a medical need," and such claims far outstrip any scientific evidence about the therapeutic value of marijuana.

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<sup>52</sup> 442 US .544 (1979).

<sup>53</sup> 442 U.S. at 557-558.

This proliferation of excuses used by marijuana smokers hiding behind state laws goes even beyond what was envisioned by some of the most ardent supporters of the original proposition, California's Proposition 215. **Scott Imler**, who co-wrote Proposition 215, stated, "Nothing in Prop. 215 allows for the sale of marijuana to anyone. We created Prop. 215 so that patients would not have to deal with black market profiteers. But today its all about the money. Most of the dispensaries operating in California are little more than dope dealers with store fronts."<sup>54</sup>

DEA is charged with enforcing the entire **CSA**, not portions of it. Thus, when individuals possess, distribute, or use **any** controlled substance outside the scope of the closed-system of distribution, the DEA must investigate and enforce the laws that protect the public health and safety.

Finally, your letter also included **a** list of law enforcement actions against marijuana suppliers throughout California.<sup>55</sup> To the extent that we are able, you should find the requested information included in the enclosed spreadsheet. We trust this information is of value to your policy **and** oversight efforts.

We hope this information is helpful. Please do not hesitate to contact this office if we can be of assistance in other matters.

Sincerely,



Keith E. Nelson  
Principal Deputy Assistant Attorney General

Enclosures

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<sup>54</sup> Jerry Wade, "A Comparison of Medical Marijuana Programs in California and Oregon", *Alternatives Magazine* Fall, 2006 Issue 39.

<sup>55</sup> Please see Attachment 1.

ORDINANCE NO. 1822

AN UNCODIFIED URGENCY INTERIM ORDINANCE OF THE  
CITY COUNCIL OF THE CITY OF LODI MAKING FINDINGS  
AND IMPOSING A TEMPORARY MORATORIUM ON THE  
ESTABLISHMENT OR OPERATION OF MEDICAL MARIJUANA  
DISPENSARIES IN THE CITY OF LODI

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WHEREAS, in 1996, the voters of the State of California approved Proposition 215, which was codified as Health and Safety Code Section 11362.5, *et seq.* and entitled the Compassionate Use Act of 1996 (“the Act”); and

WHEREAS, the intent of Proposition 215 was to enable persons who are in need of marijuana for medical purposes to obtain and use it under limited, specified circumstances; and

WHEREAS, on January 1, 2004, Senate Bill 420 became effective to clarify the scope of the Act and to allow cities and counties to adopt and enforce rules and regulations consistent with SB 420 and the Act; and

WHEREAS, under the U.S. Controlled Substances Act, marijuana is classified as a Schedule 1 drug, meaning it has no accepted medical use; and

WHEREAS, the City of Lodi (the “City”) has recently received inquiries from members of the public as to the permitting process and zoning regulations for operating medical marijuana dispensaries within the City; and

WHEREAS, medical marijuana dispensaries raise issues of first impression for the City, which currently does not address or regulate in any manner the existence or location of medical marijuana dispensaries in its Municipal Code; and

WHEREAS, based on recent trends, the City believes that it may receive a growing number of inquiries for such businesses, including an application in the immediate future; and

WHEREAS, other California cities that have permitted the establishment of medical marijuana dispensaries have witnessed an increase in crime, such as burglaries, robberies, and the sale of illegal drugs in the areas immediately surrounding such dispensaries; and

WHEREAS, the City must study and analyze concerns about the potential negative impacts on the public health, safety, and welfare arising from medical marijuana dispensaries, including, but not limited to, criminal incidents, loitering, disturbing the peace, and property damage; and

WHEREAS, the City must study the scope of the City's police power and draft the necessary municipal code provisions; and

WHEREAS, if medical marijuana dispensaries were allowed to be established in the City without appropriate regulation, such uses might be established in areas that would conflict with the General Plan currently under consideration by the Planning Commission and the City Council, be inconsistent with surrounding uses, or be detrimental to the public health, safety, and welfare; and if such uses were allowed to proceed as allowed under the current zoning,

such uses could conflict with, and defeat the purpose of, the proposal to study and adopt new regulations regarding medical marijuana dispensaries; and

WHEREAS, the issuing of permits, business licenses, or other applicable entitlements providing for the establishment and/or operation of medical marijuana dispensaries, prior to the completion of the City's study of the potential impact of such facilities, poses a current and immediate threat to the public health, safety, and welfare, and that a temporary moratorium on the issuance of such permits, licenses, and entitlements is thus necessary; and

WHEREAS, this Ordinance is not subject to the California Environmental Quality Act (CEQA) pursuant to Section 15060(c)(2) (the activity will not result in a direct or reasonably foreseeable indirect physical change in the environment) and Section 15060(c)(3) (the activity is not a project as defined in Section 15378) of the CEQA Guidelines, California Code of Regulations, Title 14, Chapter 3, because it has no potential for resulting in physical change to the environment, directly or indirectly; it prevents changes in the environment pending the completion of the contemplated General Plan adoption and zoning ordinance review; and

WHEREAS, California Government Code 565858 authorizes cities to adopt moratoriums on land use entitlements in order to study any uses that may be in conflict with a contemplated general plan, specific plan, or zoning proposal; and

WHEREAS, for the protection of the public's health, safety, and general welfare, the City desires to adopt this moratorium to maintain the current status quo and to provide time for the City to study applicable law, a permit or licensing procedure, the appropriate zoning districts for such uses, and adopt regulatory standards and conditions to be imposed on such operations; and

WHEREAS, the City desires that such moratorium take effect immediately upon its adoption in accordance with 536934 of the California Government Code.

NOW, THEREFORE, BE IT ORDAINED BY THE LODI CITY COUNCIL AS FOLLOWS:

Section 1. Imposition of Moratorium.

**A.** In accordance with Government Code Section 65858, from and after the date of this Ordinance, no use permit, variance, building permit, business license, or other applicable entitlement for use shall be approved or issued for the establishment or operation of a medical marijuana dispensary for a period of forty-five (45) days.

**B.** For purposes of this Ordinance, "medical marijuana dispensary" shall mean any facility or location where a primary caregiver intends to or does make available, sell, transmit, give, or otherwise provide medical marijuana to two or more of the following: a qualified patient, a person with an identification card, or a primary caregiver. For purposes of this ordinance, the terms "primary caregiver," "qualified patient," and "identification card" shall have the same meaning as that set forth in Health and Safety Code Section 11362.7, et seq.

**C.** For purposes of this Ordinance, a medical marijuana dispensary shall not include the following uses, as long as the location of such uses is otherwise regulated by applicable law and as long as such use complies strictly with applicable law, including, but not limited to, Health and Safety Code Section 11362.7, et seq.: (1) a clinic, licensed pursuant to Chapter 1, Division 2 of the Health and Safety Code (commencing with 51200); (2) a health care facility,

licensed pursuant to Chapter 2 of Division 2 of the Health and Safety Code (commencing with §1250); (3) a residential care facility for persons with chronic life-threatening illness, licensed pursuant to Chapter 3.01 of Division 2 of the Health and Safety Code (commencing with §1568.01); (4) a residential care facility for the elderly, licensed pursuant to Chapter 3.2 of Division 2 of the Health and Safety Code (commencing with §1569); or (5) a hospice or home health agency licensed pursuant to Chapter 8 of Division 2 of the Health and Safety Code (commencing with §1725), the owner or operator, or no more than three employees who are designated by the owner or operator, of the clinic, facility, hospice, or home health agency, if designated as a primary caregiver by that qualified patient or person with an identification card.

D. This Ordinance is an interim urgency ordinance adopted pursuant to the authority granted to the City of Lodi by Government Code Section 65858 and is for the immediate preservation of the public health, safety, and welfare. The City Council of the City of Lodi hereby finds and declares that there is a need to enact an urgency interim ordinance establishing a moratorium on medical marijuana dispensaries, based upon the following findings:

- (1) California cities that have permitted the establishment of medical marijuana dispensaries have found that such dispensaries have resulted in negative and harmful secondary effects, such as an increase in crime, including robberies, burglaries, and sales of illegal drugs in the areas immediately surrounding medical marijuana dispensaries. This potential for increased risk of crime and violence presents a clear and immediate danger to the public health, safety and welfare of the residents of the City of Lodi; and
- (2) The City has recently received inquiries from members of the public as to the permitting process and zoning regulations for operating medical marijuana dispensaries within the City; and
- (3) The City does not currently have standards in its Municipal Code relating to the location, operation, and concentration of medical marijuana dispensaries within the City; and
- (4) If medical marijuana dispensaries were allowed to be established without appropriate review of location and operational criteria and standards, such uses might be established in areas that would conflict with the General Plan under consideration by the Planning Commission and the City Council, be inconsistent with surrounding uses, or could have potential adverse secondary effects on neighborhoods in the City and be detrimental to the public health, safety, and welfare; and
- (5) The failure to adopt this 45-day moratorium may result in significant irreversible change in the character of the community and the neighborhood surrounding any marijuana dispensary that would be allowed to open under the City's Municipal Code; and
- (6) Permitting a marijuana dispensary to open while the City is studying and considering a new General Plan as well as zoning regulations to regulate and/or prohibit this use would defeat the purpose of studying these impacts in the first place; and

- (7) As a result of the negative and harmful secondary effects associated with medical marijuana dispensaries and the current and immediate threat such secondary effects pose to the public health, safety, and welfare, it is necessary to establish a temporary, forty-five (45) day moratorium on the establishment and operation of medical marijuana dispensaries in the City, pending completion of the City's study of the potential impacts of medical marijuana dispensaries and possible amendments to the City's Municipal Code.

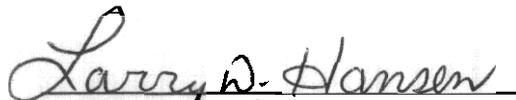
Section 2. Severability. If any section, subsection, subdivision, paragraph, sentence, clause or phrase of this Ordinance or any part thereof is for any reason held to be unconstitutional or invalid or ineffective by any court of competent jurisdiction, such decision shall not affect the validity or effectiveness of the remaining portions of this Ordinance or any part thereof. The City Council of the City of Lodi hereby declares that it would have passed each section, subsection, subdivision, paragraph, sentence, clause or phrase thereof irrespective of the fact that any one or more sections, subsections, subdivisions, paragraphs, sentences, clauses or phrases be declared unconstitutional or invalid or ineffective.

Section 3. No Mandatory Duty of Care. This Ordinance is not intended to and shall not be construed or given effect in a manner which imposes upon the City, or any officer or employee thereof, a mandatory duty of care towards persons or property within the City or outside of the City so as to provide a basis of civil liability for damages, except as otherwise imposed by law.

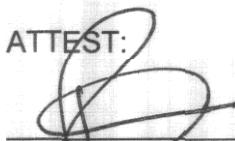
Section 4. Conflict. All ordinances and parts of ordinances in conflict herewith are repealed insofar as such conflict may exist.

Section 5. Effective Date. This urgency Ordinance shall be published one time in the "Lodi News Sentinel," a daily newspaper of general circulation printed and published in the City of Lodi, and shall be in force and take effect immediately from and after its passage and approval by at least four-fifths vote of the City Council and shall be in effect for forty-five (45) days from the date of adoption unless extended by the City Council as provided for in Government Code section 65858.

Approved this 15<sup>th</sup> day of April, 2009

  
LARRY D. HANSEN  
Mayor

ATTEST:

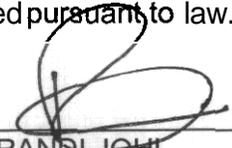
  
\_\_\_\_\_  
City Clerk

State of California  
County of San Joaquin, ss.

I, Randi Johl, City Clerk of the City of Lodi, do hereby certify that Ordinance No. 1822 was adopted as an urgency ordinance at a regular meeting of the City Council of the City of Lodi held April 15, 2009, and was thereafter passed, adopted, and ordered to print at a regular meeting of said Council held April 15, 2009, by the following vote:

AYES: COUNCIL MEMBERS – Hitchcock, Johnson, Katzakian, and Mayor Hansen  
NOES: COUNCIL MEMBERS – None  
ABSENT: COUNCIL MEMBERS – Mounce  
ABSTAIN: COUNCIL MEMBERS – None

I further certify that Ordinance No. 1822 was approved and signed by the Mayor on the date of its passage and the same has been published pursuant to law.

  
\_\_\_\_\_  
RANDI JOHL  
City Clerk

Approved to Form:

  
JANICE D. MAGDICH  
Deputy City Attorney



**GUIDELINES FOR THE SECURITY AND NON-DIVERSION  
OF MARIJUANA GROWN FOR MEDICAL USE**  
*August 2008*

In 1996, California voters approved an initiative that exempted certain patients and their primary caregivers from criminal liability under state law for the possession and cultivation of marijuana. In 2003, the Legislature enacted additional legislation relating to medical marijuana. One of those statutes requires the Attorney General to adopt “guidelines to ensure the security and nondiversion of marijuana grown for medical use.” (Health & Saf. Code, § 11362.81(d).<sup>1</sup>) To fulfill this mandate, this Office is issuing the following guidelines to (1) ensure that marijuana grown for medical purposes remains secure and does not find its way to non-patients or illicit markets, (2) help law enforcement agencies perform their duties effectively and in accordance with California law, and (3) help patients and primary caregivers understand how they may cultivate, transport, possess, and use medical marijuana under California law.

**I. SUMMARY OF APPLICABLE LAW**

**A. California Penal Provisions Relating to Marijuana.**

The possession, sale, cultivation, or transportation of marijuana is ordinarily a crime under California law. (See, e.g., § 11357 [possession of marijuana is a misdemeanor]; § 11358 [cultivation of marijuana is a felony]; Veh. Code, § 23222 [possession of less than 1 oz. of marijuana while driving is a misdemeanor]; § 11359 [possession with intent to sell any amount of marijuana is a felony]; § 11360 [transporting, selling, or giving away marijuana in California is a felony; under 28.5 grams is a misdemeanor]; § 11361 [selling or distributing marijuana to minors, or using a minor to transport, sell, or give away marijuana, is a felony].)

**B. Proposition 215 - The Compassionate Use Act of 1996.**

On November 5, 1996, California voters passed Proposition 215, which decriminalized the cultivation and use of marijuana by seriously ill individuals upon a physician’s recommendation. (§ 11362.5.) Proposition 215 was enacted to “ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person’s health would benefit from the use of marijuana,” and to “ensure that patients and their primary caregivers who obtain and use marijuana for

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<sup>1</sup> Unless otherwise noted, all statutory references are to the Health & Safety Code.

medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction.” (Q 11362.5(b)(1)(A)-(B).)

The Act further states that “Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient’s primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or verbal recommendation or approval of a physician.” (Q 11362.5(d).) Courts have found an implied defense to the transportation of medical marijuana when the “quantity transported and the method, timing and distance of the transportation are reasonably related to the patient’s current medical needs.” (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1551.)

### **C. Senate Bill 420 - The Medical Marijuana Program Act.**

On January 1, 2004, Senate Bill 420, the Medical Marijuana Program Act (MMP), became law. (§§ 11362.7-11362.83.) The MMP, among other things, requires the California Department of Public Health (DPH) to establish and maintain a program for the voluntary registration of qualified medical marijuana patients and their primary caregivers through a statewide identification card system. Medical marijuana identification cards are intended to help law enforcement officers identify and verify that cardholders are able to cultivate, possess, and transport certain amounts of marijuana without being subject to arrest under specific conditions. (§§ 11362.71(e), 11362.78.)

It is mandatory that all counties participate in the identification card program by (a) providing applications upon request to individuals seeking to join the identification card program; (b) processing completed applications; (c) maintaining certain records; (d) following state implementation protocols; and (e) issuing DPH identification cards to approved applicants and designated primary caregivers. (Q 11362.71(b).)

Participation by patients and primary caregivers in the identification card program is voluntary. However, because identification cards offer the holder protection from arrest, are issued only after verification of the cardholder’s status as a qualified patient or primary caregiver, and are immediately verifiable online or via telephone, they represent one of the best ways to ensure the security and non-diversion of marijuana grown for medical use.

In addition to establishing the identification card program, the MMP also defines certain terms, sets possession guidelines for cardholders, and recognizes a qualified right to collective and cooperative cultivation of medical marijuana. (QQ 11362.7, 11362.77, 11362.775.)

### **D. Taxability of Medical Marijuana Transactions.**

In February 2007, the California State Board of Equalization (BOE) issued a Special Notice confirming its policy of taxing medical marijuana transactions, as well as its requirement that businesses engaging in such transactions hold a Seller’s Permit. (<http://www.boe.ca.gov/news/pdf/medseller2007.pdf>.) According to the Notice, having a Seller’s Permit does not allow individuals to make unlawful sales, but instead merely provides a way to remit any sales and use taxes due. BOE further clarified its policy in a

June 2007 Special Notice that addressed several frequently asked questions concerning taxation of medical marijuana transactions. (<http://www.boe.ca.gov/news/pdf/173.pdf>.)

#### **E. Medical Board of California.**

The Medical Board of California licenses, investigates, and disciplines California physicians. (Bus. & Prof. Code, § 2000, et seq.) Although state law prohibits punishing a physician simply for recommending marijuana for treatment of a serious medical condition (§ 11362.5(c)), the Medical Board can and does take disciplinary action against physicians who fail to comply with accepted medical standards when recommending marijuana. In a May 13, 2004 press release, the Medical Board clarified that these accepted standards are the same ones that a reasonable and prudent physician would follow when recommending or approving any medication. They include the following:

1. Taking a history and conducting a good faith examination of the patient;
2. Developing a treatment plan with objectives;
3. Providing informed consent, including discussion of side effects;
4. Periodically reviewing the treatment's efficacy;
5. Consultations, as necessary; and
6. Keeping proper records supporting the decision to recommend the use of medical marijuana.

([http://www.mbc.ca.gov/board/media/releases\\_2004\\_05-13-marijuana.html](http://www.mbc.ca.gov/board/media/releases_2004_05-13-marijuana.html).)

Complaints about physicians should be addressed to the Medical Board (1-800-633-2322 or [www.mbc.ca.gov](http://www.mbc.ca.gov)), which investigates and prosecutes alleged licensing violations in conjunction with the Attorney General's Office.

#### **F. The Federal Controlled Substances Act.**

Adopted in 1970, the Controlled Substances Act (CSA) established a federal regulatory system designed to combat recreational drug abuse by making it unlawful to manufacture, distribute, dispense, or possess any controlled substance. (21 U.S.C. § 801, et seq.; *Gonzales v. Oregon* (2006) 546 U.S. 243, 271-273.) The CSA reflects the federal government's view that marijuana is a drug with "no currently accepted medical use." (21 U.S.C. § 812(b)(1).) Accordingly, the manufacture, distribution, or possession of marijuana is a federal criminal offense. (*Id.* at §§ 841(a)(1), 844(a).)

The incongruity between federal and state law has given rise to understandable confusion, but no legal conflict exists merely because state law and federal law treat marijuana differently. Indeed, California's medical marijuana laws have been challenged unsuccessfully in court on the ground that they are preempted by the CSA. (*County of San Diego v. Sun Diego NORML* (July 31, 2008) --- Cal.Rptr.3d ---, 2008 WL 2930117.) Congress has provided that states are free to regulate in the area of controlled substances, including marijuana, provided that state law does not positively conflict with the CSA. (21 U.S.C. § 903.) Neither Proposition 215, nor the MMP, conflict with the CSA because, in adopting these laws, California did not "legalize" medical marijuana, but instead exercised the state's reserved powers to not punish certain marijuana offenses under state law when a

physician has recommended its use to treat a serious medical condition. (See *City of Garden Grove v. Superior Court (Kha)* (2007) 157 Cal.App.4th 355, 371-373, 381-382.)

In light of California's decision to remove the use and cultivation of physician-recommended marijuana from the scope of the state's drug laws, this Office recommends that state and local law enforcement officers not arrest individuals or seize marijuana under federal law when the officer determines from the facts available that the cultivation, possession, or transportation is permitted under California's medical marijuana laws.

## II. DEFINITIONS

**A. Physician's Recommendation:** Physicians may not prescribe marijuana because the federal Food and Drug Administration regulates prescription drugs and, under the CSA, marijuana is a Schedule I drug, meaning that it has no recognized medical use. Physicians may, however, lawfully issue a verbal or written recommendation under California law indicating that marijuana would be a beneficial treatment for a serious medical condition. (§ 11362.5(d); *Conant v. Walters* (9th Cir. 2002) 309 F.3d 629,632.)

**B. Primary Caregiver:** A primary caregiver is a person who is designated by a qualified patient and "has consistently assumed responsibility for the housing, health, or safety" of the patient. (§ 11362.5(e).) California courts have emphasized the consistency element of the patient-caregiver relationship. Although a "primary caregiver who consistently grows and supplies . . . medicinal marijuana for a section 11362.5 patient is serving a health need of the patient," someone who merely maintains a source of marijuana does not automatically become the party "who has consistently assumed responsibility for the housing, health, or safety" of that purchaser. (*People ex rel. Lungren v. Peron* (1997) 59 Cal.App.4th 1383, 1390, 1400.) A person may serve as primary caregiver to "more than one" patient, provided that the patients and caregiver all reside in the same city or county. (§ 11362.7(d)(2).) Primary caregivers also may receive certain compensation for their services. (§ 11362.765(c) ["A primary caregiver who receives compensation for actual expenses, including reasonable compensation incurred for services provided . . . to enable [a patient] to use marijuana under this article, or for payment for out-of-pocket expenses incurred in providing those services, or both, . . . shall not, on the sole basis of that fact, be subject to prosecution" for possessing or transporting marijuana].)

**C. Qualified Patient:** A qualified patient is a person whose physician has recommended the use of marijuana to treat a serious illness, including cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief. (§ 11362.5(b)(1)(A).)

**D. Recommending Physician:** A recommending physician is a person who (1) possesses a license in good standing to practice medicine in California; (2) has taken responsibility for some aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient; and (3) has complied with accepted medical standards (as described by the Medical Board of California in its May 13, 2004 press release) that a reasonable and prudent physician would follow when recommending or approving medical marijuana for the treatment of his or her patient.

### III. GUIDELINES REGARDING INDIVIDUAL QUALIFIED PATIENTS AND PRIMARY CAREGIVERS

#### A. State Law Compliance Guidelines.

1. **Physician Recommendation:** Patients must have a written or verbal recommendation for medical marijuana from a licensed physician. (§ 11362.5(d).)

2. **State of California Medical Marijuana Identification Card:** Under the MMP, qualified patients and their primary caregivers may voluntarily apply for a card issued by DPH identifying them as a person who is authorized to use, possess, or transport marijuana grown for medical purposes. To help law enforcement officers verify the cardholder's identity, each card bears a unique identification number, and a verification database is available online ([www.calmmp.ca.gov](http://www.calmmp.ca.gov)). In addition, the cards contain the name of the county health department that approved the application, a 24-hour verification telephone number, and an expiration date. (§§ 11362.71(a); 11362.735(a)(3)-(4); 11362.745.)

3. **Proof of Qualified Patient Status:** Although verbal recommendations are technically permitted under Proposition 215, patients should obtain and carry written proof of their physician recommendations to help them avoid arrest. A state identification card is the best form of proof, because it is easily verifiable and provides immunity from arrest if certain conditions are met (see section III.B.4, below). The next best forms of proof are a city- or county-issued patient identification card, or a written recommendation from a physician.

#### 4. Possession Guidelines:

a) **MMP:**<sup>2</sup> Qualified patients and primary caregivers who possess a state-issued identification card may possess **8 oz.** of dried marijuana, and may maintain no more than 6 mature or 12 immature plants per qualified patient. (§ 11362.77(a).) But, if "a qualified patient or primary caregiver has a doctor's recommendation that this quantity does not meet the qualified patient's medical needs, the qualified patient or primary caregiver may possess an amount of marijuana consistent with the patient's needs." (§ 11362.77(b).) Only the dried mature processed flowers or buds of the female cannabis plant should be considered when determining allowable quantities of medical marijuana for purposes of the MMP. (§ 11362.77(d).)

b) **Local Possession Guidelines:** Counties and cities may adopt regulations that allow qualified patients or primary caregivers to possess

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<sup>2</sup> On May 22, 2008, California's Second District Court of Appeal severed Health & Safety Code § 11362.77 from the MMP on the ground that the statute's possession guidelines were an unconstitutional amendment of Proposition 215, which does not quantify the marijuana a patient may possess. (See *People v. Kelly* (2008) 163 Cal.App.4th 124, 77 Cal.Rptr.3d 390.) The Third District Court of Appeal recently reached a similar conclusion in *People v. Phomphakdy* (July 31, 2008) --- Cal.Rptr.3d ----, 2008 WL 2931369. The California Supreme Court has granted review in *Kelly* and the Attorney General intends to seek review in *Phomphakdy*.

medical marijuana in amounts that exceed the MMP's possession guidelines. (§ 11362.77(c).)

c) **Proposition 215:** Qualified patients claiming protection under Proposition 215 may possess an amount of marijuana that is “reasonably related to [their] current medical needs.” (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1549.)

## **B. Enforcement Guidelines.**

1. **Location of Use:** Medical marijuana may not be smoked (a) where smoking is prohibited by law, (b) at or within 1000 feet of a school, recreation center, or youth center (unless the medical use occurs within a residence), (c) on a school bus, or (d) in a moving motor vehicle or boat. (§ 11362.79.)

2. **Use of Medical Marijuana in the Workplace or at Correctional Facilities:** The medical use of marijuana need not be accommodated in the workplace, during work hours, or at any jail, correctional facility, or other penal institution. (§ 11362.785(a); *Ross v. RagingWire Telecomms., Inc.* (2008) 42 Cal.4th 920,933 [under the Fair Employment and Housing Act, an employer may terminate an employee who tests positive for marijuana use].)

3. **Criminal Defendants, Probationers, and Parolees:** Criminal defendants and probationers may request court approval to use medical marijuana while they are released on bail or probation. The court's decision and reasoning must be stated on the record and in the minutes of the court. Likewise, parolees who are eligible to use medical marijuana may request that they be allowed to continue such use during the period of parole. The written conditions of parole must reflect whether the request was granted or denied. (§ 11362.795.)

4. **State of California Medical Marijuana Identification Cardholders:** When a person invokes the protections of Proposition 215 or the MMP and he or she possesses a state medical marijuana identification card, officers should:

a) Review the identification card and verify its validity either by calling the telephone number printed on the card, or by accessing DPH's card verification website (<http://www.calmmp.ca.gov>); and

b) If the card is valid and not being used fraudulently, there are no other indicia of illegal activity (weapons, illicit drugs, or excessive amounts of cash), and the person is within the state or local possession guidelines, the individual should be released and the marijuana should not be seized. Under the MMP, “no person or designated primary caregiver in possession of a valid state medical marijuana identification card shall be subject to arrest for possession, transportation, delivery, or cultivation of medical marijuana.” (§ 11362.71(e).) Further, a “state or local law enforcement agency or officer shall not refuse to accept an identification card issued by the department unless the state or local law enforcement agency or officer

has reasonable cause to believe that the information contained in the card is false or fraudulent, or the card is being used fraudulently.” (§ 11362.78.)

**5. Non-Cardholders:** When a person claims protection under Proposition 215 or the MMP and only has a locally-issued (i.e., non-state) patient identification card, or a written (or verbal) recommendation from a licensed physician, officers should use their sound professional judgment to assess the validity of the person’s medical-use claim:

a) Officers need not abandon their search or investigation. The standard search and seizure rules apply to the enforcement of marijuana-related violations. Reasonable suspicion is required for detention, while probable cause is required for search, seizure, and arrest.

b) Officers should review any written documentation for validity. It may contain the physician’s name, telephone number, address, and license number.

c) If the officer reasonably believes that the medical-use claim is valid based upon the totality of the circumstances (including the quantity of marijuana, packaging for sale, the presence of weapons, illicit drugs, or large amounts of cash), and the person is within the state or local possession guidelines or has an amount consistent with their current medical needs, the person should be released and the marijuana should not be seized.

d) Alternatively, if the officer has probable cause to doubt the validity of a person’s medical marijuana claim based upon the facts and circumstances, the person may be arrested and the marijuana may be seized. It will then be up to the person to establish his or her medical marijuana defense in court.

e) Officers are not obligated to accept a person’s claim of having a verbal physician’s recommendation that cannot be readily verified with the physician at the time of detention.

**6. Exceeding Possession Guidelines:** If a person has what appears to be valid medical marijuana documentation, but exceeds the applicable possession guidelines identified above, all marijuana may be seized.

**7. Return of Seized Medical Marijuana:** If a person whose marijuana is seized by law enforcement successfully establishes a medical marijuana defense in court, or the case is not prosecuted, he or she may file a motion for return of the marijuana. If a court grants the motion and orders the return of marijuana seized incident to an arrest, the individual or entity subject to the order must return the property. State law enforcement officers who handle controlled substances in the course of their official duties are immune from liability under the CSA. (21 U.S.C. § 885(d).) Once the marijuana is returned, federal authorities are free to exercise jurisdiction over it. (21 U.S.C. §§ 812(c)(10), 844(a); *City of Garden Grove v. Superior Court (Kha)* (2007) 157 Cal.App.4th 355,369,386,391.)

#### IV. GUIDELINES REGARDING COLLECTIVES AND COOPERATIVES

Under California law, medical marijuana patients and primary caregivers may “associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes.” (§ 11362.775.) The following guidelines are meant to apply to qualified patients and primary caregivers who come together to collectively or cooperatively cultivate physician-recommended marijuana.

**A. Business Forms:** Any group that is collectively or cooperatively cultivating and distributing marijuana for medical purposes should be organized and operated in a manner that ensures the security of the crop and safeguards against diversion for non-medical purposes. The following are guidelines to help cooperatives and collectives operate within the law, and to help law enforcement determine whether they are doing so.

1. **Statutory Cooperatives:** A cooperative must file articles of incorporation with the state and conduct its business for the mutual benefit of its members. (Corp. Code, § 12201, 12300.) No business may call itself a “cooperative” (or “co-op”) unless it is properly organized and registered as such a corporation under the Corporations or Food and Agricultural Code. (*Zd.* at § 12311(b).) Cooperative corporations are “democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons.” (*Zd.* at § 12201.) The earnings and savings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash, property, credits, or services. (*Zbid.*) Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year. (See *id.* at § 12200, et seq.) Agricultural cooperatives are likewise nonprofit corporate entities “since they are not organized to make profit for themselves, as such, or for their members, as such, but only for their members as producers.” (Food & Agric. Code, § 54033.) Agricultural cooperatives share many characteristics with consumer cooperatives. (See, e.g., *id.* at § 54002, et seq.) Cooperatives should not purchase marijuana from, or sell to, non-members; instead, they should only provide a means for facilitating or coordinating transactions between members.

2. **Collectives:** California law does not define collectives, but the dictionary defines them as “a business, farm, etc., jointly owned and operated by the members of a group.” (*RandomHouse Unabridged Dictionary*; Random House, Inc. © 2006.) Applying this definition, a collective should be an organization that merely facilitates the collaborative efforts of patient and caregiver members – including the allocation of costs and revenues. As such, a collective is not a statutory entity, but as a practical matter it might have to organize as some form of business to carry out its activities. The collective should not purchase marijuana from, or sell to, non-members; instead, it should only provide a means for facilitating or coordinating transactions between members.

**B. Guidelines for the Lawful Operation of a Cooperative or Collective:**

Collectives and cooperatives should be organized with sufficient structure to ensure security, non-diversion of marijuana to illicit markets, and compliance with all state and local laws. The following are some suggested guidelines and practices for operating collective growing operations to help ensure lawful operation.

1. **Non-Profit Operation:** Nothing in Proposition 215 or the MMP authorizes collectives, cooperatives, or individuals to profit from the sale or distribution of marijuana. (See, e.g., § 11362.765(a) [“nothing in this section shall authorize . . . any individual or group to cultivate or distribute marijuana for profit”]).

2. **Business Licenses, Sales Tax, and Seller’s Permits:** The State Board of Equalization has determined that medical marijuana transactions are subject to sales tax, regardless of whether the individual or group makes a profit, and those engaging in transactions involving medical marijuana must obtain a Seller’s Permit. Some cities and counties also require dispensing collectives and cooperatives to obtain business licenses.

3. **Membership Application and Verification:** When a patient or primary caregiver wishes to join a collective or cooperative, the group can help prevent the diversion of marijuana for non-medical use by having potential members complete a written membership application. The following application guidelines should be followed to help ensure that marijuana grown for medical use is not diverted to illicit markets:

a) Verify the individual’s status as a qualified patient or primary caregiver. Unless he or she has a valid state medical marijuana identification card, this should involve personal contact with the recommending physician (or his or her agent), verification of the physician’s identity, as well as his or her state licensing status. Verification of primary caregiver status should include contact with the qualified patient, as well as validation of the patient’s recommendation. Copies should be made of the physician’s recommendation or identification card, if any;

b) Have the individual agree not to distribute marijuana to non-members;

c) Have the individual agree not to use the marijuana for other than medical purposes;

d) Maintain membership records on-site or have them reasonably available;

e) Track when members’ medical marijuana recommendation and/or identification cards expire; and

f) Enforce conditions of membership by excluding members whose identification card or physician recommendation are invalid or have expired, or who are caught diverting marijuana for non-medical use.

4. **Collectives Should Acquire, Possess, and Distribute Only Lawfully Cultivated Marijuana:** Collectives and cooperatives should acquire marijuana only from their constituent members, because only marijuana grown by a qualified patient or his or her primary caregiver may lawfully be transported by, or distributed to, other members of a collective or cooperative. (§§ 11362.765, 11362.775.) The collective or cooperative may then allocate it to other members of the group. Nothing allows marijuana to be purchased from outside the collective or cooperative for distribution to its members. Instead, the cycle should be a closed-circuit of marijuana cultivation and consumption with no purchases or sales to or from non-members. To help prevent diversion of medical marijuana to non-medical markets, collectives and cooperatives should document each member's contribution of labor, resources, or money to the enterprise. They also should track and record the source of their marijuana.

5. **Distribution and Sales to Non-Members are Prohibited:** State law allows primary caregivers to be reimbursed for certain services (including marijuana cultivation), but nothing allows individuals or groups to sell or distribute marijuana to non-members. Accordingly, a collective or cooperative may not distribute medical marijuana to any person who is not a member in good standing of the organization. A dispensing collective or cooperative may credit its members for marijuana they provide to the collective, which it may then allocate to other members. (§ 11362.765(c).) Members also may reimburse the collective or cooperative for marijuana that has been allocated to them. Any monetary reimbursement that members provide to the collective or cooperative should only be an amount necessary to cover overhead costs and operating expenses.

6. **Permissible Reimbursements and Allocations:** Marijuana grown at a collective or cooperative for medical purposes may be:

- a) Provided free to qualified patients and primary caregivers who are members of the collective or cooperative;
- b) Provided in exchange for services rendered to the entity;
- c) Allocated based on fees that are reasonably calculated to cover overhead costs and operating expenses; or
- d) Any combination of the above.

7. **Possession and Cultivation Guidelines:** If a person is acting as primary caregiver to more than one patient under section 11362.7(d)(2), he or she may aggregate the possession and cultivation limits for each patient. For example, applying the MMP's basic possession guidelines, if a caregiver is responsible for three patients, he or she may possess up to 24 oz. of marijuana (8 oz. per patient) and may grow 18 mature or 36 immature plants. Similarly, collectives and cooperatives may cultivate and transport marijuana in aggregate amounts tied to its membership numbers. Any patient or primary caregiver exceeding individual possession guidelines should have supporting records readily available when:

- a) Operating a location for cultivation;
- b) Transporting the group's medical marijuana; and
- c) Operating a location for distribution to members of the collective or cooperative.

8. **Security:** Collectives and cooperatives should provide adequate security to ensure that patients are safe and that the surrounding homes or businesses are not negatively impacted by nuisance activity such as loitering or crime. Further, to maintain security, prevent fraud, and deter robberies, collectives and cooperatives should keep accurate records and follow accepted cash handling practices, including regular bank runs and cash drops, and maintain a general ledger of cash transactions.

C. **Enforcement Guidelines:** Depending upon the facts and circumstances, deviations from the guidelines outlined above, or other indicia that marijuana is not for medical use, may give rise to probable cause for arrest and seizure. The following are additional guidelines to help identify medical marijuana collectives and cooperatives that are operating outside of state law.

1. **Storefront Dispensaries:** Although medical marijuana “dispensaries” have been operating in California for years, dispensaries, as such, are not recognized under the law. As noted above, the only recognized group entities are cooperatives and collectives. (§ 11362.775.) It is the opinion of this Office that a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law, but that dispensaries that do not substantially comply with the guidelines set forth in sections IV(A) and (B), above, are likely operating outside the protections of Proposition 215 and the MMP, and that the individuals operating such entities may be subject to arrest and criminal prosecution under California law. For example, dispensaries that merely require patients to complete a form summarily designating the business owner as their primary caregiver – and then offering marijuana in exchange for cash “donations” – are likely unlawful. (*Peron, supra*, 59 Cal.App.4th at p. 1400 [cannabis club owner was not the primary caregiver to thousands of patients where he did not consistently assume responsibility for their housing, health, or safety].)

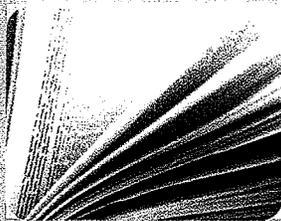
2. **Indicia of Unlawful Operation:** When investigating collectives or cooperatives, law enforcement officers should be alert for signs of mass production or illegal sales, including (a) excessive amounts of marijuana, (b) excessive amounts of cash, (c) failure to follow local and state laws applicable to similar businesses, such as maintenance of any required licenses and payment of any required taxes, including sales taxes, (d) weapons, (e) illicit drugs, (f) purchases from, or sales or distribution to, non-members, or (g) distribution outside of California.



## Americans For Safe Access

AN ORGANIZATION OF MEDICAL PROFESSIONALS, SCIENTISTS, AND PATIENTS HELPING PATIENTS

# MEDICAL CANNABIS DISPENSING COLLECTIVES AND LOCAL REGULATION



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# MEDICAL CANNABIS DISPENSING COLLECTIVES AND LOCAL REGULATION

2006

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# Americans For Safe Access

AN ORGANIZATION OF MEDICAL PROFESSIONALS, SCIENTISTS AND PATIENTS HELPING PATIENTS

## EXECUTIVE SUMMARY

California's original medical cannabis law, the Compassionate Use Act (Prop. 215), directs local officials to implement ways for qualified patients to access their medicine. With the passage of state legislation (SB 420) in 2003, and the 2005 court ruling in *People v. Urziceanu*, medical cannabis dispensing collectives (or dispensaries) are now recognized as legal entities. Since most of the more than 150,000 cannabis patients in California (NORML 2005 estimate) rely on dispensaries for their medicine, communities across the state are facing requests for business licenses or zoning decisions related to the operation of dispensaries.

Americans for Safe Access, the leading national organization representing the interests of medical cannabis patients and their doctors, has undertaken a study of the experience of those communities that have dispensary ordinances. The report that follows details those experiences, as related by local officials; it also covers some of the political background and current legal status of dispensaries, outlines important issues to consider in drafting dispensary regulations, and summarizes a recent study by a University of California, Berkeley researcher on the community benefits of dispensaries. In short, this report describes why:

Regulated dispensaries benefit the community by:

- providing access for the most seriously ill and injured

- offering a safer environment for patients than having to buy on the illicit market
- improving the health of patients through social support
- helping patients with other social services, such as food and housing
- having a greater than average customer satisfaction rating for health care

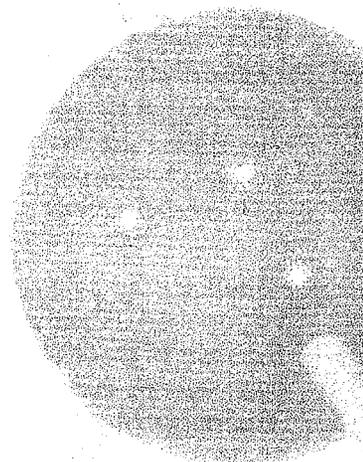
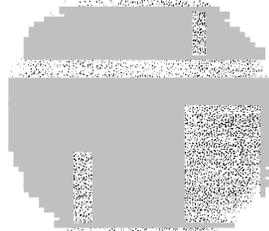
Creating dispensary regulations combats crime because:

- dispensary security reduces crime in the vicinity
- street sales tend to decrease
- patients and operators are vigilant
- any criminal activity gets reported to police

Regulated dispensaries are:

- legal under California state law
- helping revitalize neighborhoods
- bringing new customers to neighboring businesses
- not a source of community complaints

This report concludes with a section outlining the important elements for local officials to consider as they move forward with regulations for dispensaries. ASA has worked successfully with officials in Kern County, Los Angeles, San Francisco and elsewhere to craft ordinances that meet the state's legal requirements, as well as the needs of patients and the larger community. Please contact ASA if you have questions: 888-929-4367.



For more information, see [www.AmericansForSafeAccess.org](http://www.AmericansForSafeAccess.org) or contact the ASA office at 1-888-929-4367 or 510-251-1856.

## OVERVIEW OF MEDICAL CANNABIS DISPENSARIES

*"As the number of patients in the state of California who rely upon medical cannabis for their treatment continues to grow, it is increasingly imperative that cities and counties address the issue of dispensaries in our respective communities. In the city of Oakland we recognized this need and adopted an ordinance which balances patients' need for safe access to treatment while reassuring the community that these dispensaries are run right. A tangential benefit of the dispensaries has been that they have helped to stimulate economic development in the areas where they are located."*

- Desley Brooks, Oakland City Councilmember

### ABOUT THIS REPORT

Land-use decisions are now part of the implementation of California's medical marijuana, or cannabis, laws. As a result, medical cannabis dispensing collectives (dispensaries) are the subject of considerable debate by planning and other local officials. Dispensaries have been operating openly in many communities since the passage of Proposition 215 in 1996. As a compassionate, community-based response to the problems patients face in trying to access cannabis, dispensaries are currently used by more than half of all patients in the state and are essential to those most seriously ill or injured. Since 2003, when the legislature further implemented state law by expressly addressing the issue of patient collectives and compensation for cannabis, more dispensaries have opened and more communities have been faced with questions about business permits and land use options.

In an attempt to clarify the issues involved, Americans for Safe Access has conducted a survey of local officials in addition to continuously tracking regulatory activity throughout the state. ([safeaccessnow.org/regulations](http://safeaccessnow.org/regulations).) The report that follows outlines some of the underlying questions and provides an overview of the experiences of cities and counties around the state. In many parts of California, dispensaries have operated responsibly and provided essential services to the most needy without local intervention, but

city and county officials are also considering how to arrive at the most effective regulations for their community, ones that respect the rights of patients for safe and legal access within the context of the larger community.

### ABOUT AMERICANS FOR SAFE ACCESS

Americans for Safe Access (ASA) is the largest national member-based organization of patients, medical professionals, scientists and concerned citizens promoting safe and legal access to cannabis for therapeutic uses and research. ASA works in partnership with state, local and national legislators to overcome barriers and create policies that improve access to cannabis for patients and researchers. We have more than 30,000 active members with chapters and affiliates in more than 40 states.

### THE NATIONAL POLITICAL LANDSCAPE

A substantial majority of Americans support safe and legal access to medical cannabis. Public opinion polls in every part of the country show majority support cutting across political and demographic lines. Among them, a Time/CNN poll in 2002 showed 80% national support; a survey of AARP members in 2004 showed 72% of older Americans support legal access, with those in the western states polling 82% in favor.

This broad popular consensus, combined with an intransigent federal government which

refuses to acknowledge medical uses for cannabis, has meant that Americans have turned to state-based solutions. The laws voters and legislators have passed are intended to mitigate the effects of the federal government's prohibition on medical cannabis by allowing qualified patients to use it without state or local interference. Beginning with California in **1996**, voters passed initiatives in eight states plus the District of Columbia -- Alaska, Colorado, Maine, Montana, Nevada, Oregon, and Washington. State legislatures followed suit, with elected officials in Hawaii, Maryland, Rhode Island, and Vermont taking action to protect patients from criminal penalty, and the California legislature amending its voter initiative in **2003**.

Momentum for these state-level provisions for compassionate use and safe access has continued to build as more research on the therapeutic uses of cannabis is published. And the public advocacy of well-known cannabis patients such as the Emmy-winning talkshow host Montel Williams has also increased public awareness and created political pressure for compassionate state and local solutions.

Twice in the past decade the US. Supreme Court has taken up the question. In the most recent case, *Gonzales v. Raich*, a split court upheld the ability of federal officials to prosecute patients if they so choose, but did not overturn state laws. In the wake of that decision, the attorneys general of California, Hawaii, Oregon, and Colorado all issued legal opinions or statements reaffirming their state's medical cannabis laws. The duty of state and local law enforcement is to the enforcement and implementation of state, not federal, law.

## HISTORY OF MEDICAL CANNABIS IN CALIFORNIA

Local officials and voters in California have recognized the needs of medical cannabis patients in their communities and have taken action, even before voters made it legal in **1996**. In **1991**, **80%** of San Francisco voters

supported Proposition P, a ballot initiative which recommended a non-enforcement policy for the medical use, cultivation and distribution of marijuana. In **1992**, citing both the interests of their constituency and the endorsement of therapeutic use by the California Medical Association, the San Francisco Board of Supervisors adopted a resolution urging the mayor and district attorney to accept letters from recommending physicians (Resolution No. **141-98**). In **1993**, the Sonoma Board of Supervisors approved a resolution mirroring a Senate Joint Resolution passed earlier that year, noting that a UN committee had called for cannabis to be made available by prescription and calling on "Federal and State representatives to support returning [cannabis] preparations to the list of available medicines which can be prescribed by licensed physicians" (Resolution No. **93-1547**).

Since **1996** when **56%** of California voters approved the Compassionate Use Act (CUA), public support for safe and legal access to medical cannabis has only increased. A statewide Field poll in **2004** found that "three in four voters (**74%**) favors implementation of the law. Voter support for the implementation of Prop. **215** cuts across all partisan, ideological and age subgroups of the state." ([field.com/fieldpollonline/subscribers/RIs2105.pdf](http://field.com/fieldpollonline/subscribers/RIs2105.pdf))

Even before the release of that Field poll, state legislators recognized that there is both strong support among voters for implementing the safe and legal access promised by the Compassionate Use Act (CUA) and little direction as to how local officials should proceed. This led to the drafting and passage of Senate Bill **420** in **2003**, which amended the CUA to spell out more clearly the obligations of local officials for implementation.

## WHAT IS A CANNABIS DISPENSARY?

The majority of medical marijuana (cannabis) patients cannot cultivate their medicine for themselves or find a caregiver to grow it for them. Most of California's estimated **200,000** patients obtain their medicine from a Medical

Cannabis Dispensing Collective (MCDC), often referred to as a "dispensary." Dispensaries are typically storefront facilities that provide medical cannabis and other services to patients in need. There are more than 200 dispensaries operating in California as of August 2006. Dispensaries operate with a closed membership that allow only patients and caregivers to obtain cannabis and only after membership is approved (upon verification of patient documentation). Many dispensaries offer on-site consumption, providing a safe and comfortable place where patients can medicate. An increasing number of dispensaries offer additional services for their patient membership, including such services as: massage, acupuncture, legal trainings, free meals, or counseling. Research on the social benefits for patients is discussed in the last section of this report.

### **RATIONALE FOR CANNABIS DISPENSARIES**

While the Compassionate Use Act does not explicitly discuss medical cannabis dispensaries, it calls for the federal and state governments to "implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana." (Health & Safety Code § 11362.5) This portion of the law has been the basis for the development of compassionate, community-based systems of access for patients in various parts of California. In some cases, that has meant the creation of patient-run growing collectives that allow those with cultivation expertise to help other patients obtain medicine. In most cases, particularly in urban settings, that has meant the establishment of medical cannabis dispensing collectives, or dispensaries. These dispensaries are typically organized and run by groups of patients and their caregivers in a collective model of patient-directed health care that is becoming a model for the delivery of other health services.

### **MEDICAL CANNABIS DISPENSARIES ARE LEGAL UNDER STATE LAW**

In an effort to clarify the voter initiative of 1996 and aid in its implementation across the

state, the California legislature enacted Senate Bill 420 in 2004, which expressly states that qualified patients and primary caregivers may collectively or cooperatively cultivate cannabis for medical purposes (Cal. Health & Safety Code section 11362.775). This provision has been interpreted by the courts to mean that dispensing collectives, where patients may buy their medicine, are legal entities under state law. California's Third District Court of Appeal affirmed the legality of collectives and cooperatives in 2005 in the case of *People v. Urziceanu*, which held that SB 420, which the court called the Medical Marijuana Program Act (MMPA), provides collectives and cooperatives a defense to marijuana distribution charges. Drawing from the Compassionate Use Act's directive to implement a plan for the safe and affordable distribution of medical marijuana, the court found that the MMPA and its legalization of collectives and cooperatives represented the state government's initial response to this mandate. By expressly providing for reimbursement for marijuana and services in connection with collectives and cooperatives, the Legislature has abrogated earlier cases, such as *Trippett*, *Peron*, and *Young*, and established a new defense for those **who** form and operate collectives and cooperatives to dispense marijuana. (See *People v. Urziceanu* (2005) 132 Cal.App.4th 747, 33 Cal.Rptr.2d 859, 881.)

This new case law parallels the interpretation of SB 420 provided to the League of Cities last year by Berkeley Assistant City Attorney Matthew J. Orebic, in his presentation "Medical Marijuana: The conflict between California and federal law and its effect on local law enforcement and ordinances." As he states in that report:

In the 2004 legislation, Section 11362.775 ... expressly allow[s] medical marijuana to be cultivated collectively by qualified patients and primary caregivers, and by necessary implication, distributed among the collective's members... Under the collective model, qualified patients who are unwilling or unable to cultivate marijuana

on their own can still have access to marijuana by joining together with other qualified patients to form a collective.

Orebic also notes that the law allows for those involved to "receive reimbursement for services rendered in supplying the patient with medical marijuana."

## **WHY PATIENTS NEED CONVENIENT DISPENSARIES**

While some patients with long-term illnesses or injuries have the time, space, and skill to cultivate their own cannabis, the majority in the state, particularly those in urban settings, do not have the ability to provide for themselves. For those patients, dispensaries are the only option for safe and legal access. This is all the more true for those individuals who are suffering from a sudden, acute injury or illness.

Many of the most serious and debilitating injuries and illnesses require immediate relief. A cancer patient, for instance, who has just begun chemotherapy will typically need immediate access for help with nausea, which is why a Harvard study found that 45% of oncologists were already recommending cannabis to their patients, even before it had been made legal in any state. It is unreasonable to exclude those patients most in need simply because they are incapable of gardening or cannot wait months for relief.

## **WHAT COMMUNITIES ARE DOING TO HELP PATIENTS**

Many communities in California have recognized the essential service that dispensaries provide and have either tacitly allowed their creation or, more recently, created ordinances or regulations for their operation. Dispensary regulation is one way in which the city can exert local control over the policy issue and ensure the needs of patients and the community at large are being met. As of August 2006, twenty-six cities and seven counties have enacted regulations, and many more are considering doing so soon. See appendix D.)

Officials recognize their duty to implement state laws, even in instances when they may not have previously supported medical cannabis legislation. Duke Martin, mayor pro tem of Ridgecrest said during a city council hearing on their local dispensary ordinance, "it's something that's the law, and I will uphold the law."

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**" Because they are under strict city regulation, there is less likelihood of theft or violence and less opposition from angry neighbors. It is no longer a controversial issue in our city."**

**-Mike Rotkin, Santa Cruz**

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This understanding of civic obligation was echoed at the Ridgecrest hearing by Councilmember Ron Carter, who said, "I want to make sure everything is legitimate and above board. It's legal. It's not something we can stop, but we can have an ordinance of regulations."

Similarly, Whittier Planning Commissioner RD. McDonnell spoke publicly of the benefits of dispensary regulations at a city government hearing. "It provides us with reasonable protections," he said. "But at the same time provides the opportunity for the legitimate operations."

Whittier officials discussed the possibility of an outright ban on dispensary operations, but Greg Nordback said, "It was the opinion of our city attorney that you can't ban them; it's against the law. You have to come up with an area they can be in." Whittier passed its dispensary ordinance in December 2005.

Placerville Police Chief George Nielson commented that, "The issue of medical marijuana continues to be somewhat controversial in our community, as I suspect and hear it remains in other California communities. The issue of 'safe access' is important to some and not to others. There was some objection to the dispensary ordinance, but I would say it was a vocal minority on the issue."

# IMPACT OF DISPENSARIES AND REGULATORY ORDINANCES ON COMMUNITIES IN CALIFORNIA

## DISPENSARIES REDUCE CRIME AND IMPROVE PUBLIC SAFETY

Some reports have suggested that dispensaries are magnets for criminal activity or other behavior that is a problem for the community, but the experience of those cities with dispensary regulations says otherwise. Crime statistics and the accounts of local officials surveyed by ASA indicate that crime is actually reduced by the presence of a dispensary. And complaints from citizens and surrounding businesses are either negligible or are significantly reduced with the implementation of local regulations.

This trend has led multiple cities and counties to consider regulation as a solution. Kern County, which passed a dispensary ordinance in July 2006, is a case in point. The sheriff there noted in his staff report that "regulatory oversight at the local levels helps prevent crime directly and indirectly related to illegal operations occurring under the pretense and protection of state laws authorizing Medical Marijuana Dispensaries." Although dispensary-related crime has not been a problem for the county, the regulations will help law enforcement determine the legitimacy of dispensaries and their patients.

The sheriff specifically pointed out that, "existing dispensaries have not caused noticeable law enforcement of secondary effects and problems for at least one year. As a result, the focus of the proposed Ordinance is narrowed to insure Dispensary compliance with the law" (Kern County Staff Report, Proposed Ordinance Regulating Medical Cannabis Dispensaries, July 11, 2006).

The presence of a dispensary in the neighborhood can actually improve public safety and reduce crime. Most dispensaries take security

for their members and staff more seriously than many businesses. Security cameras are often used both inside and outside the premises, and security guards are often employed to ensure safety. Both cameras and security guards serve as a general deterrent to criminal activity and other problems on the street. Those likely to engage in such activities will tend to move to a less-monitored area, thereby ensuring a safe environment not only for dispensary members and staff but also for neighbors and businesses in the surrounding area.

Residents in areas surrounding dispensaries have reported improvements to the neighborhood. Kirk C, a long time San Francisco resident, commented at a city hearing, "I have lived in the same apartment along the Divisadero corridor in San Francisco for the past five years. Each store that has opened in my neighborhood has been nicer, with many new restaurants quickly becoming some of the city's hottest spots. My neighborhood's crime and vandalism seems to be going down year after year. It strikes me that the dispensaries have been a vital part of the improvement that is going on in my neighborhood."

Oakland's city administrator for the ordinance regulating dispensaries, Barbara Killey, notes that "The areas around the dispensaries may be some of the most safest areas of Oakland now because of the level of security, surveillance, etc.. since the ordinance passed."

Likewise, Santa Rosa Mayor Jane Bender noted that since the city passed its ordinance, there appears to be "a decrease in criminal activity. There certainly has been a decrease in complaints. The city attorney says there have been no complaints either from citizens nor from neighboring businesses."

Those dispensaries that go through the permitting process or otherwise comply with local ordinances tend, by their very nature, to be those most interested in meeting community standards and being good neighbors. Cities enacting ordinances for the operation of dispensaries may even require security measures, but it is a matter of good business practice for dispensary operators since it is in their own best interest. Many local officials surveyed by ASA said dispensaries operating in their communities have presented no problems, or what problems there may have been significantly diminished once an ordinance or other regulation was instituted.

Mike Rotkin, fifth-term councilmember and former four-term mayor in the City of Santa Cruz, says about his city's dispensary, "It provides a legal (under State law) service for people in medical need. Because it is well run and well regulated and located in an area acceptable to the City, it gets cooperation from the local police. Because they are under strict city regulation, there is less likelihood of theft or violence and less opposition from angry neighbors. It is no longer a controversial issue in our city."

Regarding the decrease in complaints about existing dispensaries, several officials said that ordinances significantly improved relations with other businesses and the community at large. An Oakland city council staff member noted that they, "had gotten reports of break ins. That kind of activity has stopped. That danger has been eliminated."

### **WHY DIVERSION OF MEDICAL CANNABIS IS TYPICALLY NOT A PROBLEM**

One of the concerns of public officials is that dispensaries make possible or even encourage the resale of cannabis on the street. But the experience of those cities which have instituted ordinances is that such problems, which are rare in the first place, quickly disappear. In addition to the ease for law enforcement of monitoring openly operating facilities, dispensaries universally have strict rules about how

members are to behave in and around the dispensary. Many have "good neighbor" trainings for their members that emphasize sensitivity to the concerns of neighbors, and all absolutely prohibit the resale of cannabis to anyone. Anyone violating that prohibition is typically banned from any further contact with the dispensary.

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"The areas around the dispensaries may be some of the most safest areas of Oakland now because of the level of security, surveillance, etc. since the ordinance passed."

-Barbara Killey, Oakland

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As Oakland's city administrator for the regulatory ordinance explains, "dispensaries themselves have been very good at self policing against resale because they understand they can lose their permit if their patients resell."

In the event of street or other resale, local law enforcement has at its disposal all the many legal penalties the state provides. This all adds up to a safer street environment with fewer drug-related problems than before dispensary operations were permitted in the area. The experience of the City of Oakland is a good example of this phenomenon. The city's legislative analyst, Lupe Schoenberger, stated that, "...[P]eople feel safer when they're walking down the street. The level of marijuana street sales has significantly reduced."

Dispensaries operating with the permission of the city are also more likely to appropriately utilize law enforcement resources themselves, reporting any crimes directly to the appropriate agencies. And, again, dispensary operators and their patient members tend to be more safety conscious than the general public, resulting in great vigilance and better preemptive measures. The reduction in crime in areas with dispensaries has been reported anecdotally by law enforcement in several communities.

## DISPENSARIES CAN BE GOOD NEIGHBORS

Medical cannabis dispensing collectives are typically positive additions to the neighborhoods in which they locate, bringing additional customers to neighboring businesses and reducing crime in the immediate area.

Like any new business that serves a different customer base than the existing businesses in the area, dispensaries increase the revenue of other businesses in the surrounding area simply because new people are coming to access services, increasing foot traffic past other establishments. In many communities, the opening of a dispensary has helped revitalize an area. While patients tend to opt for dispensaries that are close and convenient, particularly since travel can be difficult, many patients will travel to dispensary locations in parts of town they would not otherwise visit. Even if patients are not immediately utilizing the services or purchasing the goods offered by neighboring businesses, they are more likely to eventually patronize those businesses because of convenience.

ASA's survey of officials whose cities have passed dispensary regulations found that the vast majority of businesses adjoining or near dispensaries had reported no problems associated with a dispensary opening after the implementation of regulation.

Kriss Worthington, longtime councilmember in Berkeley, said in support of a dispensary there, "They have been a responsible neighbor and vital organization to our diverse community. Since their opening, they have done an outstanding job keeping the building clean, neat, organized and safe. In fact, we have had no calls from neighbors complaining about them, which is a sign of respect from the community. In Berkeley, even average restaurants and stores have complaints from neighbors."

Mike Rotkin, fifth term councilmember and former four term mayor in the City of Santa Cruz said about the dispensary that opened there last year, "The immediately neighboring businesses have been uniformly supportive or neutral. There have been no complaints either

about establishing it or running it."

Mark Keilty, Planning and Building director of Tulare, when asked if the existence of dispensaries affected local business, said they had "no effect or at least no one has complained."

And Dave Turner, mayor of Fort Bragg, noted that before the passage of regulations there were "plenty of complaints from both neighboring businesses and concerned citizens," but since then, it is no longer a problem. Public officials understand that, when it comes to dispensaries, they must balance both the humanitarian needs of patients and the concerns of the public, especially those of neighboring residents and business owners.

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"Dispensaries themselves have been very good at self policing against resale because they understand they can lose their permit if their patients resell." -Barbara Killey, Oakland

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Oakland City Councilmember Nancy J. Nadel wrote in an open letter to her fellow colleagues across the state, "Local government has a responsibility to the medical needs of its people, even when it's not a politically easy choice to make. We have found it possible to build regulations that address the concerns of neighbors, local businesses law enforcement and the general public, while not compromising the needs of the patients themselves. We've found that by working with all interested parties in advance of adopting an ordinance while keeping the patients' needs foremost, problems that may seem inevitable never arise."

Mike Rotkin of Santa Cruz stated that since Santa Cruz enacted an ordinance for dispensary operations, "Things have calmed down. The police are happy with the ordinance, and that has made things a lot easier. I think the fact that we took the time to give people who wrote us respectful and detailed explanations of what we were doing and why made a real difference."

## BENEFITS OF DISPENSARIES TO THE PATIENT COMMUNITY

### DISPENSARIES PROVIDE MANY BENEFITS TO THE SICK AND SUFFERING

Safe and legal access to cannabis is the reason dispensaries have been created by patients and caregivers around the state. For many people, dispensaries remove significant barriers to their ability to obtain cannabis. Patients in urban areas with no space to cultivate cannabis, those without the requisite gardening skills to grow their own, and, most critically, those who face the sudden onset of a serious illness or who have suffered a catastrophic illness - all tend to rely on dispensaries as a compassionate, community-based solution that is an alternative to potentially dangerous illicit market transactions.

Many elected officials around the state recognize the importance of dispensaries for their constituents. As Nathan Miley, former Oakland City councilmember and now Alameda County supervisor said in a letter to his colleagues, "When designing regulations, it is crucial to remember that at its core this is a healthcare issue, requiring the involvement and leadership of local departments of public health. A pro-active healthcare-based approach can effectively address problems before they arise, and communities can design methods for safe, legal access to medical marijuana while keeping the patients' needs foremost."

Likewise, Abbe Land, mayor of West Hollywood says safe access is "very important" and long-time councilmember John Duran agreed, adding, "We have a very high number of HIV-positive residents in our area. Some of them require medical marijuana to offset the medications they take for HIV." Jane Bender, mayor of Santa Rosa, says, "There are legitimate patients in our community, and I'm glad they have a safe means of

obtaining their medicine."

Oakland's city administrator for ordinances, said safe access to cannabis is "very important" for the community. "In the finding the council made to justify the ordinance, they say 'have safe and affordable access'."

And Mike Rotkin, the longtime Santa Cruz elected official, said that this is also an important matter for his city's citizens: "The council considers it a high priority and has taken considerable heat to speak out and act on the issue."

It was a similar decision of social conscience that led to Placerville's city council putting a regulatory ordinance in place. Councilmember Marian Washburn told her colleagues that "as you get older, you know people with diseases who suffer terribly, so that is probably what I get down to after considering all the other components."

While dispensaries provide a unique way for patients to obtain the cannabis their doctors have recommended, they typically offer far more that is of benefit to the health and welfare of those suffering both chronic and acute medical problems.

Dispensaries are often called "clubs" in part because many of them offer far more than a clinical setting for obtaining cannabis. Recognizing the isolation that many seriously ill and injured people experience, many dispensary operators chose to offer a wider array of social services, including everything from a place to congregate and socialize to help with finding housing and meals. The social support patients receive in these settings has far-reaching benefits that is also influencing the development of other patient-based care models.

## RESEARCH SUPPORTS THE DISPENSARY MODEL

A 2006 study by Amanda Reiman, Ph.D. of the School of Social Welfare at the University of California, Berkeley examined the experience of 130 patients spread among seven different dispensaries in the San Francisco Bay Area. Dr. Reiman's study cataloged the patients' demographic information, health status, consumer satisfaction, and use of services, while also considering the dispensaries' environment, staff, and services offered. The study found that "medical cannabis patients have created a system of dispensing medical cannabis that also includes services such as counseling, entertainment and support groups, all important components of coping with chronic illness." She also found that levels of satisfaction with the care received at dispensaries ranked significantly higher than those reported for health care nationally.

Patients who use the dispensaries studied uniformly reported being well satisfied with the services they received, giving an 80% satisfaction rating. The most important factors for patients in choosing a medical cannabis dispensary were: feeling comfortable and secure, familiarity with the dispensary, and having a rapport with the staff. In their comments, patients tended to note the helpfulness and kindness of staff and the support found in the presence of other patients.

Patients in Dr. Reiman's study frequently cited their relationships with staff as a positive factor. Comments from six different dispensaries include:

"I love this spot because of the love they give, always! They treat everyone like a family loved one!"

"This particular establishment is very friendly for the most part and very convenient for me."

"The staff and patients are like family to me!"

"The staff are warm and respectful."

"The staff at this facility are always cordial

and very friendly. I enjoy coming."

"This is the friendliest dispensary that I have ever been to and the staff is always warm and open. That's why I keep coming to this place. The selection is always wide."

## MANY DISPENSARIES PROVIDE KEY SOCIAL SERVICES

Dispensaries offer many cannabis-related services that patients cannot otherwise obtain. Among them is an array of cannabis varieties, some of which are more useful for certain afflictions than others, and staff awareness of what types of cannabis other patients report to be helpful. In other words, one variety of cannabis may be effective for pain control while another may be better for combating nausea. Dispensaries allow for the pooling of information about these differences and the opportunity to access the type of cannabis likely to be most beneficial.

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"There are legitimate patients in our community, and I'm glad they have a safe means of obtaining their medicine."

-Jane Bender, Santa Rosa

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Other cannabis-related services include the availability of cannabis products in other forms than the smokeable ones. While most patients prefer to have the ability to modulate dosing that smoking easily allows, for others, the effects of edible cannabis products are preferable. Dispensaries typically offer edible products such as brownies or cookies for those purposes. Many dispensaries also offer classes on how to grow your own cannabis, classes on legal matters, trainings for health-care advocacy, and other seminars.

Beyond providing safe and legal access to cannabis, the dispensaries studied also offer important social services to patients, including counseling, help with housing and meals, hospice and other care referrals, and, in one case,

even doggie daycare for members who have doctor appointments or work commitments. Among the broader services the study found in dispensaries are support groups, including groups for women, veterans, and men; creativity and art groups, including groups for writers, quilters, crochet, and crafts; and entertainment options, including bingo, open mike nights, poetry readings, internet access, libraries, and puzzles. Clothing drives and neighborhood parties are among the activities that patients can also participate in through their dispensary.

Social services such as counseling and support groups were reported to be the most commonly and regularly used service, with two-thirds of patients reporting that they use social services at dispensaries 1-2 times per week. Also, life services, such as free food and housing help, were used at least once or twice a week by 22% of those surveyed.

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"Local government has a responsibility to the medical needs of its people, even when it's not a politically easy choice to make. We have found it possible to build regulations that address the concerns of neighbors, local businesses law enforcement and the general public, while not compromising the needs of the patients themselves. We've found that by working with all interested parties in advance of adopting an ordinance while keeping the patients' needs foremost, problems that may seem inevitable never arise." -Nancy Nadel, Oakland

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Dispensaries offer chronically ill patients even more than safe and legal access to cannabis and an array of social services. The study found that dispensaries also provided other social benefits for the chronically ill, an important part of the bigger picture:

[T]he multiple services provided by the

social model are only part of the culture of social club facility. Another component of this model ... is the possible benefit that social support has for one diagnosed with a chronic and/or terminal physical or psychological illness. Beyond the support that medical cannabis patients receive from services is the support received from fellow patients, some of whom are experiencing the same or similar physical/psychological symptoms.... It is possible that the mental health benefits from the social support of fellow patients is an important part of the healing process, separate from the medicinal value of the cannabis itself.

Several researchers and physicians who have studied the issue of the patient experience with dispensaries have concluded that there are other important positive effects stemming from a dispensary model that includes a component of social support groups.

Dr. Reiman notes that, "support groups may have the ability to address issues besides the illness itself that might contribute to long-term physical and emotional health outcomes, such as the prevalence of depression among the chronically ill."

For those who suffer the most serious illness, such as HIV/AIDS and terminal cancer, these groups of like-minded people with similar conditions can also help patients through the grieving process. Other research into the patient experience has found that many patients have lost or are losing friends and partners to terminal illness. These patients report finding solace with other patients who are also grieving or facing end-of-life decisions. A medical study published in 1998 concluded that the patient-to-patient contact associated with the social club model was the best therapeutic setting for ill people.

## CONCLUSION

Dispensaries are proving to be an asset to the communities they serve, as well as the larger community within which they operate.

ASA's survey of local officials and monitoring of regulatory activity throughout the State of California has shown that, once working regulatory ordinances are in place, dispensaries are typically viewed favorably by public officials, neighbors, businesses, and the community at large, and that regulatory ordinances can and do improve an area, both socially and economically.

Dispensaries - now expressly legal under California state law - are helping revitalize neighborhoods by reducing crime and bringing new customers to surrounding businesses. They improve public safety by increasing the security presence in neighborhoods, reducing illicit market marijuana sales, and ensuring that any criminal activity gets reported to the appropriate law enforcement authorities.

More importantly, dispensaries benefit the community by providing safe access for those who have the greatest difficulty getting the

medicine their doctors recommend: the most seriously ill and injured. Many dispensaries also offer essential services to patients, such as help with food and housing.

Medical and public health studies have also shown that the social-club model of most dispensaries is of significant benefit to the overall health of patients. The result is that cannabis patients rate their satisfaction with dispensaries as far greater than the customer-satisfaction ratings given to health care agencies in general.

Public officials across the state, in both urban and rural communities where dispensary regulatory ordinances have been adopted, have been outspoken in praise of what. Their comments are consistent on and favorable to the regulatory schemes they enacted and the benefits to the patients and others living in their communities.

**As** a compassionate, community-based response to the medical needs of more than 150,000 sick and suffering Californians, dispensaries are working.

# APPENDIX A

## RECOMMENDATIONS ON DISPENSARY REGULATIONS

Cannabis dispensaries have been operating successfully around California for a decade with very few problems. But since the legislature and courts have acted to make their legality a matter of state law more than local tolerance, the question of how to implement appropriate zoning and business licensing is coming before local officials all across the state. What follows are recommendations on matters to consider, based on adopted code as well as ASA's extensive experience working with community leaders and elected officials.

## COMMUNITY OVERSIGHT

In order to appropriately resolve conflict in the community and establish a process by which complaints and concerns can be reviewed, it can often be helpful to create a community oversight committee. Such committees, if fair and balanced, can provide a means for the voices of all affected parties to be heard, and to quickly resolve problems.

The Ukiah City Council created such a task force in 2005; what follows is how they defined the group:

The Ukiah Medical Marijuana Review and Oversight Commission shall consist of seven members nominated and appointed pursuant to this section. The Mayor shall nominate three members to the commission, and the City Council shall appoint, by motion, four other members to the commission. Each nomination of the Mayor shall be subject to approval by the City Council, and shall be the subject of a public hearing and vote within 40 days. If the City Council fails to act on a mayoral nomination within 40 days of the date

the nomination is transmitted to the Clerk of the City Council, the nominee shall be deemed approved. Appointments to the commission shall become effective on the date the City Council adopts a motion approving the nomination or on the 41st day following the date the mayoral nomination was transmitted to the Clerk of the City Council if the City Council fails to act upon the nomination prior to such date.

Of the three members nominated by the Mayor, the Mayor shall nominate one member to represent the interests of City neighborhood associations or groups, one member to represent the interests of medical marijuana patients, and one member to represent the interests of the law enforcement community.

Of the four members of the commission appointed by the City Council, two members shall represent the interests of City neighborhood associations or groups, one member shall represent the interests of the medical marijuana community, and one member shall represent the interests of the public health community.

## DISPENSARIES REGULATIONS ARE BEST HANDLED THROUGH THE HEALTH OR PLANNING DEPARTMENTS, NOT LAW ENFORCEMENT AGENCIES

**Reason:** To ensure that qualified patients, caregivers, and dispensaries are protected, general regulatory oversight duties - including permitting, record maintenance and related protocols - should be the responsibility of the local department of public health (DPH) or planning department. Given the statutory mission and responsibilities of DPH, it is the

natural choice and best-suited agency to address the regulation of medical cannabis dispensing collectives. Law enforcement agencies are ill-suited for handling such matters, having little or no expertise in health and medical affairs.

**Examples of responsible agencies and officials:**

- Angels Camp - City Administrator
- Atascadero - Planning Commission
- Citrus Heights - City Manager
- Los Angeles - Planning Department
- Plymouth - City Administrator
- San Francisco - Department of Public Health
- Selma - City Manager
- Visalia - City Planner

**ARBITRARY CAPS ON THE NUMBER OF DISPENSARIES CAN BE COUNTER-PRODUCTIVE**

**Reason:** Policymakers do not need to set arbitrary limitations on the number of dispensing collectives allowed to operate because, as with other services, competitive market forces and consumer choice will be decisive. Dispensaries which provide quality care and patient services to their memberships will flourish, while those that do not will fail.

Capping the number of dispensaries limits consumer choice, which can result in both decreased quality of care and less affordable medicine. Limiting the number of dispensing collectives allowed to operate may also force patients with limited mobility to travel farther for access than they would otherwise need to.

Artificially limiting the supply for patients can result in an inability to meet demand, which in turn may lead to such undesirable effects as lines outside of dispensaries, increased prices, and lower quality medicine.

**Examples of cities and counties without numerical caps on dispensaries:**

- Dixon
- Elk Grove
- Fort Bragg

- Placerville
- Ripon
- Selma
- Tulare
- Calaveras County
- Kern County
- Los Angeles County
- City and County of San Francisco.

**RESTRICTIONS ON WHERE DISPENSARIES CAN LOCATE ARE OFTEN UNNECESSARY AND CAN CREATE BARRIERS TO ACCESS**

**Reason:** As described in this report, regulated dispensaries do not generally increase crime or bring other harm to their neighborhoods, regardless of where they are located. And since for many patients travel is difficult, cities and counties should take care to avoid unnecessary restrictions on where dispensaries can locate. Patients benefit from dispensaries being convenient and accessible, especially if the patients are disabled or have conditions that limit their mobility.

It is unnecessary and burdensome for patients and dispensaries, to restrict dispensaries to industrial corners, far away from public transit and other services. Depending on a city's population density, it can also be extremely detrimental to set excessive proximity restrictions (to schools or other facilities) that can make it impossible for dispensaries to locate anywhere within the city limits. It is important to balance patient needs with neighborhood concerns in this process.

**PATIENTS BENEFIT FROM ON-SITE CONSUMPTION AND PROPER VENTILATION SYSTEMS**

**Reason:** Dispensaries that allow members to consume medicine on-site have positive psychosocial health benefits for chronically ill people who are otherwise isolated. On-site consumption encourages dispensary members to take advantage of the support services that improve patients' quality of life and, in some cases, even prolong it. Researchers have shown that support groups like those offered

by dispensaries are effective for patients with a variety of serious illnesses. Participants active in support services are less anxious and depressed, make better use of their time and are more likely to return to work than patients who receive only standardized care, regardless of whether they have serious psychiatric symptoms. On-site consumption is also important for patients who face restrictions to off-site consumption, such as those in subsidized or other housing arrangements that prohibit smoking. In addition, on-site consumption provides an opportunity for patients to share information about effective use of cannabis and to use specialized delivery methods, such as vaporizers, which do not require smoking.

**Examples of localities that permit on-site consumption** (many stipulate ventilation requirements):

- Berkeley
- San Francisco
- Alameda County
- Kern County
- Los Angeles County

#### DIFFERENTIATING DISPENSARIES FROM PRIVATE PATIENT COLLECTIVES IS IMPORTANT

**Reason:** Private patient collectives, in which several patients grow their medicine collectively at a private location, should not be required to follow the same restrictions that are placed on retail dispensaries, since they are a different type of operation. A too-broadly written ordinance may inadvertently put untenable restrictions on individual patients and caregivers who are providing either for themselves or a few others.

**Example:** Santa Rosa's adopted ordinance, provision 10-40.030 (F)

"Medical cannabis dispensing collective," hereinafter "dispensary," shall be construed to include any association, cooperative, affiliation, or collective of persons where multiple "qualified patients" and/or "primary caregivers," are organized to provide education,

referral, or network services, and facilitation or assistance in the lawful, "retail" distribution of medical cannabis. "Dispensary" means any facility or location where the primary purpose is to dispense medical cannabis (i.e., marijuana) as a medication that has been recommended by a physician and where medical cannabis is made available to and/or distributed by or to two or more of the following: a primary caregiver and/or a qualified patient, in strict accordance with California Health and Safety Code Section 11362.5 et seq. A "dispensary" shall not include dispensing by primary caregivers to qualified patients in the following locations and uses, as long as the location of such uses are otherwise regulated by this Code or applicable law: a clinic licensed pursuant to Chapter 1 of Division 2 of the Health and Safety Code, a health care facility licensed pursuant to Chapter 2 of Division 2 of the Health and Safety Code, a residential care facility for persons with chronic life-threatening illness licensed pursuant to Chapter 3.01 of Division 2 of the Health and Safety Code, residential care facility for the elderly licensed pursuant to Chapter 3.2 of Division 2 of the Health and Safety Code, a residential hospice, or a home health agency licensed pursuant to Chapter 8 of Division 2 of the Health and Safety Code, as long as any such use complies strictly with applicable law including, but not limited to, Health and Safety Code Section 11362.5 et seq., or a qualified patient's or caregiver's place of residence.

#### PATIENTS BENEFIT FROM ACCESS TO EDIBLES AND MEDICAL CANNABIS CONSUMPTION DEVICES

**Reason:** Not all patients smoke cannabis. Many find tinctures (cannabis extracts) or edibles (such as baked goods containing cannabis) to be more effective for their conditions. Allowing dispensaries to carry these items is important to patients getting the best level of care possible. For patients who have existing respiration problems or who otherwise have an aversion to smoking, edibles are

essential. Conversely, for patients who do choose to smoke or vaporize, they need to procure the tools to do so. Prohibiting dispensaries from carrying medical cannabis consumption devices, often referred to as paraphernalia, forces patients to go elsewhere to procure these items. Additionally, when dispensaries do carry these devices, informed dispensary staff can explain their usage to new patients.

**Examples of localities allowing dispensaries to carry edibles and delivery devices:**

- Angels Camp
- Berkeley
- Citrus Heights
- Santa Cruz
- Sutter Creek
- West Hollywood
- Alameda County
- Kern County
- Los Angeles County.

## APPENDIX B

### MEDICAL CANNABIS DISPENSARY ORDINANCE EVALUATION SURVEY QUESTIONS

1. What is your name and position?
2. How important is safe access to medical marijuana in your community?
3. On what date did your city/county pass its ordinance?
4. Were there medical cannabis dispensaries in your district before the ordinance? How many?
5. If any, were there any complaints against them before the ordinance was passed? If yes, who made the complaints? What were the specific complaints that were made? How frequently were complaints made?
6. Were there any objections to passing an ordinance to regulate medical cannabis dispensaries?
7. If so, what were the primary objections? Who were the main objectors?
8. Has the ordinance implementation allayed or amplified those concerns?
9. How many medical cannabis dispensaries are there now? What is the estimated population of the area that may utilize them? Do you think the current number of dispensaries is enough to address the needs of the community?
10. Has there been an increase or decrease in criminal activity related to dispensaries since the regulations were implemented?
11. How has the ordinance improved the public safety in your community? Has it worsened the public safety? How?
12. Has the existence of dispensaries affected local business? How do neighboring businesses view dispensaries?
13. What would you advocate be changed in the current regulations?
14. Do you have anything else you would like to say in evaluation of the medical cannabis ordinance?

For more information, see [www.AmericansForSafeAccess.org](http://www.AmericansForSafeAccess.org) or contact the ASA office at 1-888-929-4367 or 510-251-1856.

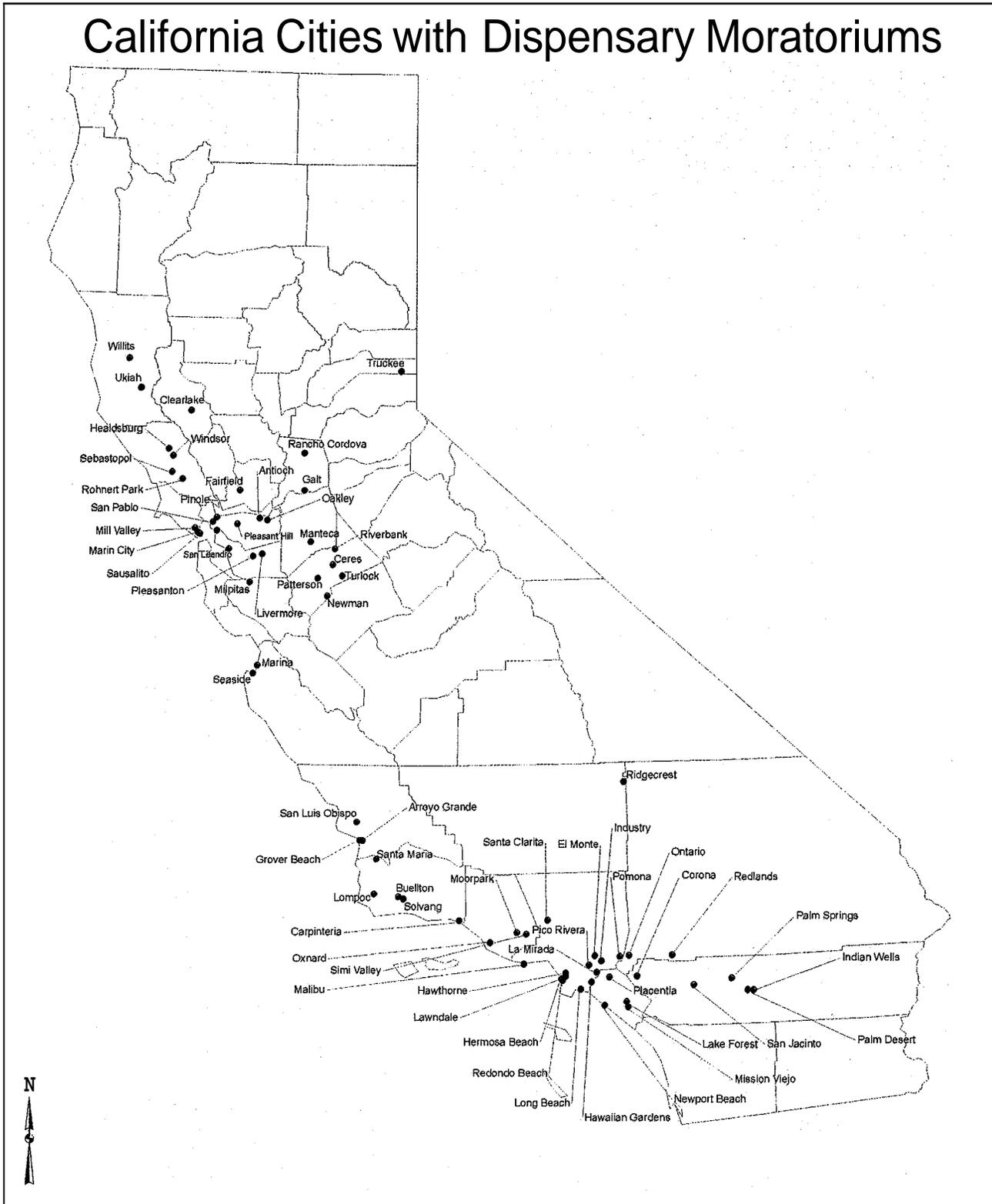
# APPENDIX C

## SURVEY ANSWER AND DATA ANALYSIS Summary

- The majority of responses were positive.
- Safe access is important to every community.
- Complaints of dispensaries generally decrease after regulation.
- Objections to the ordinance were allayed after implementation.
- Regulation improved public safety.
- Crime decreases or shows no effect after regulations
- Most businesses are either supportive of or neutral about neighboring dispensaries.

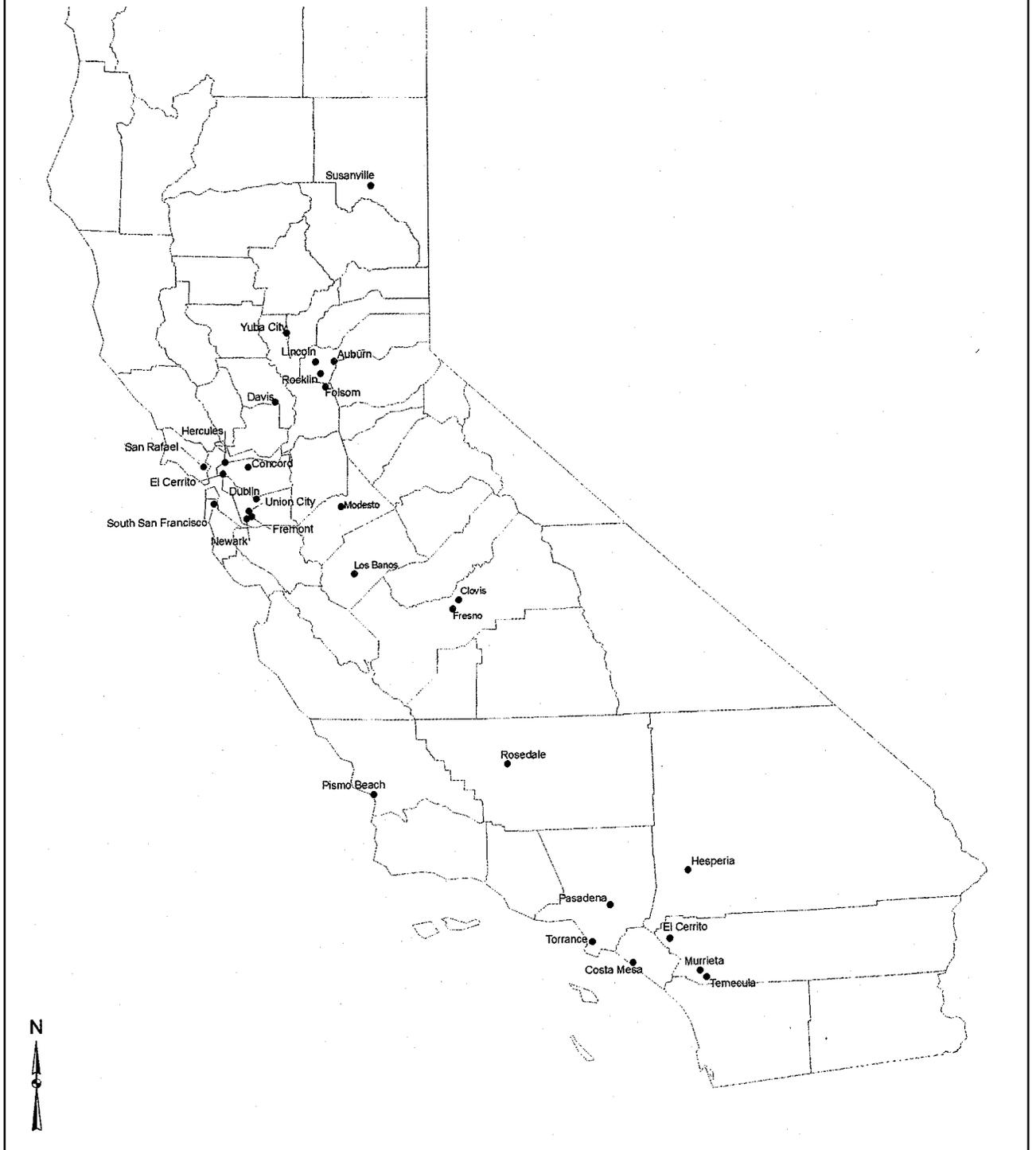
	Safe access important to local community	Dispensaries existed prior to regulation	Complaints of existing dispensaries prior to ordinance	Complaints decreased after passage of ordinance	Community objections to the ordinance	Regulation implementation allayed ordinance objections	Regulation improved public safety	Regulation resulted in decrease of crime around dispensaries	Positive effects on business post-regulation	Responses
<b>Fort Bragg</b>		✓	✓	✓						Yes
	✓									No
					✓	✓	✓	✓	✓	Neutral
<b>Oakland</b>	✓	✓	✓	✓	✓	✓	✓	✓	✓	Yes
										No
										Neutral
<b>Placerville</b>		✓			✓					Yes
										No
	✓		✓	✓		✓	✓	✓	✓	Neutral
<b>San Francisco</b>	✓	✓	✓		✓				✓	Yes
										No
				✓		✓	✓	✓		Neutral
<b>Santa Cruz Santa Cruz</b>	✓	✓	✓	✓	✓	✓	✓	✓	✓	Yes
										No
										Neutral
<b>Santa Rosa</b>	✓	✓	✓	✓	✓	✓	✓	✓		Yes
										No
								✓		Neutral
<b>Tulare</b>	✓	✓			✓					Yes
			✓			✓				No
				✓		✓	✓	✓	✓	Neutral
<b>West Hollywood</b>	✓	✓					✓			Yes
			✓		✓					No
				✓		✓		✓	✓	Neutral

# California Cities with Dispensary Moratoriums



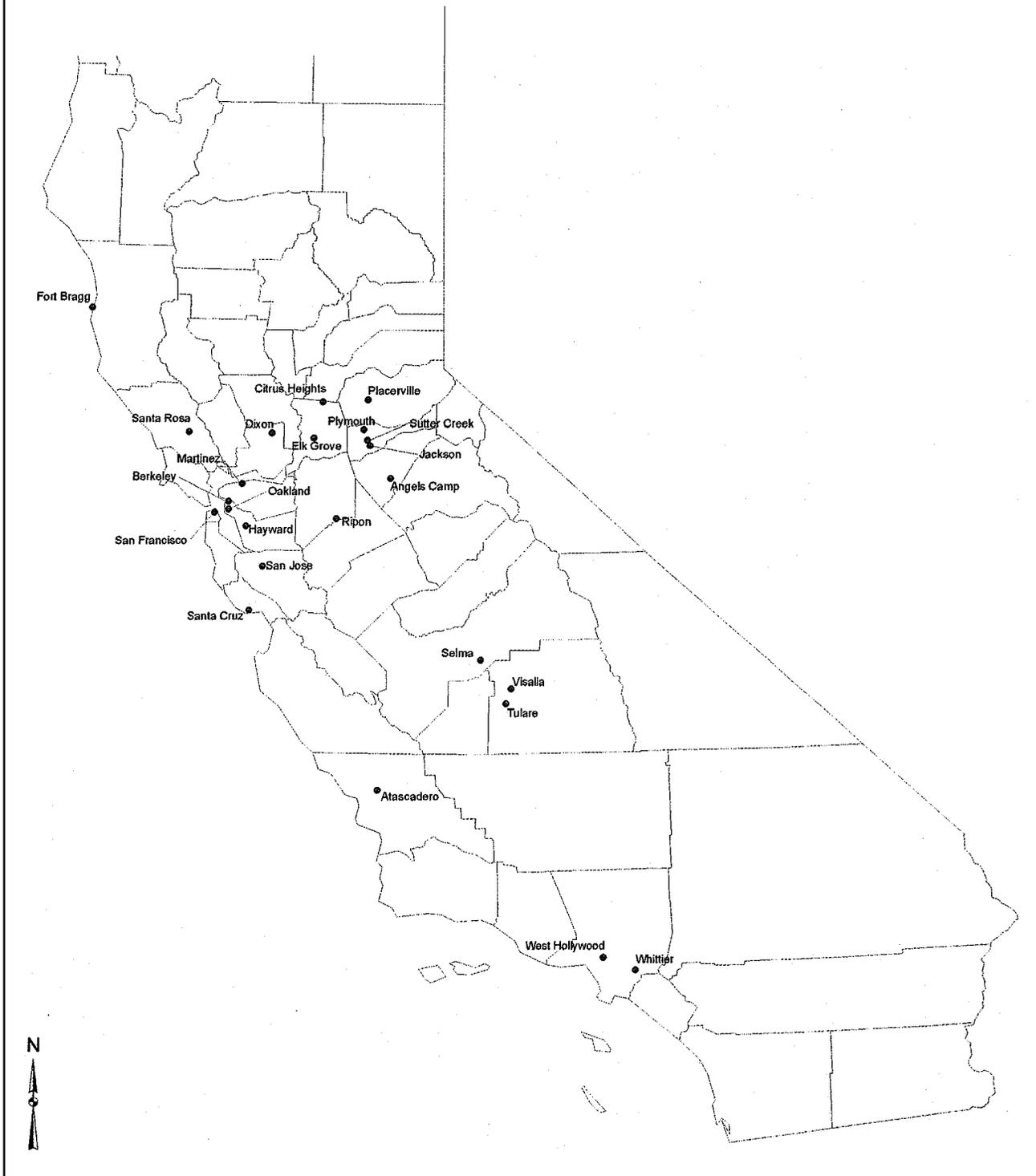
For more information, see [www.AmericansForSafeAccess.org](http://www.AmericansForSafeAccess.org) or contact the ASA office at 1-888-929-4367 or 510-251-1856.

# California Cities with Dispensary Bans



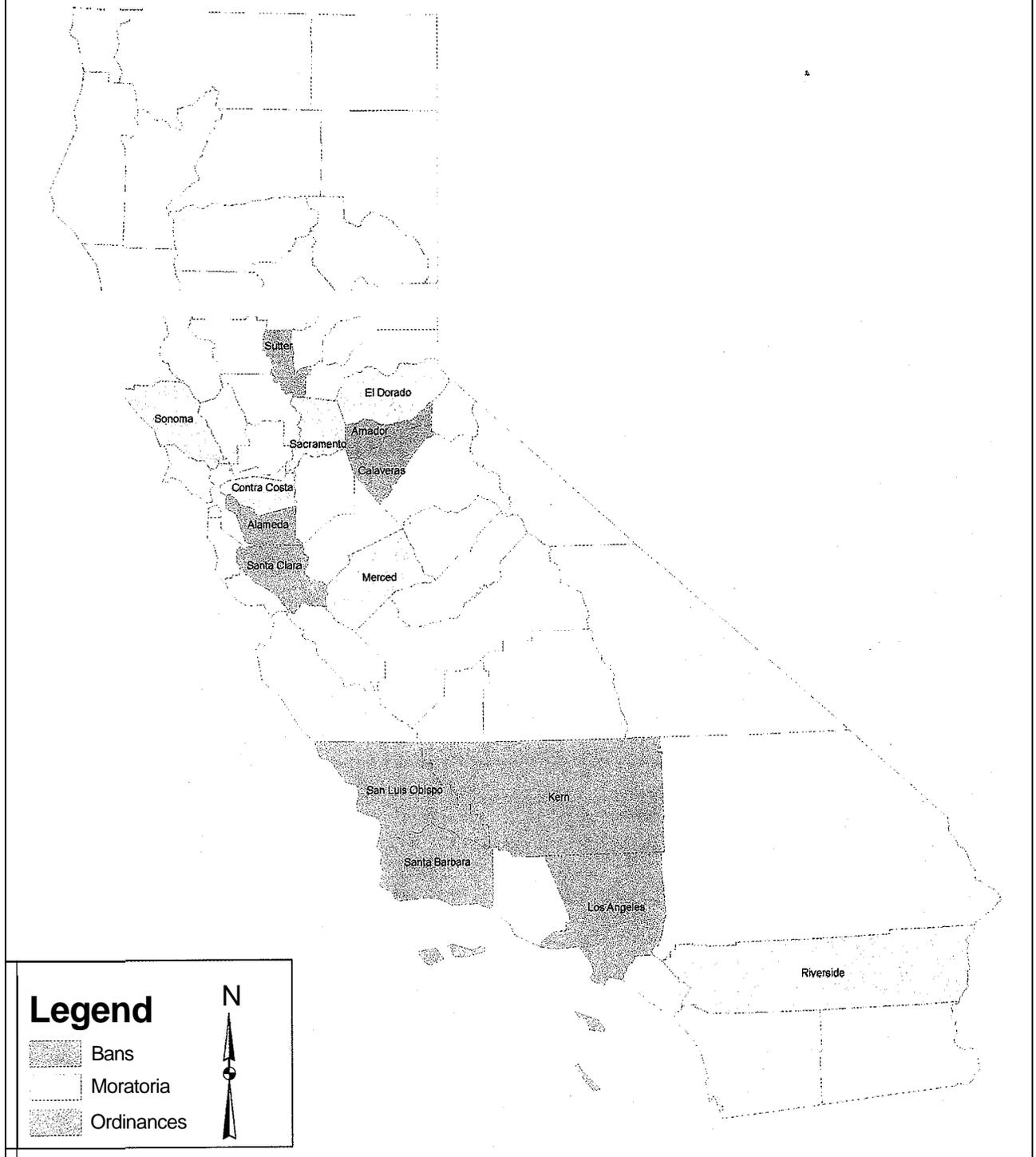
For more information, see [www.AmericansForSafeAccess.org](http://www.AmericansForSafeAccess.org) or contact the ASA office at 1-888-929-4367 or 510-251-1856.

# California Cities Allowing for and Regulating Dispensaries



For more information, see [w.AmericansForSafeAccess.org](http://w.AmericansForSafeAccess.org) or contact the ASA office at 1-888-929-4367 or 510-251-1856.

# California Counties with Moratoriums, Bans and Ordinances



For more information, see [www.AmericansForSafeAccess.org](http://www.AmericansForSafeAccess.org) or contact the ASA office at 1-888-929-4367 or 510-251-1856.



K-3

**Jennifer Perrin**

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**From:** Randi Johl  
**Sent:** Wednesday, April 15, 2009 01:59 PM  
**To:** Jennifer Perrin  
**Subject:** FW: Information for Tonight's Meeting  
**Attachments:** Lodi mmj Laws Letter.pdf

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**From:** Nathan Sands [mailto:nathan@compassionatecoalition.org]  
**Sent:** Wednesday, April 15, 2009 1:31 PM  
**To:** Randi Johl  
**Subject:** Information for Tonight's Meeting

Hello,

I'm writing to submit information regarding the medical marijuana moratorium being discussed at the City Council meeting tonight (item K-3) -I hope this isn't too late!

Attached is a letter that I would like included with this agenda item if possible.

Please let me know if you have any questions.

Thanks,  
Nathan Sands, Vice President  
The Compassionate Coalition  
[www.CompassionateCoalition.org](http://www.CompassionateCoalition.org)  
Email: nathan@CompassionateCoalition.org  
Phone: (916) 709-2483

April 15, 2009

City of Lodi  
221 W. Pine Street  
Lodi, CA 95240



To Whom It May Concern:

I'm writing to provide information regarding California Health & Safety Code 11362.5 and 11362.7 in relation to medical marijuana dispensing collectives. The current discussion is not a debate over the merits of medical marijuana, or our personal opinions about medical marijuana; these debates have already taken place, and the voters unambiguously support the rights of medical marijuana patients. The matter at hand is purely a legal question about California's medical marijuana laws, and municipal authority to regulate distribution of this medicine.

California's Compassionate Use Act, approved by California voters in 1996, created a right for patients to obtain and use medical marijuana with the recommendation of a physician (HSC 11362.5). And in 2003 the California Senate passed Senate Bill 420, which further defined the Compassionate Use Act of 1996 and created guidelines for enforcement of medical marijuana laws (HSC 11362.7-8). These laws specifically permit patients, care providers, or "any individual who provides assistance to a qualified patient" to possess and "collectively or cooperatively" cultivate medical marijuana. Additionally, California's medical marijuana laws allow caregivers to receive "reasonable compensation" for services and expenses incurred in the course of providing medical marijuana to a qualified patient.

In August of 2008 California's Attorney General published guidelines to explain our medical marijuana laws and judicial precedent in this area (*see* attached). Under these guidelines the Attorney General makes it clear that California's Medical Marijuana program "recognizes a qualified right to collective and cooperative cultivation of medical marijuana." This document also provides specific instructions for operating collectives and cooperatives in a lawful manner, and does not identify any authority for municipalities to prohibit such legal operations.

Recently, a few cities and counties have passed ordinances to permanently ban medical marijuana "dispensaries." However, these ordinances would inevitably ban the services provided by medical marijuana caregivers, collectives and cooperatives, and would therefore violate California law and trample upon the rights of medical marijuana patients. Under California law, no city or county has the legal authority to ban, or unreasonably restrict, caregivers, collectives or cooperatives acting in accordance with California Health & Safety Code 11362.5 and 11362.7. Any attempt to do so will directly violate California law, and will be subject to legal action.

The Compassionate Coalition hopes to work with your community in order to help you fully understand the laws relating to medical marijuana patients, and to help develop a fair and reasonable ordinance to regulate medical marijuana distribution. Please contact us with any questions or concerns.

Sincerely,

Nathan Sands  
*Vice President*  
The Compassionate Coalition  
[www.CompassionateCoalition.org](http://www.CompassionateCoalition.org)  
Email: [nathan@CompassionateCoalition.org](mailto:nathan@CompassionateCoalition.org)  
Phone: (916) 709-2483

EDMUND G. BROWN JR.  
Attorney General



*DEPARTMENT OF JUSTICE*  
*State of California*

**GUIDELINES FOR THE SECURITY AND NON-DIVERSION  
OF MARIJUANA GROWN FOR MEDICAL USE**  
*August 2008*

In 1996, California voters approved an initiative that exempted certain patients and their primary caregivers from criminal liability under state law for the possession and cultivation of marijuana. In 2003, the Legislature enacted additional legislation relating to medical marijuana. One of those statutes requires the Attorney General to adopt “guidelines to ensure the security and nondiversion of marijuana grown for medical use.” (Health & Saf. Code, § 11362.81(d).<sup>1</sup>) To fulfill this mandate, this Office is issuing the following guidelines to (1) ensure that marijuana grown for medical purposes remains secure and does not find its way to non-patients or illicit markets, (2) help law enforcement agencies perform their duties effectively and in accordance with California law, and (3) help patients and primary caregivers understand how they may cultivate, transport, possess, and use medical marijuana under California law.

**I. SUMMARY OF APPLICABLE LAW**

**A. California Penal Provisions Relating to Marijuana.**

The possession, sale, cultivation, or transportation of marijuana is ordinarily a crime under California law. (See, e.g., § 11357 [possession of marijuana is a misdemeanor]; § 11358 [cultivation of marijuana is a felony]; Veh. Code, § 23222 [possession of less than 1 oz. of marijuana while driving is a misdemeanor]; § 11359 [possession with intent to sell any amount of marijuana is a felony]; § 11360 [transporting, selling, or giving away marijuana in California is a felony; under 28.5 grams is a misdemeanor]; § 11361 [selling or distributing marijuana to minors, or using a minor to transport, sell, or give away marijuana, is a felony].)

**B. Proposition 215 - The Compassionate Use Act of 1996.**

On November 5, 1996, California voters passed Proposition 215, which decriminalized the cultivation and use of marijuana by seriously ill individuals upon a physician’s recommendation. (§ 11362.5.) Proposition 215 was enacted to “ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person’s health would benefit from the use of marijuana,” and to “ensure that patients and their primary caregivers who obtain and use marijuana for

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<sup>1</sup> Unless otherwise noted, all statutory references are to the Health & Safety Code.

medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction.” (§ 11362.5(b)(1)(A)-(B).)

The Act further states that “Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient’s primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or verbal recommendation or approval of a physician.” (§ 11362.5(d).) Courts have found an implied defense to the transportation of medical marijuana when the “quantity transported and the method, timing and distance of the transportation are reasonably related to the patient’s current medical needs.” (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1551.)

### **C. Senate Bill 420 - The Medical Marijuana Program Act.**

On January 1, 2004, Senate Bill 420, the Medical Marijuana Program Act (MMP), became law. (§§ 11362.7-11362.83.) The MMP, among other things, requires the California Department of Public Health (DPH) to establish and maintain a program for the voluntary registration of qualified medical marijuana patients and their primary caregivers through a statewide identification card system. Medical marijuana identification cards are intended to help law enforcement officers identify and verify that cardholders are able to cultivate, possess, and transport certain amounts of marijuana without being subject to arrest under specific conditions. (§§ 11362.71(e), 11362.78.)

It is mandatory that all counties participate in the identification card program by (a) providing applications upon request to individuals seeking to join the identification card program; (b) processing completed applications; (c) maintaining certain records; (d) following state implementation protocols; and (e) issuing DPH identification cards to approved applicants and designated primary caregivers. (§ 11362.71(b).)

Participation by patients and primary caregivers in the identification card program is voluntary. However, because identification cards offer the holder protection from arrest, are issued only after verification of the cardholder’s status as a qualified patient or primary caregiver, and are immediately verifiable online or via telephone, they represent one of the best ways to ensure the security and non-diversion of marijuana grown for medical use.

In addition to establishing the identification card program, the MMP also defines certain terms, sets possession guidelines for cardholders, and recognizes a qualified **right** to collective and cooperative cultivation of medical marijuana. (§§ 11362.7, 11362.77, 11362.775.)

### **D. Taxability of Medical Marijuana Transactions.**

In February 2007, the California State Board of Equalization (BOE) issued a Special Notice confirming its policy of taxing medical marijuana transactions, as well as its requirement that businesses engaging in such transactions hold a Seller’s Permit. (<http://www.boe.ca.gov/news/pdf/medseller2007.pdf>). According to the Notice, having a Seller’s Permit does not allow individuals to make unlawful sales, but instead merely provides a way to remit any sales and use taxes due. BOE further clarified its policy in a

June 2007 Special Notice that addressed several frequently asked questions concerning taxation of medical marijuana transactions. (<http://www.hoe.ca.gov/news/pdf/173f>.)

#### **E. Medical Board of California.**

The Medical Board of California licenses, investigates, and disciplines California physicians. (Bus. & Prof. Code, § 2000, et seq.) Although state law prohibits punishing a physician simply for recommending marijuana for treatment of a **serious** medical condition (§ 11362.5(c)), the Medical Board can and does *take* disciplinary action against physicians who fail to comply with accepted medical standards when recommending marijuana. In a May 13, 2004 press release, the Medical Board clarified that these accepted standards are the same ones that a reasonable and prudent physician would follow when recommending or approving any medication. They include the following:

1. Taking a history and conducting a good faith examination of the patient;
2. Developing a treatment plan with objectives;
3. Providing informed consent, including discussion of side effects;
4. Periodically reviewing the treatment's efficacy;
5. Consultations, as necessary; and
6. Keeping proper records supporting the decision to recommend the use of medical marijuana.

([http://www.mbc.ca.gov/board/media/releases\\_2004\\_05-13\\_marijuana.html](http://www.mbc.ca.gov/board/media/releases_2004_05-13_marijuana.html).)

Complaints about physicians should be addressed to the Medical Board (1-800-633-2322 or [www.mbc.ca.gov](http://www.mbc.ca.gov)), which investigates and prosecutes alleged licensing violations in conjunction with the Attorney General's Office.

#### **F. The Federal Controlled Substances Act.**

Adopted in 1970, the Controlled Substances Act (CSA) established a federal regulatory system designed to combat recreational drug abuse by making it unlawful to manufacture, distribute, dispense, or possess any controlled substance. (21 U.S.C. § 801, et seq.; *Gonzales v. Oregon* (2006) 546 U.S. 243, 271-273.) The CSA reflects the federal government's view that marijuana is a drug with "no currently accepted medical use." (21 U.S.C. § 812(b)(1).) Accordingly, the manufacture, distribution, or possession of marijuana is a federal criminal offense. (*Id.* at §§ 841(a)(1), 844(a).)

The incongruity between federal and state law has given rise to understandable confusion, but no legal conflict exists merely because state law and federal law treat marijuana differently. Indeed, California's medical marijuana laws have been challenged unsuccessfully in court on the ground that they are preempted by the CSA. (*County of San Diego v. San Diego NORML* (July 31, 2008) --- Cal.Rptr.3d ---, 2008 WL 2930117.) Congress has provided that states are free to regulate in the area of controlled substances, including marijuana, provided that state law does not positively conflict with the CSA. (21 U.S.C. § 903.) Neither Proposition 215, nor the MMP, conflict with the CSA because, in adopting these laws, California did not "legalize" medical marijuana, but instead exercised the state's reserved powers to not punish certain marijuana offenses under state law when a

physician has recommended its use to treat a serious medical condition. (See *City of Garden Grove v. Superior Court (Kha)* (2007) 157 Cal.App.4th 355, 371-373, 381-382.)

In light of California's decision to remove the use and cultivation of physician-recommended marijuana from the scope of the state's drug laws, this Office recommends that state and local law enforcement officers not arrest individuals or seize marijuana under federal law when the officer determines from the facts available that the cultivation, possession, or transportation is permitted under California's medical marijuana laws.

## II. DEFINITIONS

**A. Physician's Recommendation:** Physicians may not prescribe marijuana because the federal Food and Drug Administration regulates prescription drugs and, under the **CSA**, marijuana is a Schedule I drug, meaning that it has no recognized medical use. Physicians may, however, lawfully issue a verbal or written recommendation under California law indicating that marijuana would be a beneficial treatment for a serious medical condition. (§ 11362.5(d); *Conant v. Walters* (9th Cir. 2002) 309 F.3d 629,632.)

**B. Primary Caregiver:** A primary caregiver is a person who is designated by a qualified patient and "has consistently assumed responsibility for the housing, health, or safety" of the patient. (§ 11362.5(e).) California courts have emphasized the consistency element of the patient-caregiver relationship. Although a "primary caregiver who consistently grows and supplies . . . medicinal marijuana for a section 11362.5 patient is serving a health need of the patient," someone who merely maintains a source of marijuana does not automatically become the party "who has consistently assumed responsibility for the housing, health, or safety" of that purchaser. (*People ex rel. Lungren v. Peron* (1997) 59 Cal.App.4th 1383, 1390, 1400.) A person may serve as primary caregiver to "more than one" patient, provided that the patients and caregiver all reside in the same city or county. (§ 11362.7(d)(2).) Primary caregivers also may receive certain compensation for their services. (§ 11362.765(c) ["A primary caregiver who receives compensation for actual expenses, including reasonable compensation incurred for services provided . . . to enable [a patient] to use marijuana under this article, or for payment for out-of-pocket expenses incurred in providing those services, or both, . . . shall not, on the sole basis of that fact, be subject to prosecution" for possessing or transporting marijuana].)

**C. Qualified Patient:** A qualified patient is a person whose physician has recommended the use of marijuana to treat a serious illness, including cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief. (§ 11362.5(b)(1)(A).)

**D. Recommending Physician:** A recommending physician is a person who (1) possesses a license in good standing to practice medicine in California; (2) has taken responsibility for some aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient; and (3) has complied with accepted medical standards (as described by the Medical Board of California in its May 13, 2004 press release) that a reasonable and prudent physician would follow when recommending or approving medical marijuana for the treatment of his or her patient.

### III. GUIDELINES REGARDING INDIVIDUAL QUALIFIED PATIENTS AND PRIMARY CAREGIVERS

#### A. State Law Compliance Guidelines.

1. **Physician Recommendation:** Patients must have a written or verbal recommendation for medical marijuana from a licensed physician. (§ 11362.5(d).)

2. **State of California Medical Marijuana Identification Card:** Under the MMP, qualified patients and their primary caregivers may voluntarily apply for a card issued by DPH identifying them as a person who is authorized to use, possess, or transport marijuana grown for medical purposes. To help law enforcement officers verify the cardholder's identity, each card bears a unique identification number, and a verification database is available online ([www.calmmp.ca.gov](http://www.calmmp.ca.gov)). In addition, the cards contain the name of the county health department that approved the application, a 24-hour verification telephone number, and an expiration date. (§§ 11362.71(a); 11362.735(a)(3)-(4); 11362.745.)

3. **Proof of Qualified Patient Status:** Although verbal recommendations are technically permitted under Proposition 215, patients should obtain and carry written proof of their physician recommendations to help them avoid arrest. A state identification card is the best form of proof, because it is easily verifiable and provides immunity from arrest if certain conditions are met (see section III.B.4, below). The next best forms of proof are a city- or county-issued patient identification card, or a written recommendation from a physician.

#### 4. Possession Guidelines:

a) **MMP:**<sup>2</sup> Qualified patients and primary caregivers who possess a state-issued identification card may possess **8 oz.** of dried marijuana, and may maintain no more than 6 mature or 12 immature plants per qualified patient. (§ 11362.77(a).) But, if “a qualified patient or primary caregiver has a doctor’s recommendation that this quantity does not meet the qualified patient’s medical needs, the qualified patient or primary caregiver may possess an amount of marijuana consistent with the patient’s needs.” (§ 11362.77(b).) Only the dried mature processed flowers or buds of the female cannabis plant should be considered when determining allowable quantities of medical marijuana for purposes of the MMP. (§ 11362.77(d).)

b) **Local Possession Guidelines:** Counties and cities may adopt regulations that allow qualified patients or primary caregivers to possess

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<sup>2</sup> On May 22, 2008, California’s Second District Court of Appeal severed Health & Safety Code § 11362.77 from the MMP on the ground that the statute’s possession guidelines were an unconstitutional amendment of Proposition 215, which does not quantify the marijuana a patient may possess. (See *People v. Kelly* (2008) 163 Cal.App.4th 124, 77 Cal.Rptr.3d 390.) The Third District Court of Appeal recently reached a similar conclusion in *People v. Phomphakdy* (July 31, 2008) --- Cal.Rptr.3d ---, 2008 WL 2931369. The California Supreme Court has granted review in *Kelly* and the Attorney General intends to seek review in *Phomphakdy*.

medical marijuana in amounts that exceed the MMP's possession guidelines. (§ 11362.77(c).)

c) **Proposition 215:** Qualified patients claiming protection under Proposition 215 may possess an amount of marijuana that is “reasonably related to [their] current medical needs.” (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1549.)

## **B. Enforcement Guidelines**

1. **Location of Use:** Medical marijuana may not be smoked (a) where smoking is prohibited by law, (h) at or within 1000 feet of a school, recreation center, or youth center (unless the medical use occurs within a residence), (c) on a school bus, or (d) in a moving motor vehicle or boat. (§ 11362.79.)

2. **Use of Medical Marijuana in the Workplace or at Correctional Facilities:** The medical use of marijuana need not be accommodated in the workplace, during work hours, or at any jail, correctional facility, or other penal institution. (§ 11362.785(a); *Ross v. RagingWire Telecomms., Inc.* (2008) 42 Cal.4th 920,933 [under the Fair Employment and Housing Act, an employer may terminate an employee who tests positive for marijuana use].)

3. **Criminal Defendants, Probationers, and Parolees:** Criminal defendants and probationers may request court approval to use medical marijuana while they are released on bail or probation. The court's decision and reasoning must be stated on the record and in the minutes of the court. Likewise, parolees who are eligible to use medical marijuana may request that they be allowed to continue such use during the period of parole. The written conditions of parole must reflect whether the request was granted or denied. (§ 11362.795.)

4. **State of California Medical Marijuana Identification Cardholders:** When a person invokes the protections of Proposition 215 or the MMP and he or she possesses a state medical marijuana identification card, officers should:

a) Review the identification card and verify its validity either by calling the telephone number printed on the card, or by accessing DPH's card verification website (<http://www.calmmp.ca.gov>); and

b) If the card is valid and not being used fraudulently, there are no other indicia of illegal activity (weapons, illicit drugs, or excessive amounts of cash), and the person is within the state or local possession guidelines, the individual should be released and the marijuana should not be seized. Under the MMP, “no person or designated primary caregiver in possession of a valid state medical marijuana identification card shall be subject to arrest for possession, transportation, delivery, or cultivation of medical marijuana.” (§ 11362.71(e).) Further, a “state or local law enforcement agency or officer shall not refuse to accept an identification card issued by the department unless the *state or local* law enforcement agency or officer

has reasonable cause to believe that the information contained in the card is false or fraudulent, or the card is being used fraudulently.” (§ 11362.78.)

5. **Non-Cardholders:** When a person claims protection under Proposition 215 or the MMP and only has a locally-issued (i.e., non-state) patient identification card, or a written (or verbal) recommendation from a licensed physician, officers should use their sound professional judgment to assess the validity of the person’s medical-use claim:

a) Officers need not abandon their search or investigation. The standard search and seizure rules apply to the enforcement of marijuana-related violations. Reasonable suspicion is required for detention, while probable cause is required for search, seizure, and arrest.

b) Officers should review any written documentation for validity. It may contain the physician’s name, telephone number, address, and license number.

c) If the officer reasonably believes that the medical-use claim is valid based upon the totality of the circumstances (including the quantity of marijuana, packaging for sale, the presence of weapons, illicit drugs, or large amounts of cash), and the person is within the state or local possession guidelines or has an amount consistent with their current medical needs, the person should be released and the marijuana should not be seized.

d) Alternatively, if the officer has probable cause to doubt the validity of a person’s medical marijuana claim based upon the facts and circumstances, the person may be arrested and the marijuana may be seized. It will then be up to the person to establish his or her medical marijuana defense in court.

e) Officers are not obligated to accept a person’s claim of having a verbal physician’s recommendation that cannot be readily verified with the physician at the time of detention.

6. **Exceeding Possession Guidelines:** If a person has what appears to be valid medical marijuana documentation, but exceeds the applicable possession guidelines identified above, all marijuana may be seized.

7. **Return of Seized Medical Marijuana:** If a person whose marijuana is seized by law enforcement successfully establishes a medical marijuana defense in court, or the case is not prosecuted, he or she may file a motion for return of the marijuana. If a court grants the motion and orders the return of marijuana seized incident to an arrest, the individual or entity subject to the order must return the property. State law enforcement officers who handle controlled substances in the course of their official duties are immune from liability under the CSA. (21 U.S.C. § 885(d).) Once the marijuana is returned, federal authorities are free to exercise jurisdiction over it. (21 U.S.C. §§ 812(c)(10), 844(a); *City of Garden Grove v. Superior Court (Kha)* (2007) 157 Cal.App.4th 355, 369, 386, 391.)

#### IV. GUIDELINES REGARDING COLLECTIVES AND COOPERATIVES

Under California law, medical marijuana patients and primary caregivers may “associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes.” (§ 11362.775.) The following guidelines are meant to apply to qualified patients and primary caregivers who come together to collectively or cooperatively cultivate physician-recommended marijuana.

**A. Business Forms:** Any group that is collectively or cooperatively cultivating and distributing marijuana for medical purposes should be organized and operated in a manner that ensures the security of the crop and safeguards against diversion for non-medical purposes. The following are guidelines to help cooperatives and collectives operate within the law, and to help law enforcement determine whether they are doing *so*.

1. **Statutory Cooperatives:** A cooperative must file articles of incorporation with the state and conduct its business for the mutual benefit of its members. (Corp. Code, § 12201, 12300.) No business may call itself a “cooperative” (or “co-op”) unless it is properly organized and registered as such a corporation under the Corporations or Food and Agricultural Code. (*Id.* at § 12311(b).) Cooperative corporations are “democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons.” (*Id.* at § 12201.) The earnings and savings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash, property, credits, or services. (*Ibid.*) Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year. (See *id.* at § 12200, et seq.) Agricultural cooperatives are likewise nonprofit corporate entities “since they are not organized to make profit for themselves, as such, or for their members, as such, but only for their members as producers.” (Food & Agric. Code, § 54033.) Agricultural cooperatives share many characteristics with consumer cooperatives. (See, e.g., *id.* at § 54002, et seq.) Cooperatives should not purchase marijuana from, or sell to, nonmembers; instead, they should only provide a means for facilitating or coordinating transactions between members.

2. **Collectives:** California law **does** not define collectives, but the dictionary defines them as “a business, farm, etc., jointly owned and operated by the members of a group.” (*Random House Unabridged Dictionary*; Random House, Inc. © 2006.) Applying this definition, a collective should be an organization that merely facilitates the collaborative efforts of patient and caregiver members – including the allocation of costs and revenues. As such, a collective is not a statutory entity, but as a practical matter it might have to organize as some form of business to carry out its activities. The collective should not purchase marijuana from, or sell to, non-members; instead, it should only provide a means for facilitating or coordinating transactions between members.

**B. Guidelines for the Lawful Operation of a Cooperative or Collective:**

Collectives and cooperatives should be organized with sufficient structure to ensure security, non-diversion of marijuana to illicit markets, and compliance with all state and local laws. The following are some suggested guidelines and practices for operating collective growing operations to help ensure lawful operation.

1. **Non-Profit Operation:** Nothing in Proposition 215 or the MMP authorizes collectives, cooperatives, or individuals to profit from the sale or distribution of marijuana. (See, e.g., § 11362.765(a) [“nothing in this section shall authorize . . . any individual or group to cultivate or distribute marijuana for profit”]).

2. **Business Licenses, Sales Tax, and Seller’s Permits:** The State Board of Equalization has determined that medical marijuana transactions are subject to sales tax, regardless of whether the individual or group makes a profit, and those engaging in transactions involving medical marijuana must obtain a Seller’s Permit. Some cities and counties also require dispensing collectives and cooperatives to obtain business licenses.

3. **Membership Application and Verification:** When a patient or primary caregiver wishes to join a collective or cooperative, the group can help prevent the diversion of marijuana for non-medical use by having potential members complete a written membership application. The following application guidelines should be followed to help ensure that marijuana grown for medical use is not diverted to illicit markets:

- a) Verify the individual’s status as a qualified patient or primary caregiver. Unless he or she has a valid state medical marijuana identification card, this should involve personal contact with the recommending physician (or his or her agent), verification of the physician’s identity, as well as his or her state licensing status. Verification of primary caregiver status should include contact with the qualified patient, as well as validation of the patient’s recommendation. Copies should be made of the physician’s recommendation or identification card, if any;
- b) Have the individual agree not to distribute marijuana to nonmembers;
- c) Have the individual agree not to use the marijuana for other than medical purposes;
- d) Maintain membership records on-site or have them reasonably available;
- e) Track when members’ medical marijuana recommendation and/or identification cards expire; and
- f) Enforce conditions of membership by excluding members whose identification card or physician recommendation are invalid or have expired, or who are caught diverting marijuana for non-medical use.

4. **Collectives Should Acquire, Possess, and Distribute Only Lawfully Cultivated Marijuana:** Collectives and cooperatives should acquire marijuana only from their constituent members, because only marijuana grown by a qualified patient or his or her primary caregiver may lawfully be transported by, or distributed to, other members of a collective or cooperative. (§§ 11362.765, 11362.775.) The collective or cooperative may then allocate it to other members of the group. Nothing allows marijuana to be purchased from outside the collective or cooperative for distribution to its members. Instead, the cycle should be a closed-circuit of marijuana cultivation and consumption with no purchases or sales to or from non-members. To help prevent diversion of medical marijuana to non-medical markets, collectives and cooperatives should document each member's contribution of labor, resources, or money to the enterprise. They also should track and record the source of their marijuana.

5. **Distribution and Sales to Non-Members are Prohibited:** State law allows primary caregivers to be reimbursed for certain services (including marijuana cultivation), but nothing allows individuals or groups to sell or distribute marijuana to non-members. Accordingly, a collective or cooperative may not distribute medical marijuana to any person who is not a member in good standing of the organization. A dispensing collective or cooperative may credit its members for marijuana they provide to the collective, which it may then allocate to other members. (§ 11362.765(c).) Members also may reimburse the collective or cooperative for marijuana that has been allocated to them. Any monetary reimbursement that members provide to the collective or cooperative should only be an amount necessary to cover overhead costs and operating expenses.

6. **Permissible Reimbursements and Allocations:** Marijuana grown at a collective or cooperative for medical purposes may be:

- a) Provided free to qualified patients and primary caregivers who are members of the collective or cooperative;
- b) Provided in exchange for services rendered to the entity;
- c) Allocated based on fees that are reasonably calculated to cover overhead costs and operating expenses; **or**
- d) Any combination of the above.

7. **Possession and Cultivation Guidelines:** If a person is acting as primary caregiver to more than one patient under section 11362.7(d)(2), he or she may aggregate the possession and cultivation limits **for** each patient. **For** example, applying the MMP's basic possession guidelines, if a caregiver is responsible for three patients, he or she may possess up to 24 oz. of marijuana (8 oz. per patient) and may grow 18 mature or 36 immature plants. Similarly, collectives and cooperatives may cultivate and transport marijuana in aggregate amounts tied to its membership numbers. Any patient or primary caregiver exceeding individual possession guidelines should have supporting records readily available when:

- a) Operating a location for cultivation;
- b) Transporting the group's medical marijuana; and
- c) Operating a location for distribution to members of the collective or cooperative.

**8. Security:** Collectives and cooperatives should provide adequate security to ensure that patients are safe and that the surrounding homes or businesses are not negatively impacted by nuisance activity such as loitering or crime. Further, to maintain security, prevent fraud, and deter robberies, collectives and cooperatives should keep accurate records and follow accepted cash handling practices, including regular bank runs and cash drops, and maintain a general ledger of cash transactions.

**C. Enforcement Guidelines:** Depending upon the facts and circumstances, deviations from the guidelines outlined above, or other indicia that marijuana is not for medical use, may give rise to probable cause for arrest and seizure. The following are additional guidelines to help identify medical marijuana collectives and cooperatives that are operating outside of state law.

**1. Storefront Dispensaries:** Although medical marijuana “dispensaries” have been operating in California for years, dispensaries, as such, *are* not recognized under the law. As noted above, the only recognized group entities are cooperatives and collectives. (§ 11362.775.) It is the opinion of this Office that a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law, but that dispensaries that do not substantially comply with the guidelines set forth in sections IV(A) and (B), above, are likely operating outside the protections of Proposition 215 and the MMP, and that the individuals operating such entities may be subject to arrest and criminal prosecution under California law. For example, dispensaries that merely require patients to complete a form summarily designating the business owner as their primary caregiver – and then offering marijuana in exchange for cash “donations” – are likely unlawful. (*Peron, supra*, 59 Cal.App.4th at p. 1400 [cannabis club owner was not the primary caregiver to thousands of patients where he did not consistently assume responsibility for their housing, health, or safety].)

**2. Indicia of Unlawful Operation:** When investigating collectives or cooperatives, law enforcement officers should be alert for signs of mass production or illegal sales, including (a) excessive amounts of marijuana, (b) excessive amounts of cash, (c) failure to follow local and state laws applicable to similar businesses, such as maintenance of any required licenses and payment of any required taxes, including sales taxes, (d) weapons, (e) illicit drugs, (f) purchases from, or sales or distribution to, nonmembers, or (g) distribution outside of California.