

Information Summary:

Patient Access to Medical Marijuana in Washington State

July 2008



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Executive Summary

Introduction

Washington voters passed Initiative 692, the Medical Use of Marijuana Act, November 1998. This law lets patients meeting certain criteria use marijuana for medical reasons. Engrossed Substitute Senate Bill (ESSB) 6032 was passed in 2007 to clarify the law for patients, doctors, designated providers, and law enforcement.¹ It directs the Department of Health to report on patient access to an adequate, safe, consistent, and secure source of medical marijuana. The department must consider alternative distribution systems and gather information from “medical and scientific literature, consulting with experts and the public, and reviewing the best practices of other states.”²

Patients in the state get marijuana in at least four ways. Some patients grow plants on their own or with the help of another person. Some patients buy marijuana from black market dealers. Some share marijuana with other patients, and others get marijuana from the few dispensaries operating in the state. The only legally protected source is *production*, a term not defined in law but commonly understood to mean cultivating plants. There is no legal source for seeds or seedlings, however, making it unclear just how patients are supposed to begin a garden.

Methodology

The department gathered information from sources that included an extensive literature review, Internet research, review of other jurisdictions’ laws and programs, and consultation with experts. The department also reached out to stakeholders. Four public workshops were held across the state in September 2007 to gather input. In addition, people submitted comments via fax, telephone, email, mail, and online postings.

Barriers to Access

Research and stakeholder comments pointed to a number of barriers to patient access. An adequate, safe, consistent, and secure source of medical marijuana must consider these issues:

- ***Federal Law.*** Marijuana is illegal according to the federal government, even when used by state-authorized patients. Federal penalties for marijuana production and trafficking make it a challenge to provide patients with a source.
- ***Lack of a Legal Source.*** In Washington and many other states with medical marijuana laws, there is no legal source of usable marijuana or

¹ Section 1, <http://www.doh.wa.gov/hsqa/medical-marijuana/docs/BillandLaw.pdf>.

² Section 8(3).

- seeds for patients. This means patients must break the law to participate.
- ***Risk of Arrest and Prosecution.*** Federal law, the lack of a legal source, and the ambiguous wording of many state laws leave patients and providers vulnerable to arrest and prosecution. The stress of arrest and prosecution can negatively affect patient well-being.
 - ***Risk of Violence and Robbery.*** Patients risk their personal safety to get marijuana. The illicit status of the substance attracts criminals, also adding to the challenge of a safe and secure source.
 - ***Risk of Diversion.*** High demand for marijuana makes diversion to illegal users a concern for patients, the public, and law enforcement.
 - ***Cost of Supply.*** Patients struggle to afford marijuana for medical use. Limited incomes and lack of insurance coverage make maintaining an adequate and consistent supply difficult.
 - ***Physical Limitations.*** A source needs to take into account the physical abilities of patients and considerations of time, space, and location. Patients say these factors can sometimes prevent access.
 - ***Supply Quality.*** Marijuana quality involves the consistency and safety of the product. Many patients desire variations in strain and potency. Marijuana can be unsafe if grown or handled improperly.
 - ***Housing Issues.*** Renters risk eviction and property owners risk asset seizures for participating in the medical use of marijuana. These issues deter some patients from having marijuana.
 - ***Child Safety Concerns.*** Patients with children at home receive no legal guidance on how to participate in the medical use of marijuana, keep their children safe, and retain custody.

Options for Access

Washington's medical marijuana law asks the department to identify best practices in use by other states, as well as alternative distribution systems. While no clear best practices are in use by other states, unique features of state laws are identified. In addition, no distribution system is perfect. Alternatives are identified, defined, and evaluated on how they would provide patients with an adequate, safe, consistent, and secure source. In this way, the strengths and weaknesses of each model can be weighed.

What Other States are Doing

Since 1996, 12 states have passed laws allowing the medical use of marijuana. These states are Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington. The laws of these states differ in details but share some basic features. Most of these laws allow doctors to *recommend* rather than *prescribe* marijuana to

patients with qualifying conditions.³ Typically, patients can name a caregiver or provider to help with the medical use of marijuana.

Few of these states have medical marijuana supply and distribution systems. Like Washington's law, their medical marijuana laws are often unclear on what activities are legal. Some of these state laws allow patients and providers to *acquire* or *produce* marijuana. In several cases, these terms are not defined. It is unclear where or how patients are supposed to acquire marijuana without a legal source. Some states allow patients to have more than one caregiver, or allow caregivers to help multiple patients. Rarely do the laws in these states say whether this means group growing or dispensaries are legally protected. Legal ambiguity puts patients, caregivers, law enforcement, and the judicial system in the difficult position of figuring out which activities are protected.

Home cultivation is the only explicitly legal source for medical marijuana in most of these states. Patients and providers are typically left to find sources for seeds or seedlings. Patients unable to grow their own supply receive no guidance on sources for usable marijuana, or for caregivers. There are exceptions to this. California and New Mexico laws are more explicit in what supply and distribution activities they allow.

Distribution Systems

- ***Black Market Buying.*** No states explicitly let patients or caregivers buy marijuana from black market sources. Illicit sources can provide patients with quicker access than growing. However, many patients described black market buying as a last resort used in the absence of legal sources. Black market buying poses several barriers to an adequate, safe, consistent, and secure source of marijuana. Patients face legal risks, marijuana of questionable quality and safety, and the risk of violence and robbery. Encouraging reliance on black market sources puts the public at greater risk of crime. Most people said they strongly oppose a black market marijuana supply.
- ***Home Cultivation.*** Several states allow patients to grow marijuana with the help of a provider or caregiver. For some patients, home cultivation can provide an adequate, safe, consistent, and secure source of medical marijuana. It also gives them some control over their supply quality. Home cultivation is not feasible for all patients, however. Many are unable or unwilling to grow their own supply. Reasons include concerns about arrest and prosecution, break-ins, costs of starting and maintaining a garden, physical limitations, and concerns about housing and children. Many patients said they like having the option to grow their own supply, but acknowledge it's not possible or desirable for all patients.

³ Rhode Island's medical marijuana law allows doctors to "certify" that a patient has a qualifying condition rather than prescribe or recommend marijuana.

- **Group Growing.** When patients and providers work together to cultivate marijuana it's called group growing. Many patients spoke out in favor of this. Group growing might benefit some patients by providing access to a more adequate, consistent, and safer source. Expenses and expertise could be shared among group members. A larger supply might also allow for the creation of reserves, helping patients endure fluctuations in crop yield. However, larger grow sites may be harder to secure and could be targets for criminal activity. Several comments from law enforcement oppose group growing, saying it would be harder to tell legal grow sites from for-profit operations, and may lead to increased diversion and crime. California and New Mexico allow group growing of medical marijuana.
- **Dispensaries.** Dispensaries are storefront facilities that provide marijuana for patients -- and in some cases, support services. Patients in parts of Canada and California have access to marijuana from dispensaries. Dispensaries might improve patient access to an adequate, safe, and consistent source of marijuana. At the same time, dispensaries can make it more difficult to secure marijuana from diversion and could lead to increased crime and federal action. Regulation may help ensure patient and public safety by deterring crime and diversion. Most patients told the department they want legal protection for dispensaries. Some comments from individual law enforcement officers indicate support for regulated dispensaries.
- **Government-Controlled Supply.** Government-controlled supply might be done in several ways. Marijuana might be grown and dispensed by a government agency. Canada and the Netherlands provide marijuana to patients in this way. Alternately, a state could license individuals, groups, or private entities to grow and supply marijuana (as proposed in New Mexico).

It is difficult to know whether a government system would improve patient access to an adequate, safe, consistent, and secure source. Government involvement might improve security and product safety. However, legal complications and costs for patients and the public are hard to predict. Stakeholder feedback was mixed on this option. Some patients oppose government supply, citing quality concerns. Other patients and several groups, including a law enforcement group, a state prosecutors association, and the King County Bar Association, say they would support a state-regulated system.

Conclusions

- The lack of a clearly legal source for medical marijuana is a problem for patients and law enforcement. Most people who expressed an opinion to the department agree there needs to be a safe, legal source for qualified patients.
- Effective patient access should consider issues such as barriers to access, other jurisdictions' experiences, and the concerns of stakeholders.
- Patients have different views on the best way to provide access. Many said they want multiple sources. Many patients want legal protection for group growing and dispensaries.
- Group growing, dispensaries, and government supply have the potential to increase patient access to an adequate and consistent source.
- Marijuana diversion may be a challenge for group growing and dispensaries. Security measures, accounting procedures, and government oversight might reduce the risk.
- Patient and public safety may be a challenge for group growing and dispensaries. Security procedures and government regulation could reduce these risks.
- Government supply may be more secure and safe. The law enforcement community may support a state-controlled system.
- Government supply faces many challenges, including unknown costs, potential federal responses, and patient concerns about product quality.

Introduction

Washington voters passed the Medical Use of Marijuana Act in November 1998. The Act allows people with certain medical conditions and a doctor's recommendation to use marijuana for health reasons. The law defines medical use as the production, possession, or administration of marijuana. It allows patients to possess a 60-day supply. The law allowed patients to name a caregiver to help with the medical use of marijuana. Patients and caregivers can cite the medical use of marijuana as a defense against state criminal charges, thereby avoiding prosecution.

Over the years, several issues have indicated a need to clarify the law. First, the law does not define a 60-day supply. Patients and police are left to come up with their own interpretations. These interpretations are often conflicting, leading to the arrest of patients and caregivers who think they are following the law. Second, the law does not provide patients with a legal source. Without a legal source, patients are put in an awkward and dangerous situation: They must break the law to get usable marijuana or seeds to grow their own supply. The lack of a clearly legal source also affects law enforcement, who must try to distinguish legitimate patients and providers from illegal users and dealers.

In 2007, the Washington State Legislature passed Engrossed Substitute Senate Bill (ESSB) 6032. It aimed “to clarify the law on medical marijuana so that the lawful use of this substance is not impaired.”⁴ Clarification is supposed to help doctors, patients, and providers take part in the medical use of marijuana “without fear of state criminal prosecution.”⁵ It is also meant to clarify the law for police and the courts.⁶

The new law makes several changes to the previous one. Patients may now have a *designated provider* instead of a *primary caregiver*. Unlike a caregiver, a provider does not have to be responsible for the patient's housing, health, or care. The new law also says police should not seize the marijuana of a qualified and complying patient or provider. Instead, they should take only a sample if they suspect a patient or provider of exceeding the amount allowed by law.

The law directs the Department of Health to work on two projects. First, the department must draft rules to define a 60-day supply. The department must also report to the legislature on access to medical marijuana. The law says the report should address patient “access to an adequate, safe, consistent, and secure source, including alternative distribution systems.”⁷ Information should come from “medical and scientific literature, consulting with experts and the

⁴ Section 1.

⁵ Section 1.

⁶ Ibid.

⁷ Section 8(3).

public, and reviewing the best practices of other states.” This report is in response to the second directive.

Methodology

As directed by law, this report looks at issues surrounding patient access to medical marijuana. It provides information rather than recommendations to the legislature. Part One of the report identifies the terms and the barriers to access. It asks the following questions:

- What does an adequate, safe, consistent, and secure source mean?
- What are the barriers to providing this kind of access to qualifying patients?

Part Two of the report reviews other states’ medical marijuana laws and assesses distribution systems. It asks the following questions:

- What are the options for access, including alternative distribution systems?
- How do these options address patient access to an adequate, safe, consistent, and secure source of medical marijuana?

To answer these questions, the department gathered information from a variety of sources, including an extensive literature review and an Internet search. The department researched and reviewed laws and practices in other jurisdictions. This included contacting officials in other states for information. Several experts in medical marijuana distribution issues also shared insights and source material.

The department also reached out to stakeholders. Four public workshops were held across the state in September 2007. Hundreds of people shared their opinions on the two projects assigned to the department. People provided feedback on the current means of access and offered ideas and opinions on alternatives. People also shared their thoughts through phone calls, faxes, letters, emails, and postings to a dedicated Web site.⁸ Stakeholder insights were instrumental in grasping the complex array of issues tied to effective access to medical marijuana.

Even with these inclusive and thorough efforts, gaps in research remain. The reader should be aware of the following limitations:

- The department received relatively few comments from doctors, law enforcement, and the judicial system.

⁸ See Appendix C for a summary of public comments.

- There is little economic information on medical marijuana distribution systems.
- Some research is biased by either a law enforcement or patient advocacy viewpoint.
- Predicting how the federal government will react to various systems is not possible.⁹
- There are no clear best practices in use by other states.

⁹ Because of this, the report instead looks at past federal reactions as a guide for possible future reactions.

Part One: Barriers to Access

The new medical marijuana law directs the department to look at patient “access to an adequate, safe, consistent, and secure source” of medical marijuana. What does that mean? Before assessing what is currently preventing patient access and looking at other options, it is necessary to define key terms. While people have different perspectives on what effective access looks like, research and public feedback suggests that these terms might be defined as follows:

- An *adequate* supply means patients are able to get enough marijuana to meet their medical needs when they need it.
- A *safe* source means patients are able to get medical marijuana without risking their well-being. It also means the public and police are not exposed to greater danger through increased crime.
- A *consistent* supply means patients have access to a steady source over time. It also means the quality, potency, and strain of marijuana are similar over time.
- A *secure* source means medical marijuana is secure from theft and diversion to illegal users.

What are the barriers to providing patients access to an adequate, safe, consistent, and secure source of medical marijuana? Research and stakeholder comments identified numerous challenges. The following section identifies and explains these obstacles.

1. Federal Law

Marijuana, even for medical use, is considered illegal by the federal government. The federal government outlawed marijuana in 1970 with the Controlled Substances Act (CSA). The CSA places marijuana in the most restricted class of regulated substances – Schedule I. According to the DEA, Schedule I substances have no recognized medical value, have a high risk for abuse, and do not have accepted safe uses under medical supervision.¹⁰ The federal government allows the use of marijuana only in federally approved research. Very few research programs have received federal approval.¹¹ The Compassionate Investigational New Drug program is an example.

¹⁰ "Controlled Substances Act," 21 U.S.C., chapter 13 § 812, accessed December 10, 2007, <http://www.usdoj.gov/dea/pubs/csa/csa.pdf>.

¹¹ See Appendix B for information on federally approved therapeutic research programs.

While it is not necessary for state laws and federal laws to agree,¹² the illegal status of marijuana at the federal level affects patient access in many ways. Federal law prevents doctors from prescribing marijuana and pharmacies from dispensing it. Many people told the department that marijuana should be handled like other medications. This is not currently possible. Without federal approval, doctors who prescribe and pharmacists who dispense marijuana may lose their federal license. The Ninth Circuit Court of Appeals upheld the right of doctors to *discuss* or *recommend* marijuana to their patients in the 2002 case, *Conant v. Walters*.¹³

Patients and providers are at risk of serious federal penalties for taking part in the medical use of marijuana. People protected under state law may still be arrested, prosecuted, and convicted under federal law.¹⁴ The DEA enforces the marijuana criminal penalties contained in the CSA. Penalties for marijuana manufacturing and distribution are severe. In addition, people convicted of illegal drug activities may be evicted from federal public housing and be denied federal benefits under the Federal Anti-Drug Abuse Act of 1998.¹⁵

Table 1. Federal Criminal Penalties for Growing Marijuana

Number of Plants	1st Offense	2nd Offense
1 to 49	Not more than 5 years	Not more than 10 years
50 to 99	Not more than 20 years	Not more than 30 years
100 to 999	Not less than 5 years, not more than 40 years	Not less than 10 years, not more than life
1000 or more	Not less than 10 years, not more than life	Not less than 20 years, not more than life
Source: U.S. Department of Justice, DEA, "Drugs of Abuse," 2005, accessed December 18, 2007, http://www.usdoj.gov/dea/pubs/abuse/index.htm .		

¹² According to Mark Eddy's report for Congress, "The CSA is not preempted by state medical marijuana laws, under the federal system of government, nor are state medical marijuana laws preempted by the CSA." "Medical Marijuana: Review and Analysis of Federal and State Policies," Congressional Research Service Report for Congress, updated Jan. 13, 2006, p. 4, accessed Dec. 12, 2007, <http://www.safeaccessnow.org/downloads/CRS%20Report%202005.pdf>.

¹³ The U.S. Supreme Court declined to hear the appeal of the case in 2003. Drug Policy Alliance, "Medical Marijuana Cases: Conant v. Walters," accessed Jan. 23, 2007, <http://www.drugpolicy.org/marijuana/medical/challenges/cases/conant/>.

¹⁴ Eddy, p. 13.

¹⁵ U.S. Department of Justice, DEA, "Drugs of Abuse," 2005, p. 9, accessed December 18, 2007, <http://www.usdoj.gov/dea/pubs/abuse/index.htm>.

2. Lack of a Legal Source

Washington's medical marijuana law does not provide a legal source for marijuana. This means patients and providers must break the law and risk their liberty and safety to get a supply. Many patients, providers, and advocates said this is a major obstacle to access. Many people who submitted comments to the department agreed this is an obstacle. They called for a legal source for patients.

Legally protected activities are listed in ESSB6032 under definition of the medical use of marijuana. Medical use is defined as the "production, possession, or administration of marijuana, as defined in RCW 69.50.101(q), for the exclusive benefit of a qualifying patient in the treatment of his or her terminal or debilitating illness."¹⁶ The law does not define "production."¹⁷ Many people interpret it to mean cultivation. The law does not say where or how patients are supposed to get seeds or seedlings to begin growing.

Patients told the department they get marijuana from sources other than home cultivation. Some said they buy it from dealers. Some said they get it from dispensaries. Patients also said they sometimes share with other patients in need.

The law does not offer legal protection to patients or providers who buy marijuana from illicit dealers, nor does it offer legal protection to people who sell to qualified patients. Purchasing marijuana is not included in the legal definition of medical use.

The medical marijuana law does not address dispensaries. It says designated providers may assist only "one patient at any one time."¹⁸ This would seem to preclude the operation of dispensaries, which act as providers for multiple patients. However, a small number of dispensaries exist in the state. One dispensary operator told the department his group operates under the premise that it is the provider for only one patient at any one time, and therefore complies with the law.

¹⁶ ESSB 6032, Section 3(2).

¹⁷ The original version of ESSB 6032 bill defined production as "the manufacturing, planting, cultivating, growing, harvesting, and other steps reasonably related to the provision of medical marijuana individually by one patient, or by or with the assistance of his or her designated provider, or cooperatively by qualifying patients, or by or with the assistance of their designated providers, for the exclusive benefit of the qualifying patient or patients in the treatment of terminal or debilitating medical conditions." Senate Bill 6032, Section 3(3). <http://apps.leg.wa.gov/documents/billdocs/2007-08/Pdf/Bills/Senate%20Bills/6032.pdf>. The definition of production was not retained in the final version of the law. It is also interesting to note that ESSB 6032 defines "administration" by referring to definition in the state Uniform Controlled Substances Act, chapter 69.50.101(q). Production is defined in another section of this law as "the manufacturing, planting, cultivating, growing, or harvesting of a controlled substance," 69.50.101(y) RCW.

¹⁸ ESSB 6032 § 3(1)(d)

Similarly, the law does not explicitly address sharing marijuana among qualified patients. While the law specifies that providers can assist only one patient at a time, it does not say how many providers a patient may designate. In theory, a patient could designate an unlimited number of providers. It seems possible that providers could be other patients. Where providers may get their supply, however, is still unanswered.

The lack of a legal source is a problem for law enforcement as well. Without a legal source, “officers are forced to use limited resources to pursue both legitimate and illegitimate users until such a point that the legitimate users can be correctly identified.”¹⁹

3. Risk of Arrest and Prosecution

Many patients told the department that the possibility of arrest and prosecution is a major obstacle to safe medical marijuana access. Those risks can be a deterrent for patients. Patients told the department that the stress of arrest and possible prosecution may cause preexisting health problems to worsen. In addition, patients in police custody are unable to use marijuana to treat their health conditions. The arrest of providers also hurts patient access by causing supply disruptions. Many patients called for protection from arrest, not just prosecution.

The medical marijuana law gives qualified patients and providers legal protection from state prosecution if they are in compliance. Complying is challenging for a few reasons. The lack of a legal source is one example. The law says patients and providers may have a 60-day supply of medical marijuana. Because the 60-day supply of marijuana is not yet defined, patients, providers, and police may come up with different amounts.²⁰ This confusion may result in the prosecution of patients and providers who thought they were legally protected.

It is also difficult to prove compliance with the law because there is no standard documentation of a doctor’s recommendation. The law says patients and providers must have proof of such a recommendation. It can be a written statement from the doctor, a copy of the statement, or a copy of the patient’s medical records with a doctor’s recommendation. Law enforcement said distinguishing real recommendations from fakes is difficult. A few patients said police had decided their recommendations were fakes and arrested them.²¹

¹⁹ Rosalie Pacula, Jamie Chiqui, Deborah Reichmann, and Yvonne Terry-McElrath, “State Medical Marijuana Laws: Understanding the Laws and their Limitations,” *Journal of Public Health Policy*, Vol. 23(4), p. 435.

²⁰ The Department of Health is currently drafting rules to define the allowed amounts of usable marijuana and plants. Clarity on this issue should make enforcement easier for police, and compliance easier for patients and providers.

²¹ Some people think this is a good reason to have a medical marijuana registry for patients and providers. See Appendix D for a review of this debate.

Even patients and designated providers who comply with the state medical marijuana law are sometimes arrested and prosecuted. Federal agents rarely arrest patients and designated providers directly. Instead, local and state law enforcement account for the vast majority of marijuana arrests nationwide.²² This occurs through the federal government funding local drug task forces. Patients told the department that these task forces raid patients and designated providers. Many patients and designated providers criticized state and local police for upholding federal drug laws at the expense of the state medical marijuana law. Some people suggested the state prohibit state and local police from carrying out federal marijuana laws against state-qualified patients and designated providers.

4. Risk of Violence and Robbery

The risk of violence and robbery is a major obstacle to safe and secure medical marijuana access. The high demand for marijuana attracts criminal activity. Patients and designated providers may risk physical violence, intimidation, or robbery when buying marijuana from black market dealers. Home cultivators also worry about robbery. One patient told the department he is afraid to leave his apartment because he is afraid someone will break in and steal his plants. Dispensaries and larger grow sites are often more visible so they are more obvious targets for criminal activity.

5. Risk of Diversion

The risk of diversion of medical marijuana is a challenge to secure access. Illicit demand for marijuana provides a strong financial incentive for diversion to illegal markets. Based on comments received at the workshops, this is a serious concern for law enforcement. Police described abuse of the state medical marijuana law by people seeking to make a profit. They also contend that larger amounts of marijuana are harder to track, making diversion easier.

6. Cost of Supply

Cost can be a major obstacle to the adequate and consistent supply of medical marijuana. Many patients told the department they have limited incomes. Health insurance doesn't cover the cost of medical marijuana. Patients cited cost concerns with all of the current means of access. Patients who buy their marijuana from illicit dealers face high prices and fluctuations in price. Home cultivation requires expensive equipment and adds to utility costs. Some patients say dispensaries charge too much for their product. A couple of dispensary operators said patient demand often exceeds their supply.

²² Marijuana Policy Project, "State-by-State Medical Marijuana Laws: How to Remove the Threat of Arrest," 2007, p. 1, accessed Dec. 18, 2007, http://www.mpp.org/assets/pdfs/pdf/SBSR_2007.pdf.

7. Physical Limitations

Physical limitations can prevent patient access to a consistent and adequate supply. Patients may be unable to fully take part in the medical use of marijuana due to physical ability, time, space, or location. Patients may have medical conditions that make certain activities impractical, such as maintaining a garden. Other patients may need marijuana immediately. For example, patients about to undergo chemotherapy may not have the months necessary to grow a supply. Space and location also play a role in access. Patients may be unable to grow their own supply, get to a dispensary, or have an outdoor garden due to these complications.

8. Supply Quality

Assuring the safety and consistency of the medical marijuana is not possible without knowing the quality of the supply. Many patients are concerned about this. Unsafe growing and handling techniques may compromise the safety of the product. Marijuana may be contaminated with molds, bacteria, pesticides, herbicides, and heavy metals. Black market dealers may also lace marijuana with other drugs. Tainted marijuana may endanger the health of patients, many of whom have compromised immune systems.

ESSB 6032 directs the department to report on patient access to a consistent supply. Controlling dosage and predicting results may be easier with a supply of consistent quality. Some people told the department that marijuana should be a standardized product like other prescription drugs. Many patients disagreed. They told the department they want access to a variety of strains rather than to a standardized product. They said certain strains of marijuana are more effective at treating the symptoms of certain medical conditions. There is research suggesting that the combination and potency of the active ingredients in marijuana may produce different benefits for different medical conditions.²³ Patients said this is an important reason to allow access to multiple strains and varying potencies rather than a standardized product.

9. Housing Issues

Patients may be deterred from the medical use of marijuana due to housing issues. Washington's law does not address housing issues. Adult homes, nursing homes, and hospice facilities may have policies preventing patients from possessing, using, or growing marijuana. Even without an explicit policy, it may be unclear how patients in these situations are supposed to

²³ Marijuana contains approximately 60 unique cannabidinoids. Of these, tetahydrocannabinol (THC) is the most well-known. It is responsible for most of the psychoactive effects. Cannabidiol is the second most common active ingredient. It may help reduce anxiety. Cannabinol may have anticonvulsant and sedative effects. Gregory T. Carter, Patrick Weydt, Muraco Kynasha-Tocha, and Donald Abrams, "Medicinal Cannabis: Rational Guidelines for dosing," *Idrugs* 2004 7(5).

participate without risking their housing and care. Their caregivers also have questions. A nurse working in a hospice facility told the department she does not understand how she is supposed to help her patients receive medical marijuana.

Patients living in rental housing risk eviction for using, possessing, or growing marijuana for medical use. This not only endangers the well-being of patients; it also puts their spouses, children, and roommates at risk of eviction. Designated providers also share this serious risk. Property owners have questions about their rights when renting to people growing marijuana for medical use. One property owner said he found a tenant growing marijuana for medical use. He did not want his property damaged by the potent smell and evicted the tenant. Property owners also risk losing their assets by renting to dispensaries. The DEA has notified property owners renting to dispensaries in California that they may have their properties seized. This may make renting space more difficult for dispensary operators in Washington.

10. Child Safety Concerns

Concerns about child safety and custody are barriers to a safe and secure supply of medical marijuana. Washington's medical marijuana law is silent on child custody and safety issues. Some people told the department they worry about the safety of the children living with medical marijuana patients and providers. Early results from a drug policy study suggest that limiting the amount of marijuana kept at home might reduce access by teenagers.²⁴ A few patients said they keep their marijuana supply locked up and hidden away to prevent their children from accessing it.

Patients with children have serious concerns about how to take part in the medical use of marijuana and retain custody of their children. The risk of losing custody of their children for using or growing marijuana causes some patients considerable anxiety. This risk deters some patients and providers from taking part in the medical use of marijuana. Patients told the department they have had their use of medical marijuana used against them in child custody cases. One patient described to the department how Child Protective Services took her children away because she used and grew marijuana. Patients and advocates said they would like guidance on how to participate and retain custody of their children.²⁵

²⁴ Rosalie Pacula, Drug Policy Research Center, "State Medical Marijuana Laws: The Issue of Supply," ImpacTeen Illicit Drug Surveillance Initiative, PowerPoint presentation to the San Diego City Council, 2003.

²⁵ Americans for Safe Access offers a few suggestions for parents who are medical marijuana patients in their "California Legal Manual," 2007, pp. 14-15, accessed Dec. 10, 2007, http://www.safeaccessnow.org/downloads/CA_Legal_Manual_2007.pdf.

Part Two: Options for Access

ESSB 6032 directs the department to consider alternative distribution systems and other states' best practices when reporting on patient access to medical marijuana. Many options exist for patient access to a supply, but they are not equally viable. The following section reviews what other states are doing. While no best practices were found, unique features and similar practices are identified. This section also looks at supply and distribution models, including alternatives. The department evaluated models on the extent they would provide patients with an adequate, safe, consistent, and secure source of medical marijuana.

What Other States are Doing

In the years since the federal criminalization of marijuana, many states have passed laws recognizing the therapeutic value of marijuana. Thirty-eight states have current laws or previously had medical marijuana laws. Some laws rescheduled marijuana at the state level. Some allowed doctors to prescribe marijuana. Others created research programs where select patients could use marijuana. Generally, federal laws have prevented these laws from providing patient access to medical marijuana.²⁶

Since 1996, 12 states have passed laws allowing the medical use of marijuana. These states are Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington. The laws differ in details but share some basic features. Most allow doctors to *recommend* rather than *prescribe* marijuana to patients with qualifying conditions.²⁷ Typically, patients can name a caregiver or provider to help with the medical use of marijuana.

Few of these states have medical marijuana supply and distribution systems. Like Washington's law, their medical marijuana laws are often unclear on what activities are legal. Some of these state laws allow patients and providers to *acquire* or *produce* marijuana. In several cases, these terms are not defined. It is unclear where or how patients are supposed to acquire marijuana without a legal source. Some states allow patients to have more than one caregiver, or allow caregivers to help multiple patients. Rarely do the laws in these states say whether this means group growing or dispensaries are legally protected. Legal ambiguity puts patients, caregivers, law enforcement, and the judicial system in the difficult position of figuring out which activities are protected.

²⁶ See Appendix A for an explanation of state rescheduling laws, physician prescription laws, and therapeutic research programs.

²⁷ Rhode Island's medical marijuana law allows doctors to "certify" that a patient has a qualifying condition rather than prescribe or recommend marijuana.

Home cultivation is the only explicitly legal source for medical marijuana in most of these states. Patients and providers are typically left to find sources for seeds or seedlings. Patients unable to grow their own supply receive no guidance on sources for usable marijuana or caregivers. However, there are some exceptions. California and New Mexico have laws that are more explicit in what supply and distribution activities they allow.

Table 2. Legally Protected Supply and Distribution Activities by State

State	Black Market Buying	Patient & Caregiver Growing	Multiple Patient-to-Caregiver	Group Growing	Dispensary	Government Supply & Distribution	Other*
Alaska	?	X	X				
California		X	X	X	X		
Colorado	?	X	X				
Hawaii	?	X					
Maine		X					
Montana	?	X	X				
Nevada		X					
New Mexico		X	X	X	X	X	X
Oregon		X					X
Rhode Island	?	X	X				
Vermont	?	X					
Washington		X					
Notes: "?" indicates states that allow patients to "acquire" marijuana but do not define the term "acquire." * "Other" includes New Mexico, which plans to license producers, including "associations of persons" and "private entities" and Oregon, which registers growers.							

Below is a brief review of other states' medical marijuana supply and distribution practices. Detailed information on the laws and practices of other states is available in Appendix A.

Alaska. Qualified patients can have one primary caregiver and one alternate caregiver to help with the medical use of marijuana. Medical use includes acquiring and growing²⁸ marijuana. The law does not say where patients should acquire marijuana, nor does it address sources for seeds or starter plants.

California. Qualified patients and caregivers can grow marijuana.²⁹ Caregivers can care for more than one patient.

²⁸ Acquisition is not defined in the law. "Medical Uses of Marijuana for Persons Suffering from Debilitating Conditions Act," Alaska Statute 17.37, Legislature Textual Infobases, accessed Aug. 23, 2007, http://www.legis.state.ak.us/cgi-bin/folioisa.dll/stattx99/query=*/doc/{@6909}?

²⁹ California Health and Safety Code § 11362.5(b)(d), accessed Dec. 4, 2007, <http://info.sen.ca.gov/cgi-bin/displaycode?section=hsc&group=11001-12000&file=11357-11362.9>.

³⁰ Patients can compensate caregivers for costs and services.³¹ The law protects collective and cooperative production.³² This means patients and caregivers can work together to grow marijuana for medical use. Dispensaries operate in many areas under the premise that they are buyers' cooperatives. Several counties and cities in California reportedly have resolutions preventing local law enforcement from working with the DEA on medical marijuana raids.³³

Colorado. Qualified patients and caregivers can acquire and produce marijuana.³⁴ The law is silent on sources for seeds, seedlings, and usable marijuana. There are no patient-caregiver limits set in law.³⁵ A news article said a dispensary had opened in the northern part of the state.³⁶ Dispensaries are not explicitly protected in law.

Hawaii. Qualified patients and their caregivers can acquire and cultivate marijuana.³⁷ Grow sites must be registered with the state Narcotics Enforcement Division and marked with the patient's registry identification number.³⁸ According to the Narcotics Enforcement Division, dispensaries are not allowed.³⁹ The law does not say where patients are supposed to acquire marijuana. The law does not provide for a legal source for seeds or plants.

³⁰ Caregivers can assist more than one patient if they all live in the same county. California Senate Bill 420, "Medical Marijuana," 11362.7(2), 2003, accessed Dec. 21, 2007, http://www.dhs.ca.gov/mmp/Legislative_History/Links/SB420_Chaptered.htm.

³¹ California Health and Safety Code 11362.765(b)(3)(c).

³² California Health and Safety Code 11362.775. Collective and cooperative production is not defined.

³³ Zach Rinser, California Cannabis Clubs, "Contact San Francisco Cannabis Clubs," e-mail message, Nov. 14, 2007.

³⁴ "Production" and "acquisition" are not defined in law. "Medical Use of Marijuana for Persons Suffering from Debilitating Medical Conditions," 0-4-287 - Article 18, Section 14, Colorado Department of Public Health and Environment, accessed Aug. 23, 2007, <http://www.cdph.state.co.us/hs/medicalmarijuana/mjamendment.html>.

³⁵ A patient won a lawsuit against the state health department for imposing a five-patient limit for caregivers. Sue Lindsay, "Denver Judge Increases Safe Access to Medical Marijuana for Patients," Rocky Mountain News, Nov. 20, 2007, Marijuana Policy Project, accessed on Dec. 18, 2007, <http://www.mpp.org/news/in-the-news/denver-judge-increases-safe.html>.

³⁶ Joshua Zaffos, "Medical Marijuana Caregivers Prepare to Open the County's First Dispensary," Rocky Mountain Chronicle, Fort Collins, Colo., Nov. 29, 2007, mmjlist@CannabisMD.org, accessed Nov. 29, 2007.

³⁷ Hawaii Revised Statute, Chapter 329, part IX, accessed Dec. 18, 2007, http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0121.htm. The term "acquire" is not defined in the law. The Department of Public Safety does clearly state that "any evidence of sale of marijuana can result in prosecution and years of prison time, regardless of the buyers or seller's medical condition or medical authorization to use marijuana." Law Enforcement Division, Narcotics Enforcement Division, "Medical Marijuana Patient Information," June 15, 2005, accessed Aug. 21, 2007, http://kumu.icsd.hawaii.gov/psd/law_home.php.

³⁸ Hawaii Department of Public Safety, "Medical Marijuana Patient Information."

³⁹ Keith Kamita, Narcotics Enforcement Division, Hawaii Department of Public Safety, "Medical Marijuana Survey," e-mail message, Nov. 13, 2007.

Maine. Qualified patients and their caregivers can grow marijuana.⁴⁰ The law is silent on sources. There is no patient-caregiver ratio set in law.

Montana. Qualified patients and their caregivers can acquire and grow marijuana.⁴¹ The law does not say how patients should acquire seeds, seedlings, or usable marijuana. Patients can compensate caregivers for services provided. Caregivers can assist more than one patient with medical marijuana use.⁴²

Nevada. Qualified patients and caregivers can produce marijuana.⁴³ Production is defined to include cultivation.⁴⁴ Caregivers may assist only one patient. Patients may not be caregivers for other patients.⁴⁵

New Mexico. Recent legislation directs the state to oversee medical marijuana production and distribution for qualified patients. The state health department has proposed rules to license producers.⁴⁶ Patients, caregivers, groups, private entities, and state agencies may apply for licensure. Producers are allowed to grow and dispense marijuana to qualified patients. They must submit security plans to the state medical marijuana program and meet other requirements. In addition, caregivers can assist up to four patients.⁴⁷ Patients can compensate caregivers for the cost of supplies and utilities associated with medical marijuana.⁴⁸

⁴⁰ Maine Public Law, Chapter 580, S.P. 183 - L.D. 611, "An Act to Aid Implementation of the Maine Medical Marijuana Act of 1998," 2001, accessed Sept. 5, 2007, <http://janus.state.me.us/legis/ros/lom/LOM120th/3Pub551-600/Pub551-600-84.htm>.

⁴¹ Montana Initiative No. 148, "Montana Medical Marijuana Act," accessed Sept. 4, 2007, <http://www.dphhs.mt.gov/medicalmarijuana/i148text.pdf>. The term "acquire" is not defined in the law.

⁴² Montana Department of Public Health and Human Services, Quality Assurance Division, Montana Medical Marijuana Program, "Frequently Asked Questions about the Montana Medical Marijuana Act," accessed Sept. 4, 2007, <http://www.dphhs.mt.gov/medicalmarijuana/frequentlyaskedquestions1.pdf>.

⁴³ Nevada Revised Statutes (NRS), Chapter 453A, "Medical Use of Marijuana," accessed Aug. 21, 2007, <http://www.leg.state.nv.us/NRS/NRS-453A.html>.

⁴⁴ NRS 453, "Uniform Controlled Substances Act," posted July 18, 2006, accessed February 13, 2008, <http://bop.nv.gov/LawBook/LawBook-NRS453.pdf>.

⁴⁵ Nevada Administrative Code, Chapter 453A, "Medical Use of Marijuana," accessed Dec. 18, 2007, <http://www.leg.state.nv.us/nac/nac-453a.html#NAC453ASec150>.

⁴⁶ Proposed 7.34.4.8 New Mexico Administrative Code (NMAC), "Internal Draft Licensure Production Rule," New Mexico Department of Health, Division of Health Improvement, accessed Dec. 4, 2007, <http://www.health.state.nm.us/pdf/Licensure%20Production%20Rule.pdf>.

⁴⁷ New Mexico Senate Bill 523, "The Lynn and Erin Compassionate Use Act," 2007, accessed Aug. 24, 2007, <http://legis.state.nm.us/Sessions/07%20Regular/final/SB0523.pdf>.

⁴⁸ Proposed 7.34.3 NMAC, "Registry Identification Card Public Comment Draft Rule," New Mexico Department of Health, Division of Health Improvement, Nov. 28, 2007, accessed Dec. 4, 2007, <http://www.nmhealth.org/pdf/ID%20Card%20Rules.pdf>.

Oregon. Qualified patients and caregivers can cultivate marijuana.⁴⁹ Patients can also designate a grower. These growers must register with the state medical marijuana program. They can grow marijuana for up to four patients.⁵⁰ Growers must post proof of registration for each patient at the grow site. Patients and caregivers can compensate growers for the costs and utilities used to grow marijuana.⁵¹ Patients may share marijuana with other qualified patients.⁵² A medical marijuana advisory committee composed of stakeholders addresses concerns about the program and makes recommendations. The law is silent on sources for seeds and plants.

Rhode Island. Qualified patients and caregivers may acquire and grow marijuana. The law does not say where or how patients may legally acquire marijuana. It does not address sources for seeds or starter plants. Patients can have two caregivers. Caregivers can assist up to five patients. Patients can compensate caregivers for expenses.⁵³

Vermont. Qualified patients and caregivers may acquire and grow marijuana. The law is silent on sources for seeds, plants, and usable marijuana. Marijuana must be grown in an indoor, secure facility.⁵⁴ Patients must list their grow site on the state medical marijuana registration form.⁵⁵

Supply and Distribution Models

There are numerous supply and distribution models that may provide patients with access to medical marijuana. The department is directed by law to report on sources, including alternative distribution systems. Supply and distribution systems are evaluated in this section. First, they are defined. Then examples of the models are provided to illustrate how they might work in real life. Finally, systems are evaluated on how they would provide patient access to an adequate, safe, consistent, and secure source of medical marijuana.

⁴⁹ Oregon Revised Statutes (ORS) 475.300 - 475.346, "Oregon Medical Marijuana Act," accessed Aug. 20, 2007, <http://oregon.gov/DHS/ph/ommp/docs/mmact475.pdf>. Oregon Administrative Rules (OAR) 333-008-0010 § 18, January 2006, accessed Aug. 20, 2007, <http://oregon.gov/DHA/ph/ommp/docs/oar333008.pdf>.

⁵⁰ OAR 333-008-0025 § 10.

⁵¹ ORS 475.304 § 7.

⁵² OAR 333-008-0010 § 5(b).

⁵³ Rhode Island General Laws, chapter 21-28.6, "The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act", 2007, accessed Aug. 21, 2007, <http://www.rilin.state.ri.us/PublicLaws/law05/law05443.htm>. The term "acquire" is not defined in the law.

⁵⁴ Vermont Senate Bill 76, "An Act Relating to Marijuana Use by Persons with Severe Illness", accessed Aug. 21, 2007, <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2004/bills/passed/S-076.HTM>. The term "acquire" is not defined in the law.

⁵⁵ Vermont Department of Public Safety, Division of Criminal Justice Services, Criminal Information Center, "Vermont Medical Marijuana Registry," updated Sept. 10, 2007, accessed Feb. 13, 2008, <http://www.dps.state.vt.us/cjs/marijuana.htm>.

The section begins with a review of the two primary methods in use in Washington: black market buying, and patient and provider growing. It then moves on to group growing, dispensaries, and government supply and distribution. The reader should be aware there are more potential variations to each system than can be covered by any one report. In addition, it may be possible to combine features from different systems to create something altogether new.

1. Black Market Buying

Buying marijuana on the black market means getting marijuana from illegal, unregulated, for-profit, privately operating suppliers and distributors. This method of obtaining marijuana is not so much a “system” as what happens in the absence of other methods.

Information on the black market supply of marijuana is limited. The illegal status of marijuana makes obtaining information difficult.⁵⁶ Some economic research on marijuana markets indicates, “Marijuana distribution appears to be embedded in social networks, not dominated by transactions with ‘professional’ sellers.”⁵⁷ Black market sources may also include gifts from strangers, trades, or purchases.⁵⁸ Patients who have family, friends, or acquaintances able to get marijuana for them might be able to avoid buying from “street dealers.” Patients without these connections risk violence, intimidation, and robbery in buying marijuana from street dealers.

Example 1: Social network buying

A patient speaking at one of the public workshops described her experience buying marijuana. She had recently been diagnosed with cancer and was scheduled to start chemotherapy in a few days. Her doctor recommended marijuana to help alleviate the nausea caused by her treatment. She did not have time to grow her own supply. She was able to find a friend who could sell her marijuana. She was very grateful to this friend for helping her get marijuana quickly. She did not like putting her friend at risk for illegally selling marijuana and felt guilty for asking her.

Example 2: Buying from street dealers

⁵⁶ Jonathan Caulkins and Rosalie Pacula, "Marijuana Markets: Inferences from Reports by the Household Population," June 25, 2005, Carnegie Mellon Heinz School, p. 2, accessed Oct. 10, 2007,

<http://www.heinz.cmu.edu/wpapers/detail.jsp?jsessionid=1470061201913250825?id=6391>.

⁵⁷ Ibid., p. 23.

⁵⁸ Summary of the Caulkins and Pacula study findings cited above. RAND Drug Policy Research Center, "Innovative National Study of U.S. Marijuana Markets Yields New Insights," Vol. 1(7), 2006, accessed Oct. 10, 2007, http://www.rand.org/mulit/dprc/newsletter/2006_issue7.html.

A patient attending one of the public workshops said he bought marijuana from a street dealer as a last resort. He had been growing his own plants until police raided his home. They said he had too many plants and took most of them, he said. They left him with just a few small plants. The remaining plants did not produce enough marijuana to meet his medical needs. Out of desperation one night, he went out looking for marijuana to ease his pain. A dealer in a parking lot said he would get him some marijuana. Instead, the patient was robbed and beaten. He spent a week in the hospital recovering from his injuries.

Analysis

Does black market buying provide patients with an adequate, safe, consistent, and secure source of medical marijuana? Most research and stakeholder comments agree that it does not. While a black market supply can help patients with an immediate need when no other legal source exists, it is less than ideal. Most patients said buying marijuana from illegal dealers is a last resort. While no state medical marijuana laws explicitly allow black market buying, laws that are silent on legal sources have a similar effect: “they implicitly encourage patients to obtain marijuana through illegal channels.”⁵⁹ Patients remain vulnerable to state and federal criminal penalties.⁶⁰ Law enforcement also suffers from laws without legal sources by creating “legitimacy for the black market supply of marijuana.”⁶¹ Notable problems with a black market source of marijuana include:

- ***Risk of Arrest and Prosecution.*** A black market source of marijuana is by nature illegal. Patients who rely on black market buying risk arrest and prosecution. This can jeopardize their safety and well-being. People selling marijuana to qualified patients also may be arrested and prosecuted.
- ***Risk of Violence and Robbery.*** Patients and providers who buy marijuana from illegal suppliers risk intimidation, violence, and robbery. Research indicates the black market marijuana trade “has grown more violent as highly organized, well-armed groups that once focused on cocaine and heroin are now dealing in marijuana, as well.”⁶² The black market supply of marijuana can put the public and police in greater danger. Illegal growers sometimes use guns, traps, and attack dogs to protect their grow sites from theft and police raids.

⁵⁹ Pacula et al., p. 435.

⁶⁰ Ibid.

⁶¹ Ibid.

⁶² King County Bar Association, Drug Policy Project, "Effective Drug Control: Toward a New Legal Framework," 2005, p. 57, accessed Dec. 26, 2007, <http://www.kcba.org/ScriptContent/KCBA/druglaw/pdf/EffectiveDrugControl.pdf>.

- ***Cost of Supply.*** Prices for black market marijuana are unpredictable, according to patient reports. Many patients said the high cost of illicit marijuana prevents them from obtaining an adequate supply. Prices rise and fall due to changes in supply and demand. Economic research indicates several factors may influence the prices people pay for marijuana. Those include the quantity purchased, time and setting of the sale, the potency of the marijuana, the relationship between the buyer and the seller, the previous experience of the buyer, and gender, ethnicity, and income differences.⁶³ Some patients said they have had to ration their supply because they could not afford to buy as much as they needed.

In addition, a black market supply of marijuana adds additional cost to law enforcement efforts. Without a legal source for medical marijuana, “officers are forced to use limited resources to pursue both legitimate and illegitimate users until such a point that the legitimate users can be correctly identified.”⁶⁴

- ***Physical Limitations.*** Maintaining an adequate and consistent supply can be a challenge with a black market supply. Patients or their providers must be able to find a source. Even then, patients are at the mercy of an unsteady and unreliable supply. Police sometimes interrupt grow operations. Dealers can be caught or decide to stop selling. These unpredictable variables can cause the amount of marijuana available to fluctuate, making it difficult for patients to get a steady supply of marijuana in the amounts they need.
- ***Supply Quality.*** Marijuana from black market sources varies in quality. Different strains and potencies are offered by different dealers or at different times. Some patients view this as an advantage to a black market supply. However, quality is unknown and uncontrolled with a black market supply. Dealers sometimes lace marijuana with other drugs. Marijuana can also be contaminated due to poor growing techniques. A local medical marijuana advocacy Web site describes the risks, saying:

Producing medical grade cannabis is not rocket science – it is a fine art. In addition, the use of commercial pesticides, plus the mold, mildew, and other potential contaminants found in most indoor gardens can prove toxic, even fatal, to the majority of marijuana patients who live with impaired immune systems. Commercial pot growers motivated by huge profits and the risk of long prison sentences usually have no regard for the health and well-being of

⁶³ Caulkins et al., p. 12, 16-18, and 33.

⁶⁴ Pacula et al., p. 435.

their customers. Medical-grade cannabis is usually produced with care and dedication rarely found in illegal operations.⁶⁵

Summary

No states explicitly let patients or caregivers buy marijuana from black market sources. Illicit sources can provide patients with quicker access than growing. However, many patients described black market buying as a last resort used in the absence of legal sources. Black market buying poses several barriers to an adequate, safe, consistent, and secure source of marijuana. Patients face legal risks, marijuana of questionable quality and safety, and the risk of violence and robbery. In addition, encouraging reliance on black market sources by offering legal protection to patient purchasing or by not providing legal sources is counter to law enforcement goals. It puts the public at greater risk of crime. Most people said they strongly oppose a black market marijuana supply.

2. Home Cultivation

Some patients grow their own supply of marijuana, either by themselves or with the help of another person. Crop yields and quality depend on several factors including grower's skill, soil conditions, and weather. The location of the grow site also influences the amount of marijuana produced. Indoor gardens yield less but produce throughout the year, an important factor for many cold-weather states. Outdoor gardens produce larger amounts but typically yield only once a year due to climate and weather conditions. Several patients told the department that Washington's climate, particularly in the western part of the state, makes growing outdoors difficult.

Medical marijuana laws passed in recent years typically allow patients to cultivate at home. Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington have laws that explicitly or implicitly allow patient and provider growing. Home cultivation, according to one research report:

...is perhaps the most liberal approach for states to take in their efforts to provide patient access to marijuana. By enabling patients to grow marijuana in their own homes, states can get around federal laws prohibiting the manufacture, distribution, and sale of marijuana.⁶⁶

All of these laws say a patient can be helped by a caregiver or provider. Definitions for caregivers and providers vary by state. Generally, a caregiver must be responsible for the housing, health, and care of the patient.⁶⁷ The ratio

⁶⁵ "Legal Access to Medical Marijuana in the Evergreen State," CannabisMD.org, accessed Sept. 6, 2007, <http://cannabismd.org/foundation/legalaccess.php>.

⁶⁶ Pacula et al., p. 431.

⁶⁷ The terms "caregiver" and "provider" are used interchangeably in this report.

of patients to caregivers also varies by states. A few states have laws that allow only one patient per caregiver and vice versa. These states include Hawaii, Nevada, and Vermont. Other states allow more than one caregiver per patient or more than one patient per caregiver. Alaska, California, Montana, New Mexico, and Rhode Island allow higher patient-caregiver numbers. Medical marijuana laws in Colorado and Maine allow patient and provider growing but do not specify a limit. Washington's law says designated providers can assist only one patient at a time, but does not specify how many designated providers one patient may have.

Patients may have easier access to marijuana with higher patient-caregiver ratios. Higher ratios may enable larger groups to work together to produce and distribute a supply. Higher ratios can be interpreted as implicitly allowing group growing and distribution. State medical marijuana programs are very reticent on this point. For example, Montana's program Web site tells patients interested in cooperative growing that "the law does not address this" and instructs them to "consult with your local law enforcement officer or personal attorney."⁶⁸

Example: Home cultivation in Washington

A patient attending one of the department's public workshops described his experience growing marijuana at home. He said he grows his own supply without the help of a provider. He said it was very expensive to start up his garden. He also said his utility use and cost went up drastically. He began his garden with a large number of plants, expecting to harvest more than enough for his 60-day supply. Unfortunately, bugs destroyed his plants. His crop yielded much less than he expected. He said home growing is a nice option to have but can be very unpredictable. He also mentioned concerns about his safety and security. He worries someone will break into his apartment when he is gone and steal his plants.

Analysis

Does home cultivation provide for an adequate, safe, consistent, and secure source of medical marijuana? Many patients told the department they like having the option to grow their own supply. Many patients also acknowledged that home cultivation does not meet the needs of all patients. There are numerous challenges to relying on patient-provider growing. These include:

- ***Federal Law.*** Because the federal government does not recognize state-authorized medical use of marijuana as legal, home growing puts patients and providers at risk of federal drug manufacturing charges. Lower plant numbers are less of a target for the federal government.⁶⁹

⁶⁸ Montana Medical Marijuana Program, "Frequently Asked Questions."

⁶⁹ Pacula, "State Medical Marijuana Laws: The Issue of Supply."

- ***Lack of a Legal Source.*** Another barrier to safe and effective access is the lack of a legal source for marijuana seeds and starter plants. States that allow patients and caregivers to cultivate plants typically do not provide a legal source for seeds or starter plants. In these cases, people deciding to cultivate at home must find seeds or starter plants from illicit sources.
- ***Risk of Arrest and Prosecution.*** Patients and their providers risk arrest and prosecution due to federal law and the lack of a legal source. They may also be arrested by state and local police. State and local drug task forces work with federal agents to enforce federal laws for drug manufacturing and trafficking.

State and local police also arrest patients and designated providers not obeying the state law. Many state medical marijuana laws are ambiguous in what they allow, making it tough for patients to know how to comply. Patients also told the department that the medical marijuana law is unevenly enforced. They said patients are able to grow their own supply in some areas of the state with little police interference, while in other areas police forbid patients from growing a single plant.

- ***Risk of Diversion.*** Home cultivation presents some security risks. Marijuana can be diverted to unauthorized users, either intentionally or unintentionally. Several patients said they worried about possible break-ins and plant theft. A few states have tried to address these concerns. New Mexico's proposed rules call for growers to submit a security plan.⁷⁰ Vermont requires that marijuana be grown in a "secure, indoor facility" defined as "a building or room equipped with locks or other security devices that permit access only by a registered caregiver or registered patient."⁷¹
- ***Cost of Supply.*** Growing costs can block patient access to a consistent and adequate supply of marijuana. Home cultivation requires significant start-up costs, according to many patients' comments. While outdoor grow sites require an appropriate, secure, and discreet location, they typically cost less to start and maintain. However, growing outdoors may not be possible or practical due to climate or legal considerations. Indoor gardens require expensive lights and equipment. The largest expense for indoor growing, however, is often

⁷⁰ Proposed 7.34.4.8 NMAC, "Internal Draft Licensure Production Rule."

⁷¹ Vermont Senate Bill 7 § 4472(8), "An Act Relating to the Compassionate Use of Marijuana for Medical Purposes," accessed Aug. 21, 2007, <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT058.HTM>.

the electricity needed to run grow lights.⁷²

- **Physical Limitations.** Physical limitations can prevent patients from maintaining an adequate and consistent supply. Some patients are unable to grow marijuana due to physical disability or severe illness. They may lack the physical ability to plant, tend, and harvest a garden. They may not have the months needed to grow plants and process them into usable medicine. Some patients do not have the extra space for plants or lack an appropriate location for a garden.

Caregivers or providers can ease the burden for some patients. However, several patients said it is hard to find trustworthy providers. Patients must find caregivers or providers on their own. Patients sometimes experience supply disruptions when something happens to their caregiver. For example, one patient said he had a good provider who died unexpectedly in a car accident, leaving him without a source. Allowing higher patient-caregiver ratios may reduce the risk of supply disruptions for some patients.

Even with the physical ability, time, space, location to grow and the assistance of a provider, there are still challenges. Home cultivation can be a very unreliable source. Crop yields vary and even expert growers can end up with too little marijuana. Many patients growing their own supply said they struggle to produce a consistent, adequate amount. Reasons for difficulty range from grower inexperience to common gardeners' problems like bugs, molds, and disease.

- **Supply Quality.** Patients and providers may have more control over the quality of marijuana grown at home. If educated on safe growing techniques, they may be able to produce marijuana free from harmful contaminants. With experience, growers may learn how to grow different strains and how to vary the potency. Without experience, training, or help from an expert, supply quality may be inconsistent.
- **Housing Issues.** Patients may be prevented or discouraged from home cultivation due to housing issues. They may lack extra space or an appropriate location for a grow site. People renting apartments, living in federally subsidized housing, or adult care or hospice facilities are in some cases prohibited from growing marijuana, or lack a secure, discreet site. The well-being of spouses and roommates is a concern for some patients growing their own supply or interested in doing so.

⁷² Armand P. La Barge, Chief of Police, and Karen Noakes, Detective Sergeant, York regional Police, Ontario, Canada, "Indoor Marijuana Growing Operations," *Police Chief Magazine*, Vol. 72(3), March 2005, accessed Feb. 6, 2008, http://policechiefmagazine.org/magazine/index.cfm?fuseaction=print_display&article_id=534&issue_id=32005.

Patients who own their own property said they worry about property seizures.

Property owners also have concerns about home cultivation. Indoor marijuana gardens can damage property. One property owner told the department he had unwittingly rented an apartment to a patient who started growing marijuana. He was worried the pungent odor would damage his property and evicted the patient. A more serious danger is the increased risk of fires. The high-powered lights used for indoor growing can be a fire hazard.⁷³ This is not only a property concern, but also a concern for patient and public safety.

Only one state medical marijuana law addresses housing issues. Rhode Island's law prohibits property owners from denying housing to medical marijuana patients solely because of their patient status.⁷⁴ It is not clear if this protection extends to home cultivation.

- **Child Safety Concerns.** The department received several comments from people worried about children living in homes where marijuana is grown. In addition, several patients who are also parents spoke at the public workshops about their child safety concerns. State medical marijuana laws are silent on child safety issues. A few patients shared their methods for protecting children while engaging in the medical use of marijuana. Methods include using marijuana discreetly, keeping it safely locked away, and discussing with older children the difference between medical use and recreational use.

Summary

Several states allow patients to grow marijuana with the help of a provider or caregiver. For some patients, home cultivation may provide an adequate, safe, consistent, and secure source of medical marijuana. It can give them some control over their supply quality. Home cultivation is not feasible for all patients, however. Legal issues, physical limitations, security concerns, and expenses may prevent effective access. Many patients are unable or unwilling to grow their own supply for various reasons. These include concerns about arrest and prosecution, break-ins, costs of starting and maintaining a garden, physical limitations, and concerns about housing and children. Many patients said they like having the option to grow their own supply but acknowledge it is not possible or desirable for all patients.

⁷³ Steven Pierce, Captain, Davis Police Department, "Report on Medical Marijuana Dispensaries Moratorium," to City Council, Aug. 27, 2004, p. 7, accessed Nov. 6, 2007, http://www.californiapolicechiefs.org/nav_files/marijuana_files/mmd_moratorium_2004.pdf.

⁷⁴ Rhode Island General Laws, chapter 21-28.6-4(b).

3. Group Growing

Groups of patients and providers might combine supplies, time, and effort to grow marijuana. Group growing can range from small, informal groups to larger, formal systems of cooperative or collective farming. The difference between collective and cooperative cultivation is unclear. According to the CannabisMD Web site, “If a marijuana grower were to maintain a number of plants grown for various qualified patients simultaneously, that would be a co-operative garden.” In contrast, a collective garden means that growers “farm together with no outside market.”⁷⁵

Two states, California and New Mexico, explicitly allow group growing. New Mexico’s proposed licensure rules include a provision to license groups. California’s Senate Bill 420 says qualified patients and providers “who associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions.”⁷⁶ The law does not define what collective or cooperative marijuana growing means.⁷⁷ The law’s unclear wording has resulted in different interpretations. One is the legal protection of dispensaries, or “buyer’s cooperatives,” in many parts of the state. Because group growing can exist *without* storefront dispensaries, this section evaluates it separate from dispensaries.

Example: The Wo/Men’s Alliance for Medical Marijuana

The Wo/Men’s Alliance for Medical Marijuana (WAMM) is a collective of patients and caregivers in Santa Cruz County, California. A medical marijuana patient, Valerie Corral, and her husband, Michael Corral, started the group in 1993.⁷⁸ The group has around 200 members. To become a member, a patient must have a valid doctor’s recommendation, be under a doctor’s care, and sign an agreement to abide by the collective’s rules. Rules for patients include promising that WAMM will be their sole marijuana provider, that they will not sell or give marijuana to others, and that they will not take marijuana out of state.⁷⁹

⁷⁵ “Legal Access to Medical Marijuana in the Evergreen State,” CannabisMD.org.

⁷⁶ Section 11362.775

⁷⁷ Medical marijuana dispensaries operate under this provision as collective or cooperative buyer’s clubs.

⁷⁸ The County of Santa Cruz, California voted to allow the medical use of marijuana to patients with doctor’s recommendations in 1992. “FAQ: County of Santa Cruz et. al. v. Ashcroft et. al.,” Drug Policy Alliance, p.1, accessed Jan. 15, 2008, <http://www.drugpolicy.org/law/marijuana/santacruz/faq/index.cfm>.

⁷⁹ “Declaration of Valerie Corral in Support of Plaintiff’s Motion for Preliminary Injunction,” *Santa Cruz v. Ashcroft*, United States District Court, Northern District of California, San Jose Division, accessed Jan. 15, 2008, http://www.drugpolicy.org/docUploads/Corral_Declaration.pdf.

WAMM does not sell or buy marijuana. Instead, “each member receives according to need and returns according to ability.”⁸⁰ Marijuana is free for patients with a doctor’s recommendation. Although it is not required, patients may directly take part in cultivating marijuana. If patients are unable to contribute time and effort to the collective, they are encouraged to appoint a caregiver to take part. Patients and caregivers can help tend the collective garden. They also have the option of growing their own supply at home. People who cultivate at home receive on-site visits from other members of the collective. These visits help prevent abuse of the law, according to Corral. They also offer new growers a chance to get advice on growing methods.⁸¹

The collective operates with support of local government. According to Corral, WAMM “openly cultivates its medical marijuana, and local law enforcement officials and the district attorney’s office have full knowledge of the cultivation.”⁸² The City of Santa Cruz enacted the Personal Medical Marijuana Use Ordinance in 2005. This law defines a “medical marijuana provider association” as “a collective of individuals comprised of qualified patients and primary caregivers, the sole intent of which is to provide education, referral, or network services and to facilitate/assist in the lawful production, acquisition, and provision of medical marijuana to qualified patients.”⁸³ WAMM is recognized as a provider association.⁸⁴ It supplies members with identification cards and home growers with certificates. Corral says these measures have helped police tell legal patients and producers from illegal.⁸⁵

The federal government raided the collective in 2002 in spite of local support and state legal protection. DEA agents seized about 150 marijuana plants. Corral said the raid had a chilling effect on the collective’s ability to provide for patients. She said it “stripped WAMM of more than just its marijuana plants. It redefined our ability to effectively and legitimately treat illness.”⁸⁶ However, the DEA did not charge the Corrals with any crimes.

Instead, WAMM, Valerie Corral, the city and Santa Cruz County sued the federal government over the raid. The case, *County of Santa Cruz v. Gonzales*, contends the Attorney General’s Office went too far when it seized WAMM’s plants. It was dismissed in 2007. However, the dismissal left open two claims made by the county – the argument that medical necessity outweighs federal law and the 10th Amendment claim that states are the authority over

⁸⁰ WAMM, “About Us,” accessed Oct. 22, 2007, <http://www.wamm.org/aboutus.htm>.

⁸¹ Valerie Corral, telephone conversation, Jan. 18, 2008.

⁸² “Declaration of Valerie Corral,” p. 9.

⁸³ City of Santa Cruz, Municipal Codes, chapter 6.90.010(4), “Personal Medical Marijuana Use,” accessed Jan. 15, 2008, http://nt2.scbbs.com/cgi-bin/om_isapi.dll?clientID=372121304&infobase=procode-1&softpage=Browse_Frame_Pg.

⁸⁴ “Declaration of Valerie Corral,” p. 7.

⁸⁵ Corral, telephone conversation.

⁸⁶ “Declaration of Valerie Corral,” p. 12.

marijuana, not the federal government.⁸⁷ According to an area newspaper, the county plans to appeal the decision.⁸⁸ Meanwhile, members of the collective continue to grow marijuana for patient-members.

Analysis

Does group growing provide patients with access to an adequate, safe, consistent, and secure source of medical marijuana? In some ways, group growing would meet these criteria. In other ways, it falls short. A larger supply network may help patients obtain a more adequate, consistent, and affordable supply. Using safe growing and handling methods may help ensure that the product is safe for medical use. However, the safety and security of large marijuana grow sites poses challenges. Major issues related to group growing include:

- **Federal Law.** Because group growing scenarios would probably involve a large number of marijuana plants, they might attract the attention of federal agents.
- **Risk of Violence and Robbery.** Larger grow sites can be targets for criminal activity, posing safety risks to patients, providers, the public, and law enforcement. According to one Washington drug task force officer, larger grow operations are associated with violent crime and burglaries by criminals looking for marijuana or cash. Home invasions by robbers have reportedly been a problem for grow houses in California as well.⁸⁹
- **Risk of Diversion.** Law enforcement is concerned that group growing would increase the risk of diversion. Don Pierce, the executive director of the Washington Association of Sheriffs and Police Chiefs, said in the Senate hearing for ESSB 6032 that he opposes growing cooperatives because they may lead to abuse.⁹⁰ A representative of the Washington Association of Prosecuting Attorneys testifying on the bill said he opposes cooperative production because marijuana is harder to track.⁹¹ A drug task force officer also commented that group growing

⁸⁷ Kurtis Alexander, "Court Hands Setback to WAMM's Fight for Legal MMJ," *Santa Cruz Sentinel*, Sept. 1, 2007, p. 1, accessed Jan. 15, 2008, <http://cannabisnews.com/news/23/thread23300.shtml>.

⁸⁸ Ibid.

⁸⁹ "Marijuana Grow Houses," *KHUM Humboldt Review*, Oct. 4, 2007, p. 4, accessed Feb. 6, 2008, <http://humboldtreview.wordpress.com/2007/09/29/marijuana-grow-houses-%E2%80%93-october-4-2007/>.

⁹⁰ Senate Health and Long Term Care Committee, "Public Hearing on ESSB 6032," Washington, Washington State Public Affairs Network, Feb. 21, 2007, Olympia, <http://www.tvw.org/media/mediaplayer.cfm?evid=2007020238&TYPE=V&%3ccfif%20bha%20is%20%27NO%27%3eCFID=2889843&CFTOKEN=ee597da4aa628089-F1270DFD-3048-349E-4E65B6F060E83515%3c/cfif%3e&bhcp=1>.

⁹¹ Ibid.

would make it more difficult for police to tell legal medical marijuana growers from for-profit operations.

- ***Cost of Supply.*** Group growing might lower costs for patients and providers by allowing them to pool resources. Without some form of regulation, however, group growing could create extra work and expense for police struggling to tell legal grows from illegal grows.
- ***Physical Limitations.*** Group growing has similar challenges to providing access as patient and provider growing. Shared gardens still require space, an accessible location, and time to grow a supply. Some patients will be too ill to participate directly in cultivation. Group members could work together to make up for members who are too ill to participate. In this way, group growing might help prevent supply disruptions by creating a larger pool of shared resources.
- ***Supply Quality.*** Group growing would allow patients and providers some control over the type or types of marijuana grown. It also allows experienced growers to teach new growers. Sharing knowledge could help growers learn safe methods for dealing with gardening challenges like pests, mold, plant diseases, and weather. This might improve patient safety by reducing the risk of using marijuana contaminated by herbicides, pesticide, heavy metals, and molds.

Summary

Group growing is when patients and providers work together to cultivate marijuana. Many patients spoke out in favor of this. Group growing might benefit some patients by providing access to a more adequate, consistent, and safer supply of medical marijuana. Expenses and expertise could be shared among group members. A larger supply might also allow for the creation of a supply reserve, helping patients endure fluctuations in crop yield. However, larger grow sites may be harder to secure and could be targets for criminal activity. Several comments from law enforcement oppose group growing, saying it would be harder to tell legal grow sites from for-profit operations, and may lead to increased diversion and crime. Currently, California and New Mexico allow group growing of medical marijuana.

4. Dispensaries

Dispensaries are another method for the distribution of medical marijuana. Dispensaries are storefront facilities that supply patients with marijuana and marijuana preparations. They might be run by patients, caregivers, or providers. They could be for-profit or not-for-profit. Operators sometimes grow their own supply, get it from members, or buy it from black market sources. Dispensaries might be regulated or unregulated.

Dispensaries vary in the scope of services they provide. A doctor of social work, Amanda Reisman, expands on the work of Lester Grinspoon, describing three types of dispensaries.⁹² They are the pharmacy model, the social model, and the hybrid model.

- The ***pharmacy model*** is fashioned after the typical pharmacy. Patients get marijuana from a counter and cannot use marijuana on-site.
- The ***social model*** dispensary is more like a community center than a pharmacy. Patients get marijuana and marijuana-based products, and may use them on-site. Social services such as counseling, support groups, housing guidance, natural therapies, and classes may be offered on safe growing, administration, and medical marijuana laws.
- The ***hybrid model*** has emerged in California due to increasing dispensary regulations. Some areas now prohibit on-site use of marijuana at dispensaries. Hybrid dispensaries offer marijuana, marijuana products, and social services, but do not allow patients to use marijuana on-site.

Not only are dispensaries a source of usable marijuana, they are also a source of social support for many patients. Reisman's research indicates that people with chronic, terminal, or psychological illness may benefit from the support of people undergoing similar experiences. She says, "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."⁹³ Many patients echoed this sentiment at the department's public workshops.

Dispensaries sometimes operate as gray market enterprises -- that is, not necessarily illegal but operating outside of authorized distribution channels. Canada has several dispensaries, called compassion clubs. A recent news article reported that a patient in Colorado is opening a dispensary.⁹⁴ California has hundreds of dispensaries. A few dispensaries reportedly operate in Washington. It is not clear if dispensaries are operating in other states as well.

Example 1: California's buyers' clubs

California's Senate Bill 420 protects collective and cooperative marijuana production. It allows caregivers to receive "reasonable compensation" for

⁹² Amanda Reisman, "Cannabis Care: Medical Cannabis Facilities as Health Service Providers," doctoral dissertation, School of Social Welfare/Alcohol Research Group: University of California, Berkeley, 2006, p. 15.

⁹³ Reisman, p. 39.

⁹⁴ Zaffros.

costs and services.⁹⁵ The California Court of Appeal 2005 decision, *People v. Urziceanu*, interpreted this to mean dispensaries are legally protected. The decision found that the law exempted dispensaries from state criminal sanctions by allowing compensation and group growing.⁹⁶ Counties and cities have come to their own conclusions about the legality of dispensaries. Some areas have regulated them. Other areas have banned them or imposed moratoria.⁹⁷

The district attorney of Riverside County, California describes the operation of a San Francisco dispensary in the following excerpt:

A guard or employee may check for medical marijuana cards or physician recommendations at the entrance. Many types and grades of marijuana are usually available. Sales clerks will probably make recommendations about what type of marijuana will best relieve a given medical symptom....Baked goods containing marijuana may be available and sold....The dispensary will give the patient a form to sign declaring that the dispensary is their 'primary caregiver' (a process fraught with legal difficulties). The patient then selects the marijuana they want and is told what the 'contribution' will be for the product. The code specifically prohibits the sale of marijuana to a patient so 'contributions' are made to reimburse the dispensary for its time and care in making 'product' available....The marijuana sold at the dispensary was obtained from growers who brought it to the store in backpacks.⁹⁸

Dispensary regulations are similar in many areas. They often "include provisions restricting the facilities to more than 1,000 feet from a school, park or other dispensary, requiring security measures and restricting operating hours to the daytime."⁹⁹ Regulations recommended by the City of Los Angeles Narcotics Division also include quality and safety testing, clear product labeling, non-profit structure, a community relations staff member, and collective operation by caregivers.¹⁰⁰

⁹⁵ California Health and Safety Code 11362.765(b)(3)(c).

⁹⁶ Court of Appeal of California, Third Appellate District, *The People v. Michael C. Urziceanu*, Sept. 12, 2005, Head Note 28, accessed January 15, 2008, <http://www.drugpolicy.org/docUploads/PeoplevUrziceanu2005.pdf>

⁹⁷ As of December 2006, dispensaries were banned in five counties, 70 cities and six counties passed moratoria, and twenty-four cities and seven counties established ordinances for the local regulation of dispensaries. Los Angeles Narcotics Division, "Fact Sheet: Medical Marijuana Facilities within the City of Los Angeles," Dec. 14, 2006, pp. 3-4, accessed November 6, 2007, http://www.californiapolicechiefs.org/nav_files/marijuana_files/fact_sheet.pdf.

⁹⁸ Riverside County District Attorney's Office, "Medical Marijuana: History and Current Complications," White Paper, California, September 2006, p.6, accessed Nov. 6, 2007, http://www.californiapolicechiefs.org/nav_files/marijuana_files/riverside_county_marijuana_white_paper.pdf.

⁹⁹ Harrison Sheppard, "State Still Hashing out Medical Marijuana Rules," *Contra Costa Times*, Sept. 30, 2007, mmjlist@cannabismd.org, accessed Oct. 1, 2007.

¹⁰⁰ Los Angeles Narcotics Division, pp. 10-16.

Complying with local codes has helped some dispensaries gain local support.¹⁰¹ A survey of local government officials by a medical marijuana advocacy group found 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.”¹⁰²

Law enforcement does not necessarily share this perspective. The California Police Chiefs Association Web site contains numerous documents submitted by law enforcement agencies attributing increased crime to dispensaries and their off-site grow operations.¹⁰³ Davis Police Captain Steven Pierce said other California police departments report dispensaries may lead to the following crimes:

- robberies of dispensaries
- robberies of patients
- patients reselling marijuana to unauthorized users
- street dealers undercutting dispensaries by selling marijuana for lower prices.¹⁰⁴

Example 2: Canada’s compassion clubs

Seven compassion clubs and societies provide medical marijuana to qualified patients in Canada.¹⁰⁵ Although dispensaries in Canada operate outside the law,¹⁰⁶ they reportedly serve more than 11,000 people.¹⁰⁷ They “focus on holistic care and harm reduction.”¹⁰⁸

Canada’s first compassion club, the British Columbia Compassion Club Society (BCCCS), has served as a model for other dispensaries. There are several steps to becoming a member.¹⁰⁹ First, the club verifies the applicant’s medical condition. Members must agree not to redistribute marijuana. Then they must attend an orientation session. The session covers club services, as

¹⁰¹ Reisman, p. 19.

¹⁰² Americans for Safe Access, “Medical Cannabis Dispensing Collectives and Local Regulation,” Americans for Safe Access Foundation, 2006, p. 13, <http://www.safeaccessnow.org/downloads/dispensaries.pdf>.

¹⁰³ “Medical Marijuana Dispensary Information,” accessed Dec. 12, 2007, http://www.californiapolicechiefs.org/nav_files/medical_marijuana.html.

¹⁰⁴ Pierce, pp. 6-7.

¹⁰⁵ Philippe Lucas, “Regulating Compassion: An Overview of Canada’s Federal Medical Cannabis Policy and Practice,” *Harm Reduction Journal*, Vol. 5(5), Jan, 28, 2008, p. 8, accessed Feb, 7, 2008, <http://www.harmreductionjournal.com/content/5/1/5>.

¹⁰⁶ “Regulatory Impact Analysis Statement,” *Canada Gazette*, Vol. 135(14), July 4, 2001, p. 41, accessed Sept, 12, 2007, <http://canadagazette.ca/partII/2001/20010704/html/sor227-e.html>.

¹⁰⁷ Lucas, p. 10.

¹⁰⁸ *Ibid.*, p. 27.

¹⁰⁹ Rielle Capler, “The BC Compassion Club Society,” *Cannabis Culture Marijuana Magazine*, Nov, 7, 2005, p. 3, accessed Feb, 7, 2008, <http://www.cannabisculture.com/articles/4549.html>.

well as patient rights and responsibilities. It also covers other useful topics, including “an introduction to the plant and cannabinoids, strain selection, methods of ingestion, safe smoking techniques, dosage, potency, tolerance and dependence, side effects, quality, drug interactions, the current laws and political climate, and the legal risks involved in – and the legal route for – using cannabis as a medicine.”¹¹⁰

The club offers patients a variety of marijuana strains and preparations. Efforts are made to keep prices low for patients. Growers work under contract and must meet rigorous standards in annual inspections. Organic marijuana is always available. Non-organic marijuana is tested for safety. The club also runs a wellness center offering alternative health therapies to patients, with fees on a sliding scale.

Medical marijuana experts in Canada used the club’s practices to develop guidelines for dispensary best practices. Recommendations outlined in the 2006 report, “Guidelines for the Community-Based Distribution of Medical Cannabis in Canada,” include:

- Have a minimum age or parental permission requirement for membership
- Give special consideration to patients with mental health conditions
- Practice sterile handling and storage methods
- Dispense marijuana in clear and identifying packages
- Keep accurate sales records
- Offer alternatives to patient purchasing, such as caregiver pick-up or delivery
- Maintain positive relationships with the surrounding community
- Make facilities handicapped-accessible
- Protect patient privacy and confidentiality¹¹¹

Analysis

Do dispensaries provide patients with access to an adequate, safe, consistent, and secure source of medical marijuana? Feedback is mixed. Dispensaries could reduce the burden on patients by providing a legal source. Dispensaries could provide a consistent supply of marijuana and help patients have an adequate and safe supply. However, dispensaries may be hard to secure, may increase crime, and have been targets for federal action. Major issues related to dispensaries include:

- **Federal Law.** The federal government has targeted dispensaries in California. The DEA has raided many dispensaries, charging operators

¹¹⁰ Ibid.

¹¹¹ Rielle Capler and Philippe Lucas, "Guidelines for the Community-Based Distribution of Medical Cannabis in Canada," May 2006, pp. 7-20, accessed Oct. 12, 2007, http://thevics.com/PDF/medcan_guidelines.pdf.

with federal drug trafficking. Property owners renting to dispensaries have also been warned by the DEA that their properties may be seized.¹¹² According to the U.S. Supreme Court's 2001 decision, *U.S. v. Oakland Cannabis Buyers' Cooperative*, dispensaries are not protected from federal charges on the basis that they are supplying state-qualified patients with medical marijuana.¹¹³ Because dispensaries have to be somewhat visible to attract patients, they are easier targets for federal action than home cultivation.

- ***Risk of Violence and Robbery.*** As known sources of marijuana, dispensaries can be targets for criminals. This might jeopardize the safety of patients and the public. The danger seems greatest with unregulated dispensaries. As one California news article says, "Law enforcement agencies remain concerned about the potential for unregulated dispensaries, with their stashes of drugs and cash, to attract crime to neighborhoods."¹¹⁴

Regulating dispensaries might prevent increases in crime. Requiring security measures such as on-site security staff, security cameras, and locking up marijuana after hours could help deter crime in and around dispensaries.¹¹⁵ Several areas in California with unregulated dispensaries said public safety was improved after regulations were introduced, according to a survey conducted by a medical marijuana advocacy organization.¹¹⁶ Regulations may help ensure the safety of patients, dispensary staff, and community members.

- ***Risk of Diversion.*** It might be more difficult to secure marijuana if dispensaries are allowed. Larger amounts of marijuana are harder to track, making diversion to illegal users easier. Regulation could reduce this possibility by imposing transparency and accountability to dispensaries.
- ***Cost of Supply.*** It is unclear how dispensaries will affect the cost of marijuana for patients. If the marijuana available at dispensaries is less expensive than black market marijuana or home cultivation, patients might have an easier time obtaining an adequate supply. Costs to patients will depend on a variety of factors, including whether dispensaries are for profit or non-profit. Lucas describes costs for the

¹¹² Wyatt Buchanan, "Pot Dispensaries Closing under Threat of Feds," *San Francisco Chronicle*, February 7, 2008, p. 2, accessed Feb. 7, 2008, <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2008/02/07/BAE4UTGBG.DTL&hw=POT+DISPENSARIES+CLOSING+UNDER+THREAT+OF+FEDS&sn=001&sc=1000>.

¹¹³ U.S. Supreme Court, *U.S. v. Oakland Cannabis Buyers' Cooperative*, 2001, accessed Feb. 7, 2008, <http://www.drugpolicy.org/docUploads/USvsOCBC.pdf>.

¹¹⁴ Sheppard.

¹¹⁵ Americans for Safe Access, p. 7.

¹¹⁶ *Ibid.*, p. 19.

non-profit, self-regulated British Columbia Compassion Club Society (BCCCS) in the following table:

Table 3. British Columbia Compassion Club Society Costs

Program Variables	BCCCS
Patients	3000
Program Cost	\$2, 217, 772
Total Cost/Person	739.245
Quantity of Cannabis	262 kg
Cost of Cannabis	\$1, 299, 409
Cost of Cannabis/Person	\$433.13
Price Mark-Up	66%
Operating Costs	\$718,948
Operating Costs/Person	\$239.34
Operations as Percent of Total Cost	32%
Source: Adapted from "Table 1: Cost Comparison of PPS Contract Extension for Oct 2006-Sept 2007 to BCCCS Costs for Fiscal Year of November 2005-October 2006" in Philippe Lucas' "Regulating Compassion: An Overview of Canada's Federal Medical Cannabis Policy and Practice," p. 35. Note: Cost information is in Canadian dollars.	

- **Physical Limitations.** Patients without the time, ability, or space to grow their own supply may find it easier to get an adequate and consistent supply of marijuana from dispensaries. Location still has an effect on patient access, however. For example, some patients in the state said they have to travel for hours to get to a dispensary in Seattle. Many patients said they would like dispensaries close to where they live. Dispensaries could improve access by delivering to patients unable to commute. Several dispensaries in California deliver marijuana to qualified patients living within a reasonable distance.¹¹⁷
- **Supply Quality.** Dispensaries could exert some control over marijuana quality through safe growing and handling methods. This might improve product consistency and safety. Dispensaries can work with growers or produce their own supply, if allowed. Many dispensaries in California and Canada offer patients a variety of strains and products. Preliminary results from a survey of medical marijuana users in Canada finds most patients support access to multiple strains of marijuana (97 percent) and organic growing methods (81 percent).¹¹⁸

Summary

Dispensaries are a source for marijuana, and in some cases, support services, for patients. Patients in parts of Canada and California have access to

¹¹⁷ Based on a Google search for "medical marijuana delivery."

¹¹⁸ Lucas, p. 25.

marijuana from dispensaries. Dispensaries might improve patient access to an adequate, safe, and consistent source of marijuana. Supply could be more consistent, adequate, and safe. However, dispensaries can make it more difficult to secure marijuana from diversion and could lead to increased crime and federal action. Regulation may help ensure patient and public safety by deterring crime and diversion. Most patients told the department they want legal protection for dispensaries. Some comments from individual law enforcement officers indicate support for regulated dispensaries.

5. Government-Controlled Supply

Another model for patient access is government control of marijuana supply. There are a number of ways this could be done. In theory, marijuana could be produced and distributed by the federal, state, or local government. Alternately, a state might license individuals or groups to grow and supply marijuana. The products offered could vary as well, ranging from seeds to usable marijuana. Not all of these arrangements are equally viable. A few of these scenarios are in practice in other places.

Example 1: New Mexico's state-licensed producers

New Mexico passed the “The Lynn and Erin Compassionate Use Act” on March 13, 2007. It is a unique law in that it calls for the state health department to oversee the production and distribution of marijuana for registered patients. The health department has proposed rules for implementing this law. They involve licensing multiple marijuana producers and distributors. According to the proposed rules, “A licensed producer may be:

- (1) a qualified patient
- (2) a caregiver
- (3) an association of persons
- (4) a private entity that operates a facility on secure grounds; or
- (5) a state owned and/or operated facility.”¹¹⁹

Licensing requirements vary based on who acts as a producer-distributor. Patients and caregivers have the fewest requirements. They will have to register with the state health department and describe the grow site. Patients and caregivers wanting to grow marijuana also have to “provide a written description of the qualified patient’s security policies, safety and security procedures, personal safety and crime prevention techniques.”¹²⁰

There are additional requirements for associations. These groups must submit additional documentation. This should include a description of the group’s legal and governance structure, copies of articles of incorporation, and

¹¹⁹ Proposed NMAC 7.34.4.

¹²⁰ Proposed NMAC 7.34.4.8(C) and (D).

information on the people involved in the organization. Group members must pass national and statewide criminal background checks. People with felony convictions are barred from participating. Groups must also describe the grow site, security procedures, and their plan for providing for patients.¹²¹

Private organizations will have to meet extra requirements to become licensed.¹²² They will have to submit floor plans and get fire authority approval. Security plans must include a surveillance system, an alarm system, a controlled access area, use of a depository or safe, and after-hours security measures.¹²³ Production, distribution, and accounting procedures may also end up being more stringent for private entities. The proposed rules call for extra documentation on patients, caregivers, and staff. Also, private entities must maintain an alcohol- and drug-free workplace policy, and train staff on professional conduct and ethics, confidentiality, medical marijuana and qualified conditions, patient rights, and safety and security procedures.¹²⁴

Standards for a state-owned or -operated system are similar to those for private entities. After the state health department expressed “fear that the federal government could prosecute state workers” for direct participation,¹²⁵ state production was reportedly put on hold.¹²⁶ The rules leave open the possibility that the state may directly grow and dispense if there is a shift in federal policy.

Example 2: Canada’s national production and distribution system

Canada has had a medical marijuana program since 2001. Doctors can prescribe marijuana to patients with qualifying conditions. Patients and providers can be licensed to grow marijuana.¹²⁷ Patients may also order seeds and marijuana through Health Canada’s Marihuana Medical Access Division.

The marijuana for Canadian patients comes from a private company working under contract for Health Canada. Prairie Plant Systems, a plant-based pharmaceuticals company, has a five-year contract to grow marijuana in a “biosecure underground growth chamber.”¹²⁸ The contract cost \$5.7

¹²¹ Proposed NMAC 7.34.4.8(E).

¹²² Proposed NMAC 7.34.4.8(F).

¹²³ Proposed NMAC 7.34.4.8(F)(5) and 7.34.4.11.

¹²⁴ Proposed NMAC 7.34.4.8(F)(6) and 7.34.4.10.

¹²⁵ Deborah Baker, “N.M. Won’t Oversee Marijuana Production,” *Associated Press/Chandler News-Dispatch*, Aug. 15, 2007, accessed on Sept. 6, 2007, <http://www.mpp.org/news/in-the-news/nm-wont-oversee-marijuana-8.html>.

¹²⁶ Barry Massey, “N.M. Resumes Planning Medical Marijuana,” *Associated Press/Pioneer Times-Journal*, Aug. 18, 2007, accessed on Sept. 6, 2007, <http://www.mpp.org/news/in-the-news/nm-resumes-planning-medical-8.html>.

¹²⁷ Health Canada uses the alternate spelling for marijuana, “marihuana.” “Marihuana Medical Access Regulations,” *Canada Gazette*, Vol. 135(14), July 4, 2001, pp. 10, 14, and 31, accessed Sept. 12, 2007, <http://canadagazette.ca/partII/2001/20010704/html/sor227-e.html>.

¹²⁸ Health Canada, “About Prairie Plant Systems, Inc.,” accessed Feb. 7, 2008, http://www.hc-sc.gc.ca/dhp-mps/marihuana/supply-approvis/prairie_e.html.

million.¹²⁹ According to Health Canada, “The production of marihuana is highly standardized and secure.”¹³⁰ Marijuana is tested for heavy metals, mold, and potency, and is irradiated to destroy mold spores.¹³¹

Patients call a toll-free number to place an order. They must provide their name, address, authorization numbers (found on the identification cards issued by the program), and amount needed. The program then verifies this information. Supplies arrive in two to three weeks via courier. Cost in Canadian dollars is \$20 for 30 seeds and \$5 for a gram of usable marijuana. Patients pay by money order, check or credit card.¹³² Shipments are ceased for patients more than 30 days in arrears.¹³³

Some people have criticized the national program. A medical marijuana expert and dispensary operator, Philippe Lucas, said fewer than 20 percent of Canada’s authorized medical marijuana users were using the federal marijuana supply as of June 2007.¹³⁴ Eighty percent of patients registered with the federal program grow their own supply.¹³⁵ Lucas’ review of more than 200 pages of patients’ complaints to the federal program revealed the following issues:

- The program is difficult to access.
- There are unexplained delays in application and renewal processing.
- The quality of federal marijuana is poor.¹³⁶

Lucas calculates the operating costs of the federal program at \$3,889.49 per person.¹³⁷

Example 3: The Netherlands production and distribution system

Although the Dutch are famous for their marijuana “coffeeshops,” the formal distribution of medical marijuana is a relatively recent development. Beginning in September of 2003, doctors could prescribe marijuana to patients and pharmacies could dispense it.¹³⁸ The Netherlands, like Canada,

¹²⁹ Lucas, p. 18, citing the Health Canada Web site. Information on the contract cost is no longer on the Web site.

¹³⁰ Health Canada, “Health Canada’s Marihuana Supply,” accessed on Sept. 12, 2007, http://hc-sc.gc.ca/dhp-mps/marihuana/supply-approvis/index_e.html.

¹³¹ Health Canada, “Health Canada’s Supply of Marihuana Seeds and Dried Marihuana for Medical Purposes - Frequently Asked Questions,” February 2006, p.1, accessed on September 12, 2007, http://www.hc-sc.gc.ca/dhp-mps/marihuana/supply-approvis/faq_e.html.

¹³² Ibid., pp. 2-3.

¹³³ Lucas, p. 23.

¹³⁴ Lucas, p. 18.

¹³⁵ Ibid.

¹³⁶ Ibid., p. 14.

¹³⁷ Ibid., p. 24.

¹³⁸ Arno Hazekamp, “An Evaluation of the Quality of Medicinal Grade Cannabis in the Netherlands,” *Cannabinoids*, 2006, Vol. 1(1):1-9, p. 1, accessed Oct. 12, 2007, http://www.cannabis-med.org/english/journal/en_2006_01_1.pdf.

organized its system as a state monopoly to comply with international treaties.¹³⁹ The Dutch Office of Medicinal Cannabis (OMC) oversees the medical marijuana program.

Like the Canadian program, the Dutch program contracted production and distribution to private companies. Two companies, Bedrocan and the Stichting Institute of Medicinal Marijuana (SIMM), grow and distribute medical marijuana.¹⁴⁰ Grow site locations are kept secret for security reasons. Growers are required to comply with national and international agricultural best practices.¹⁴¹ They produce three strains of marijuana, each with a different potency and combination of active ingredients. The OMC tests the marijuana for contaminants and irradiates it to destroy molds and bacteria.

The national program tells the companies how much to produce to meet patient demand. The companies handle packaging and distribution, including taking orders, collecting payments, and shipping marijuana to pharmacies and hospitals. While marijuana is en route to pharmacies, it is state property.¹⁴² Pharmacies offer both dried marijuana and marijuana ointment.¹⁴³ As of January 2007, the cost for 5 grams of marijuana was around 44 to 50 Euros, or \$63.72 to \$79.66 .

Demand for government marijuana has been lower than expected. Some patients have complained that the marijuana is too weak, too potent, too dry, or, most often, too expensive.¹⁴⁴ Concerns have also been expressed about the safety of the irradiation process.¹⁴⁵ One study comparing the potency of marijuana from Dutch coffeeshops and the national program found,

Price comparisons and superficial inspections easily leads to favouring the cheaper material from the coffeeshops over the more expensive, but seemingly equal, pharmacy grade. The fact that only the quality of the latter is guaranteed through regular controls does not seem to impress most consumers. However, it is obvious that the standards for any medicinal preparation are high and that these can be enforced only by appropriate analytical testing. According to the OMC, another reason why the price of Cannabis available in pharmacies is currently somewhat higher than expected, is because sales are relatively low. If the number of patients would

¹³⁹ Willem Scholten, Head of the Office of Medicinal Cannabis of the Ministry of Health, Welfare and Sport, "Therapeutic Cannabis in the Netherlands," oral presentation at the 3rd National Clinical Conference on Cannabis Therapeutics, Charlottesville, Va., May 2004, accessed Nov. 13, 2007, <http://www.medicalcannabis.com/video/video2004.html>.

¹⁴⁰ Office of Medicinal Cannabis, "Frequently Asked Questions about Medicinal Cannabis," Netherlands, accessed January 9, 2007, <http://www.cannabisoffice.nl/eng/>.

¹⁴¹ Willem Scholten, "Medicinal Cannabis Now Available in the Netherlands," *Cannabis Health*, Issue 7, November/December 2003, accessed Nov. 12, 2007, http://www.cannabishealth.com/issue_07/#feature.

¹⁴² OMC, "Frequently Asked Questions about Medicinal Cannabis."

¹⁴³ Scholten, "Therapeutic Cannabis in the Netherlands."

¹⁴⁴ Hazekamp, p.2.

¹⁴⁵ Ibid.

increase, this could influence the price because the fixed costs per sold unit would drop.¹⁴⁶

The Office of Medicinal Cannabis has said it is willing to export medical marijuana to other countries with the appropriate federal government approval to reduce costs.¹⁴⁷

Example 4: The liquor store model

A few people suggested the state distribute marijuana in liquor stores or through a similar system. The liquor store model, although not used for medical marijuana distribution anywhere, would be a state-run distribution system. States already license and regulate alcohol manufacturers, distributors, and retailers. Federal issues notwithstanding, a state-regulated marijuana distribution system could follow a similar structure.

The King County Bar Association released a report in 2005, "Effective Drug Control: Toward a New Legal Framework," calling for the state regulation of drugs.¹⁴⁸ Although the report is not specifically about medical marijuana, it does describe how the liquor control system could serve as a model for marijuana regulation.

The Licensing Division licenses distributors and retail outlets, e.g., restaurants, taverns, grocery stores and breweries, and regulates non-retail licensees such as manufacturers, distributors and importers. The Licensing Division also advises manufacturers, distributors and retailers on advertising and promotion laws and rules, and approves labels for all beer and wine sold in the state. Finally, the division manages the permit program for bartenders and alcohol servers.

The Enforcement and Education Division has 74 liquor and tobacco enforcement agents throughout the state of Washington, who visit restaurants and bars to ensure that minors are not being served and to prevent over-service. The agents also check grocery and convenience stores to ensure that they do not sell to minors, and the agents also educate licensees on liquor and tobacco laws and rules.

Retail services of the Washington State Liquor Control Board include purchasing, distribution and retail stores. The Purchasing Division recommends new product listings and de-listings, places orders with suppliers, fills special orders, and negotiates military contracts and tribal vendor agreements. The Liquor Control Board is the sole wholesaler of

¹⁴⁶ Ibid., p. 7.

¹⁴⁷ Scholten, "Therapeutic Cannabis in the Netherlands."

¹⁴⁸ King County Bar Association, Drug Policy Project, "Effective Drug Control: Toward a New Legal Framework," 2005, accessed Dec. 26, 2007, <http://www.kcba.org/ScriptContent/KCBA/druglaw/pdf/EffectiveDrugControl.pdf>.

spirits in the state and runs a distribution center. Liquor is shipped to stores by independent carriers that operate on a bailment system (the supplier owns the product until it leaves the distribution center). The Retail Services Division manages the operation of 157 state-run stores in larger communities and 155 contract liquor stores in smaller communities....

The Liquor Control Board sets the marked-up prices for spirits sold in state and contract liquor stores. Profits from the sales of spirits and state excise tax on beer, wine, and spirits are distributed to the State General Fund; city, county and border areas; health services; education and prevention; and research.¹⁴⁹

This sort of system might address concerns about marijuana security and safety. It could reduce diversion and minimize the potential for abuse. As the bar association notes, “The original purpose of establishing a control model was so that the state could control the availability of alcohol through factors such as restricted number of outlets, no advertising and using state employees to sell spirits who have no financial incentive to sell or promote sales.”¹⁵⁰ The financial effect of this model is indeterminate as it is not in place in anywhere. It is likely to be substantial.

Other Ideas

Several other related ideas were proposed by stakeholders or uncovered through research. These ideas are briefly reviewed below.

- **Government Seed Banks.** Some people suggested the state run a marijuana seed bank as an initial source for marijuana. Patients in Canada can get seeds through the national program. A seed bank has not been tried in the United States. Nevada’s medical marijuana law called for the state to establish a seed bank and distribute marijuana to patients. This provision was never implemented.¹⁵¹ A legal source for seeds still presents a challenge. It is possible that a state could accept anonymously donated seeds and test them for safety. Although a seed bank would provide an initial legal source for home cultivation, it would not address the needs of patients unable to grow marijuana.
- **Redistribution of Seized Marijuana.** Some people proposed that the state give patients marijuana seized by law enforcement. Redistributing seized marijuana presents a few issues. The origin, age, and quality of seized marijuana are typically unknown. Distributing marijuana from out-of-state sources would violate federal laws prohibiting the interstate distribution of marijuana. Police would

¹⁴⁹ Ibid., pp. 64-65.

¹⁵⁰ Ibid.

¹⁵¹ Jennifer Bartlett, Program Officer, Nevada Department of Agriculture, Medical Marijuana Program, telephone conversation, Dec. 18, 2007.

probably be very reluctant, if not outright resistant, to be involved in the redistribution of marijuana, even to qualified patients. Finally, the marijuana would need to be tested for safety before redistribution. Several states had laws with provisions for redistributing seized marijuana; these provisions were not implemented.¹⁵²

- **Registered Growers.** Patients in Oregon can designate a grower to produce marijuana for them. Growers can produce marijuana for up to four patients. The amount of marijuana a registered grower may cultivate is the combined amount for the grower's patients. This option could improve access to an adequate, consistent source for some patients. Patients would still have to find growers and growers would still have to find initial sources.
- **Federal Supply and Distribution.** The federal government produces and distributes marijuana for research purposes. The University of Mississippi grows marijuana under contract with the National Institutes of Drug Abuse (NIDA). A 1996 Washington State University report to the state legislature on the secure production of marijuana for clinical research found that NIDA was a cost-effective supply source.¹⁵³ However, getting marijuana from the federal program is unlikely. NIDA produces marijuana for federally approved research studies, not widespread distribution to state-approved patients. In addition, patients in the federal program have criticized the quality and potency of federally produced marijuana as well as the reliability of the supply.¹⁵⁴
- **Local Supply and Distribution.** Some patients suggested that local governments produce and distribute marijuana for patients. The city of Santa Cruz, California, voted to create an Office of Compassionate Use in October 2005.¹⁵⁵ The office will obtain, store, and dispense marijuana to qualified patients. Marijuana must come from a legal source, meaning marijuana "obtained or cultivated legally under current law or court order, organically grown in accordance with California Certified Organic Farmers certification standards."¹⁵⁶

¹⁵² Marijuana Policy Project, p. 11.

¹⁵³ Mahmoud Abdel-Monem, "Tamper Free Production of Marijuana for Medicinal Uses," February 1995, Washington State University, accessed Feb. 4, 2008, http://mfiles.org/Marijuana/medicinal_use/b3_wash_state_univ.html.

¹⁵⁴ Ethan Russo, Mary Lynn Mathre, Al Byrne, Robert Velin, Paul Bach, Juan Sanchez-Ramos, Kristing Kirlin, "Chronic Cannabis Use in the Compassionate Investigational New Drug Program: An Examination of Benefits and Adverse Effects of Legal Clinical Cannabis," *Journal of Cannabis Therapeutics*, Vol. 2(1), 2002, Haworth Press, p. 47, accessed Oct. 5, 2007, http://www.drugpolicy.org/docUploads/Chronic_Cannabis.pdf.

¹⁵⁵ Ordinance No. 2005-28, accessed Jan. 15, 2008, <http://www.ci.santa-cruz.ca.us/council/ordinance/2005/28.pdf>.

¹⁵⁶ Ibid., 6.92.010 (4).

The office is expected to be revenue neutral, supported by user fees.¹⁵⁷ It has not yet been created, however. The last provision of the ordinance says the office will not be formed without federal approval.¹⁵⁸

Analysis

Would a government-controlled supply and distribution system provide patients with an adequate, safe, consistent, and secure source of medical marijuana? There are many potential variations to consider. National systems do not easily translate into state or local systems. While the alcohol control system has been used for years, it also does not directly translate to medical marijuana. Even state licensing of producers and distributors, as proposed in New Mexico, has not been put into place yet. A government-controlled system contains many unknowns – federal reaction, costs, and supply quality. These unknowns make it difficult to determine whether such a system would improve patient access. Major issues related to this system include:

- **Federal Law.** It is not clear how federal law would interact with a system controlled by state or local government. National medical marijuana programs in Canada, the Netherlands, and the U.S. comply with the 1961 United Nations Treaty on Illicit Drugs. They do this by creating national monopolies on marijuana supply. The U.S. monopoly is controlled by NIDA. Under the rules of the treaty, an individual state would not be able to create a separate, state-level monopoly.¹⁵⁹

New Mexico's plan may be the most instructive, although it is too soon to tell how the federal government will respond. New Mexico's proposed licensing rules directly address federal law, saying,

“While federal law currently contains a broad prohibition of marijuana use, it also offers broad immunity from civil or criminal liability under the Controlled Substances Act for any duly authorized officer of any State who is lawfully engaged in the enforcement of any law relating to controlled substances. These rules define the duties of those engaged in the production and distribution of marijuana for medical use to enforce the Public Health Act and ensure proper enforcement of any criminal laws for behavior that has been deemed unlawful by the State of New Mexico....duly licensed producers and distributors are deemed duly authorized officers of the State of New Mexico.”¹⁶⁰

¹⁵⁷ Ibid., 6.92.100.

¹⁵⁸ Ibid., 6.92.100(3).

¹⁵⁹ According to Articles 2, 23, and 28 of the treaty, marijuana may be produced for medical and scientific purposes by a single government agency. Single Convention on Narcotic Drugs, 1961, United Nations, accessed January 2008, http://www.incb.org/pdf/e/conv/convention_1961_en.pdf.

¹⁶⁰ Proposed NMAC 7.34.4.2.

The rules emphasize that licensing is a drug enforcement activity. It is meant to distinguish legal producers and distributors from criminals.¹⁶¹ Licensing is intended to increase security and safety by preventing “diversion and accessibility for potential abusers.”¹⁶²

A state-run system might face significant federal opposition. The 2005 Supreme Court decision, *Gonzales v. Raich*, found that Congress has authority over the non-profit, *intrastate* production of marijuana authorized by states for personal medical use.¹⁶³ This decision, in effect, expands the federal government’s power to regulate commerce, according to the King County Bar Association. The result is less innovation by states and a restricted ability by states to use police power.¹⁶⁴ The bar association warns that if states “depart fundamentally from the federal model of drug prohibition and attempt to establish an alternative regulatory system to control psychoactive substances, such efforts might run headlong into a century of case law supporting federal preemption.”¹⁶⁵

- ***Risk of Arrest and Prosecution.*** A government-controlled system could improve patient safety by reducing the arrest and prosecution of patients. There would be less reason for local, state, and federal law enforcement to target patients if a state or a local agency was supplying them. Even if government does not directly supply patients, a regulated system could help police distinguish legitimate patients and providers from illegitimate.

Shifting legal risks off patients is not without problems. If the state were to produce and distribute marijuana, state workers might face legal repercussions. New Mexico wrestled with this dilemma when deciding how to implement its law. The head of the medical marijuana program sought the advice of the state attorney general, who advised, “a department employee, or representative acting on behalf of the department, may be subject to federal prosecution under the Controlled Substances Act.”¹⁶⁶ Under New Mexico law, the Attorney General’s office can legally defend state workers only against *civil* charges, not

¹⁶¹ Proposed NMAC 7.34.4.3.

¹⁶² Proposed NMAC 7.34.4.6.

¹⁶³ U.S. Supreme Court, *Gonzales v. Raich*, 2005, accessed Feb. 7, 2008, <http://a257.g.akamaitech.net/7/257/2422/06jun20051130/www.supremecourtus.gov/opinions/04pdf/03-1454.pdf>.

¹⁶⁴ King County Bar Association, p.85.

¹⁶⁵ Ibid.

¹⁶⁶ Suttle, Steve and Zachary Shandler, New Mexico assistant attorneys general, "Request for Opinion - Exposure to Federal Prosecution," letter, addressed to Dr. Alfredo Vigil, Cabinet Secretary Designate, New Mexico Department of Health, Aug. 6, 2007, accessed Oct. 4, 2007, http://www.californiapolicechiefs.org/nav_files/marijuana_files/new_mexico_0806-07.pdf.

criminal charges.¹⁶⁷ The opinion does leave the possibility open that a state could pass a law to legally defend state workers against federal criminal charges for producing and distributing medical marijuana. The costs for such a legal defense could be very high.

- ***Risk of Violence and Robbery.*** A government source for medical marijuana could help reduce the risk of violence and robbery patients deal with when buying marijuana on the black market or home cultivating. In this way, a government system might provide patients with a safer and more secure supply. In addition, a government-controlled system could reduce dependence on black market sources. This may help protect the public and law enforcement from possible threats to safety.
- ***Risk of Diversion.*** A government-controlled system might be more secure than other systems. Strict monitoring of supply and distribution activities could help prevent diversion to illegal users. This point was emphasized in New Mexico's licensing rules.
- ***Cost of Supply.*** It is unclear whether patient costs would be lessened with a government system. Too many variables would affect the amount paid by patients. If quality marijuana is available for less than it costs on the black market, patients could have an easier time maintaining an adequate and consistent supply. If the price of government marijuana is more expensive than an illicit supply, patients would still struggle to get the amount they need.

Larger costs for a state-controlled medical marijuana system are also hard to predict. They, too, would depend on several factors. System design, scale, security procedures, quality control measures, and legal challenges could all add to government costs. Patient demand is another factor that would influence cost. Demand would depend on the number of patients, their recommended dosages, marijuana potency, and the number of sources available.

Degree of government involvement would heavily influence cost. State licensing would likely cost much less than production and distribution by state or local government. Licensing, monitoring, and enforcement activities could conceivably be fee-supported. Licensing fees may be a concern for people and groups who are providing for patients now. Centralized production, as used in Canada and the Netherlands, can be costly. Quality assurance testing and low patient demand add to program costs. Costs for a liquor store model are hard to predict. A separate system would likely have substantial costs. Offering medical marijuana in already existing liquor stores would

¹⁶⁷ Ibid., p. 3.

cost less, but could still be expensive due to the unique issues surrounding this substance.

A 1995 study for the legislature looked at potential costs for supplying patients with marijuana for clinical research. The cost of supplying 200 patients with 300 marijuana cigarettes produced by the state was estimated as follows:

- Outdoors
 - One time start-up cost of about \$1 million
 - Recurring costs of about \$400,000
- Indoors
 - One time start-up cost of about \$3 million
 - Recurring costs of about \$350,000¹⁶⁸

This report found that an outdoor growing facility would allow for expansion with minimum cost increases.¹⁶⁹

- **Physical Limitations.** Like dispensaries, a government-run system might help patients unable to grow their own supply. A larger source could help ensure that enough marijuana is available for patients when they need it. Consideration of location and physical ability is still necessary. Distribution centers located across the state, like liquor stores, could help ensure access. Another idea is home delivery. Canada's program delivers marijuana to patients' homes. Delivery by mail in the U.S. would risk federal prosecution due to federal jurisdiction over the U.S. Postal Service.¹⁷⁰ Delivery by courier is an alternative but could be costly.
- **Supply Quality.** A government system would allow more control over marijuana quality. This could help ensure product safety and consistency. While some degree of plant variation is unavoidable, government-produced marijuana in Canada, the Netherlands, and the U.S., is produced within a targeted potency range. Both Canada and the Netherlands test their marijuana to ensure it is free from harmful substances.

Some patients in Washington said they do not want government-grown marijuana. They said the quality would be poor and they may not have access to multiple strains. A variety of strains and potencies could be achieved by licensing multiple producers. Multiple producers might

¹⁶⁸ Abdel-Monem, pp. 5-8.

¹⁶⁹ Ibid., p. 5.

¹⁷⁰ Peter Pan, "In Search of a Viable Distribution System for Hawaii's Medical Marijuana Program," Legislative Reference Bureau, Report No.4, 2004, p. 29, accessed Sept. 4, 2007, <http://www.hawaii.gov/lrb/rpts04/medmari.pdf>.

also prevent complaints about marijuana quality by encouraging competition.

Summary

Government-controlled production and distribution might be done in several ways. Marijuana might be grown and dispensed by a government agency. Canada and the Netherlands provide marijuana to patients in this way. Alternately, a state could license individuals, groups, or private entities to grow and supply marijuana. This is the plan proposed in New Mexico.

It is difficult to know whether a government system would improve patient access to an adequate, safe, consistent, and secure source. Government involvement might improve security and product safety. However, legal complications and costs for patients and the public are hard to predict. Stakeholder feedback was mixed on this option. Some patients oppose government supply, citing quality concerns. Other patients and several groups, including a law enforcement group, a state prosecutors association, and the King County Bar Association, say they would support a state-regulated system.

Conclusions

- The lack of a clearly legal source for medical marijuana is a problem for patients and law enforcement. Most people agree there needs to be a safe, legal source for qualified patients.
- Effective patient access will take into account barriers to access, other jurisdictions' experiences, and the concerns of stakeholders.
- Patients have different views on the best way to provide access. Many patients said they want multiple sources. Many patients want legal protection for group growing and dispensaries.
- Group growing, dispensaries, and government supply have the potential to increase patient access to an adequate and consistent source.
- Marijuana diversion may be a challenge for group growing and dispensaries. Security measures, accounting procedures, and government oversight might reduce the risk.
- Patient and public safety may be a challenge for group growing and dispensaries. Security procedures and government regulation could reduce these risks.

- Government supply may be more secure and safe. The law enforcement community may support a state-controlled system.
- Government supply faces many challenges, including unknown costs, potential federal responses, and patient concerns about product quality.

Models

Key Features

Black Market	
<i>Other Jurisdictions</i>	<ul style="list-style-type: none"> Not explicitly legal in any other states
<i>Strengths</i>	<ul style="list-style-type: none"> Marijuana is available quickly for patients with immediate needs
<i>Weaknesses</i>	<ul style="list-style-type: none"> Patients risk violence and robbery Undermines law enforcement goals Cost of product fluctuates Quality of product is unknown, putting patient safety at risk
<i>Public Comments</i>	<ul style="list-style-type: none"> Most people opposed black market supply and distribution
Home Cultivation	
<i>Other Jurisdictions</i>	<ul style="list-style-type: none"> Explicitly legal in most medical marijuana states and Canada
<i>Strengths</i>	<ul style="list-style-type: none"> Patients can have some control over marijuana quality and safety
<i>Weaknesses</i>	<ul style="list-style-type: none"> Patients risk federal criminal penalties No legal source for initial seeds or starter plants Criminals may break-in to grow sites and steal plants Cost for starting and maintaining indoor garden can obstacle for patients Requires physical ability, time, extra space, and an appropriate location Renters may be evicted, property may be seized or damaged Children might be taken away from patients-parents growing at home
<i>Public Comments</i>	<ul style="list-style-type: none"> Many people support this option but admit it does not work for all patients
Group Growing	
<i>Other Jurisdictions</i>	<ul style="list-style-type: none"> Explicitly legal in California and New Mexico
<i>Strengths</i>	<ul style="list-style-type: none"> Could help patients maintain an adequate, consistent supply Costs may be lower for patients, improving access to adequate supply Marijuana safety and consistency might improve by sharing expertise
<i>Weaknesses</i>	<ul style="list-style-type: none"> Large gardens could draw federal attention and result in severe penalties Grow sites might be more visible targets for criminals Larger amounts are harder to secure, making diversion easier
<i>Public Comments</i>	<ul style="list-style-type: none"> Many patients and advocates support this idea; law enforcement does not
Dispensaries	
<i>Other Jurisdictions</i>	<ul style="list-style-type: none"> Exist in California, Colorado, Washington, and Canada
<i>Strengths</i>	<ul style="list-style-type: none"> Could help patients maintain an adequate, consistent supply Non-profit dispensaries can provide affordable marijuana to patients Marijuana safety and consistency could be assured through quality testing Regulated dispensaries may minimize risk of diversion and crime
<i>Weaknesses</i>	<ul style="list-style-type: none"> Federal government might target dispensaries as they have in California Unregulated dispensaries can increase crime and drug diversion
<i>Public Comments</i>	<ul style="list-style-type: none"> Many patients and advocates support this option
Government-Controlled Supply	
<i>Other Jurisdictions</i>	<ul style="list-style-type: none"> New Mexico, Canada, and the Netherlands have government systems
<i>Strengths</i>	<ul style="list-style-type: none"> Could help patients maintain an adequate, consistent supply Would remove risk of arrest and prosecution from patients Might reduce reliance on illegal sources, thereby reducing crime Might be secure source, helping to prevent diversion Could assure marijuana safety through quality assurance testing
<i>Weaknesses</i>	<ul style="list-style-type: none"> Federal reaction to state or local supply system is unknown State workers may be at risk of federal criminal charges Cost to patients and public is hard to predict Quality of government produced marijuana is criticized by patients
<i>Public Comments</i>	<ul style="list-style-type: none"> Patient feedback is mixed; law enforcement might support this option

Appendix A

Engrossed Substitute Senate Bill 6032

CERTIFICATION OF ENROLLMENT
ENGROSSED SUBSTITUTE SENATE BILL 6032

Chapter 371, Laws of 2007

60th Legislature
2007 Regular Session

MARIJUANA--MEDICAL USE

EFFECTIVE DATE: 07/22/07

Passed by the Senate April 20, 2007
YEAS 37 NAYS 9

BRAD OWEN
President of the Senate

Passed by the House April 18, 2007
YEAS 68 NAYS 27

FRANK CHOPP
**Speaker of the House of
Representatives**

I, Thomas Hoemann, Secretary of
the Senate of the State of
Washington, do hereby certify that
the attached is **ENGROSSED
SUBSTITUTE SENATE BILL
6032** as passed by the Senate and the
House of Representatives on the
dates hereon set forth.

THOMAS HOEMANN
Secretary

FILED

Approved May 8, 2007, 4:06 p.m.

May 10, 2007

CHRISTINE GREGOIRE
**Governor of the State of
Washington**

**Secretary of State
State of Washington**

CERTIFICATE

ENGROSSED SUBSTITUTE SENATE BILL 6032

AS RECOMMENDED BY THE CONFERENCE COMMITTEE

Passed Legislature - 2007 Regular Session

State of Washington 60th Legislature 2007 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored
by Senators Kohl-Welles, McCaslin, Kline, Regala and Keiser)

READ FIRST TIME 02/28/07.

1 AN ACT Relating to medical use of marijuana; amending RCW
2 69.51A.005, 69.51A.010, 69.51A.030, 69.51A.040, 69.51A.060, and
3 69.51A.070; adding a new section to chapter 69.51A RCW; and creating a
4 new section.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF
WASHINGTON:

6 NEW SECTION. **Sec. 1.** The legislature intends to clarify the law
7 on medical marijuana so that the lawful use of this substance is not
8 impaired and medical practitioners are able to exercise their best
9 professional judgment in the delivery of medical treatment, qualifying
10 patients may fully participate in the medical use of marijuana, and
11 designated providers may assist patients in the manner provided by this
12 act without fear of state criminal prosecution. This act is also
13 intended to provide clarification to law enforcement and to all
14 participants in the judicial system.

15 **Sec. 2.** RCW 69.51A.005 and 1999 c 2 s 2 are each amended to read
16 as follows:

17 The people of Washington state find that some patients with
18 terminal or debilitating illnesses, under their physician's care, may

1 benefit from the medical use of marijuana. Some of the illnesses for
2 which marijuana appears to be beneficial include chemotherapy-related
3 nausea and vomiting in cancer patients; AIDS wasting syndrome; severe
4 muscle spasms associated with multiple sclerosis and other spasticity
5 disorders; epilepsy; acute or chronic glaucoma; and some forms of
6 intractable pain.

7 The people find that humanitarian compassion necessitates that the
8 decision to authorize the medical use of marijuana by patients with
9 terminal or debilitating illnesses is a personal, individual decision,
10 based upon their physician's professional medical judgment and
11 discretion.

12 Therefore, the people of the state of Washington intend that:

13 Qualifying patients with terminal or debilitating illnesses who, in
14 the judgment of their physicians, ~~((would))~~ may benefit from the
15 medical use of marijuana, shall not be found guilty of a crime under
16 state law for their possession and limited use of marijuana;

17 Persons who act as ~~((primary caregivers))~~ designated providers to
18 such patients shall also not be found guilty of a crime under state law
19 for assisting with the medical use of marijuana; and

20 Physicians also be excepted from liability and prosecution for the
21 authorization of marijuana use to qualifying patients for whom, in the
22 physician's professional judgment, medical marijuana may prove
23 beneficial.

24 **Sec. 3.** RCW 69.51A.010 and 1999 c 2 s 6 are each amended to read
25 as follows:

26 The definitions in this section apply throughout this chapter
27 unless the context clearly requires otherwise.

28 (1) "Designated provider" means a person who:

29 (a) Is eighteen years of age or older;

30 (b) Has been designated in writing by a patient to serve as a
31 designated provider under this chapter;

32 (c) Is prohibited from consuming marijuana obtained for the
33 personal, medical use of the patient for whom the individual is acting
34 as designated provider; and

35 (d) Is the designated provider to only one patient at any one time.

36 (2) "Medical use of marijuana" means the production, possession, or

1 administration of marijuana, as defined in RCW 69.50.101(q), for the
2 exclusive benefit of a qualifying patient in the treatment of his or
3 her terminal or debilitating illness.

4 ~~((2) "Primary caregiver" means a person who:~~

5 ~~(a) Is eighteen years of age or older;~~

6 ~~(b) Is responsible for the housing, health, or care of the patient;~~

7 ~~(c) Has been designated in writing by a patient to perform the~~
8 ~~duties of primary caregiver under this chapter.))~~

9 (3) "Qualifying patient" means a person who:

10 (a) Is a patient of a physician licensed under chapter 18.71 or
11 18.57 RCW;

12 (b) Has been diagnosed by that physician as having a terminal or
13 debilitating medical condition;

14 (c) Is a resident of the state of Washington at the time of such
15 diagnosis;

16 (d) Has been advised by that physician about the risks and benefits
17 of the medical use of marijuana; and

18 (e) Has been advised by that physician that they may benefit from
19 the medical use of marijuana.

20 (4) "Terminal or debilitating medical condition" means:

21 (a) Cancer, human immunodeficiency virus (HIV), multiple sclerosis,
22 epilepsy or other seizure disorder, or spasticity disorders; or

23 (b) Intractable pain, limited for the purpose of this chapter to
24 mean pain unrelieved by standard medical treatments and medications; or

25 (c) Glaucoma, either acute or chronic, limited for the purpose of
26 this chapter to mean increased intraocular pressure unrelieved by
27 standard treatments and medications; or

28 (d) Crohn's disease with debilitating symptoms unrelieved by
29 standard treatments or medications; or

30 (e) Hepatitis C with debilitating nausea or intractable pain
31 unrelieved by standard treatments or medications; or

32 (f) Diseases, including anorexia, which result in nausea, vomiting,
33 wasting, appetite loss, cramping, seizures, muscle spasms, or
34 spasticity, when these symptoms are unrelieved by standard treatments
35 or medications; or

36 (g) Any other medical condition duly approved by the Washington
37 state medical quality assurance ((board [commission])) commission in

1 consultation with the board of osteopathic medicine and surgery as
2 directed in this chapter.

3 (5) "Valid documentation" means:

4 (a) A statement signed by a qualifying patient's physician, or a
5 copy of the qualifying patient's pertinent medical records, which
6 states that, in the physician's professional opinion, the ~~((potential~~
7 ~~benefits of the medical use of marijuana would likely outweigh the~~
8 ~~health risks for a particular qualifying))~~ patient may benefit from the
9 medical use of marijuana; ((and))

10 (b) Proof of identity such as a Washington state driver's license
11 or identicard, as defined in RCW 46.20.035; and

12 (c) A copy of the physician statement described in (a) of this
13 subsection shall have the same force and effect as the signed original.

14 **Sec. 4.** RCW 69.51A.030 and 1999 c 2 s 4 are each amended to read
15 as follows:

16 A physician licensed under chapter 18.71 or 18.57 RCW shall be
17 excepted from the state's criminal laws and shall not be penalized in
18 any manner, or denied any right or privilege, for:

19 (1) Advising a qualifying patient about the risks and benefits of
20 medical use of marijuana or that the qualifying patient may benefit
21 from the medical use of marijuana where such use is within a
22 professional standard of care or in the individual physician's medical
23 judgment; or

24 (2) Providing a qualifying patient with valid documentation, based
25 upon the physician's assessment of the qualifying patient's medical
26 history and current medical condition, that the ~~((potential benefits of~~
27 ~~the))~~ medical use of marijuana ~~((would likely outweigh the health risks~~
28 ~~for the))~~ may benefit a particular qualifying patient.

29 **Sec. 5.** RCW 69.51A.040 and 1999 c 2 s 5 are each amended to read
30 as follows:

31 (1) If a law enforcement officer determines that marijuana is being
32 possessed lawfully under the medical marijuana law, the officer may
33 document the amount of marijuana, take a representative sample that is
34 large enough to test, but not seize the marijuana. A law enforcement
35 officer or agency shall not be held civilly liable for failure to seize
36 marijuana in this circumstance.

1 (2) If charged with a violation of state law relating to marijuana,
2 any qualifying patient who is engaged in the medical use of marijuana,
3 or any designated ~~((primary caregiver))~~ provider who assists a
4 qualifying patient in the medical use of marijuana, will be deemed to
5 have established an affirmative defense to such charges by proof of his
6 or her compliance with the requirements provided in this chapter. Any
7 person meeting the requirements appropriate to his or her status under
8 this chapter shall be considered to have engaged in activities
9 permitted by this chapter and shall not be penalized in any manner, or
10 denied any right or privilege, for such actions.

11 ~~((2) The))~~ (3) A qualifying patient, if eighteen years of age or
12 older, or a designated provider shall:

13 (a) Meet all criteria for status as a qualifying patient or
14 designated provider;

15 (b) Possess no more marijuana than is necessary for the patient's
16 personal, medical use, not exceeding the amount necessary for a sixty-
17 day supply; and

18 (c) Present his or her valid documentation to any law enforcement
19 official who questions the patient or provider regarding his or her
20 medical use of marijuana.

21 ~~((3) The))~~ (4) A qualifying patient, if under eighteen years of
22 age at the time he or she is alleged to have committed the offense,
23 shall ~~((empty))~~ demonstrate compliance with subsection ~~((2))~~ (3)(a)
24 and (c) of this section. However, any possession under subsection

25 ~~((2))~~ (3)(b) of this section, as well as any production, acquisition,
26 and decision as to dosage and frequency of use, shall be the
27 responsibility of the parent or legal guardian of the qualifying
28 patient.

29 ~~((4) The designated primary caregiver shall:~~

30 ~~(a) Meet all criteria for status as a primary caregiver to a~~
31 ~~qualifying patient;~~

32 ~~(b) Possess, in combination with and as an agent for the qualifying~~
33 ~~patient, no more marijuana than is necessary for the patient's~~
34 ~~personal, medical use, not exceeding the amount necessary for a sixty-~~
35 ~~day supply;~~

36 ~~(c) Present a copy of the qualifying patient's valid documentation~~
37 ~~required by this chapter, as well as evidence of designation to act as~~

1 primary caregiver by the patient, to any law enforcement official
2 requesting such information;

3 (d) ~~Be prohibited from consuming marijuana obtained for the~~
4 ~~personal, medical use of the patient for whom the individual is acting~~
5 ~~as primary caregiver; and~~

6 (e) ~~Be the primary caregiver to only one patient at any one time.))~~

7 **Sec. 6.** RCW 69.51A.060 and 1999 c 2 s 8 are each amended to read
8 as follows:

9 (1) It shall be a misdemeanor to use or display medical marijuana
10 in a manner or place which is open to the view of the general public.

11 (2) Nothing in this chapter requires any health insurance provider
12 to be liable for any claim for reimbursement for the medical use of
13 marijuana.

14 (3) Nothing in this chapter requires any physician to authorize the
15 use of medical marijuana for a patient.

16 (4) Nothing in this chapter requires any accommodation of any on-
17 site medical use of marijuana in any place of employment, in any school
18 bus or on any school grounds, ~~((or))~~ in any youth center, in any
19 correctional facility, or smoking medical marijuana in any public place
20 as that term is defined in RCW 70.160.020.

21 (5) It is a class C felony to fraudulently produce any record
22 purporting to be, or tamper with the content of any record for the
23 purpose of having it accepted as, valid documentation under RCW
24 69.51A.010~~((5))~~ (6)(a).

25 (6) No person shall be entitled to claim the affirmative defense
26 provided in RCW 69.51A.040 for engaging in the medical use of marijuana
27 in a way that endangers the health or well-being of any person through
28 the use of a motorized vehicle on a street, road, or highway.

29 **Sec. 7.** RCW 69.51A.070 and 1999 c 2 s 9 are each amended to read
30 as follows:

31 The Washington state medical quality assurance ~~((board~~
32 ~~[commission]))~~ commission in consultation with the board of osteopathic
33 medicine and surgery, or other appropriate agency as designated by the
34 governor, shall accept for consideration petitions submitted ~~((by~~
35 ~~physicians or patients))~~ to add terminal or debilitating conditions to
36 those included in this chapter. In considering such petitions, the

1 Washington state medical quality assurance ((~~board~~ [~~commission~~]))
2 commission in consultation with the board of osteopathic medicine and
3 surgery shall include public notice of, and an opportunity to comment
4 in a public hearing upon, such petitions. The Washington state medical
5 quality assurance ((~~board~~ [~~commission~~])) commission in consultation
6 with the board of osteopathic medicine and surgery shall, after
7 hearing, approve or deny such petitions within one hundred eighty days
8 of submission. The approval or denial of such a petition shall be
9 considered a final agency action, subject to judicial review.

10 NEW SECTION. Sec. 8. A new section is added to chapter 69.51A
RCW

11 to read as follows:

12 (1) By July 1, 2008, the department of health shall adopt rules
13 defining the quantity of marijuana that could reasonably be presumed to
14 be a sixty-day supply for qualifying patients; this presumption may be
15 overcome with evidence of a qualifying patient's necessary medical use.

16 (2) As used in this chapter, "sixty-day supply" means that amount
17 of marijuana that qualifying patients would reasonably be expected to
18 need over a period of sixty days for their personal medical use.
19 During the rule-making process, the department shall make a good faith
20 effort to include all stakeholders identified in the rule-making
21 analysis as being impacted by the rule.

22 (3) The department of health shall gather information from medical
23 and scientific literature, consulting with experts and the public, and
24 reviewing the best practices of other states regarding access to an
25 adequate, safe, consistent, and secure source, including alternative
26 distribution systems, of medical marijuana for qualifying patients.
27 The department shall report its findings to the legislature by July 1,
28 2008.

Passed by the Senate April 20, 2007.

Passed by the House April 18, 2007.

Approved by the Governor May 8, 2007.

Filed in Office of Secretary of State May 10, 2007.

Appendix B

Summary of Other States' Laws

Review of State Medical Marijuana Laws

State	Medical Marijuana Law	Currently Operational Law	Protection from Arrest	Exemption from State Prosecution	Affirmative Defense	Medical Necessity Defense	Physician Prescription Law	State Rescheduling	Therapeutic Research Program Law	Currently Operational TRP	Previously Operational TRP	Resolution for Federal Action
AK	X	X			X			X ⁷	X			
AL	X								X			
AR	X						X ^{2, 6}	X ⁸				
AZ	X						X	X ⁴	X			
CA	X	X	X	X	X				X	X		X
CO	X	X		X	X				X			
CT	X						X					
DC	X							X ⁷				
DE												
FL	X								X			
GA	X								X		X	
HI	X	X			X	X						
IA	X						X	X ^{5, 7}	X			
ID												
IL	X								X			
IN												
KS												
KY												
LA	X						X ²		X			
MA	X								X			
MD	X	X				X						
ME	X	X			X				X			
MI	X							X ^{3, 6}	X		X	X
MN	X							X ⁴	X ⁴			
MO	X											X
MS												
MT	X	X	X	X	X			X ^{2, 7}				
NC	X						X	X ⁶				
ND												
NE												
NH	X											X
NJ	X								X			
NM	X	X	X					X ^{5, 7}	X		X	X
NV	X	X		X	X				X			
NY	X								X		X	
OH	X					X ⁶			X			
OK												
OR	X	X		X	X		X ⁶		X			
PA												
RI	X	X	X	X	X				X			X
SC	X								X			
SD												
TN	X							X ^{5, 7}	X		X	
TX	X								X			
UT												
VA	X						X					
VT	X	X		X			X					
WA	X	X			X			X ^{3, 7}	X		X	X
WI	X						X					
WV	X								X			
WY												
Total	38	13	4	7	10	3	10	12	26	1	6	7

Sources:

"21 States Have Authorized Medical Marijuana Studies, but Only Six Implemented Programs," The Science of Medical Marijuana, accessed October 10, 2007, <http://www.medmjscience.org/Pages/science/fact1.html>.

"State-by-State Medical Marijuana Laws: How to Remove the Threat of Arrest," Marijuana Policy Project, 2007, accessed December 18, 2007, http://www.mpp.org/assets/pdfs/pdf/SBSR_2007.pdf.

Rosalie Pacula, Jamie Chiqui, Deborah Reichmann, and Yvonne Terry-McElrath, "State Medical Marijuana Laws: Understanding the Laws and their Limitations," *Journal of Public Health Policy*, Vol. 23(4), pp. 413-438.

Some individual state laws were also consulted.

Notes:

- ¹ Federal government prevented popular ballot measure from coming to vote
- ² Only with federal approval
- ³ Only applies to therapeutic research program (may or may not be operational)
- ⁴ For THC only
- ⁵ Only for approved medical purposes or patients
- ⁶ Law was previously in effect (either expired or was repealed)
- ⁷ Law is currently in effect
- ⁸ Moved marijuana to a more restrictive schedule

Current Access Laws

This category includes states with current medical marijuana laws allowing patient access to medical marijuana. Patients and their caregivers or providers may be able to avoid state criminal prosecution through arrest protection, an affirmative defense, or a medical necessity defense. Several state laws include more than one type of defense. In many of these cases, patients and caregivers in possession of a state medical marijuana registry identification card receive stronger protection from criminal penalties than those who are not registered. Law enforcement may still arrest people in these states if they have reason to believe they are in violation of the law.

Protection from Arrest

A few states provide qualified patients and their caregivers with protection from arrest for state criminal charges. Patients and caregivers are still subject to federal laws prohibiting marijuana.

Exemption from State Prosecution

Several states offer qualified patients and their caregivers exemption from state prosecution. This type of protection implies that patients and providers in compliance with the law may still be arrested but may not have to go to court to assert an affirmative defense or claim of medical necessity.

Affirmative Defense

Some states provide qualified patients and their providers with an affirmative defense against state criminal charges. Patients and providers may still be arrested and prosecuted in these states. They may have to go to court to prove they are in compliance with the state law.

Medical Necessity Defense

A couple states have laws allowing patients to claim a medical necessity defense in court. In these states, patients can be arrested, prosecuted, and convicted for using marijuana for medical reasons. Patients may be able to avoid conviction if they are able to prove that their medical use of marijuana was necessary for medical reasons. Research indicates that medical necessity defense “is based on a case-by-case analysis and does not lend itself to broad application.”¹⁷¹

Physician Prescription Laws

Several states have passed laws allowing doctors to prescribe marijuana to patients. Eight states currently allow doctors to prescribe marijuana.¹⁷² The federal government controls the prescription process. Doctors must register with the DEA to prescribe controlled substances. Pharmacies must also register with the DEA to dispense controlled substances. The Washington State Medical Association writes,

The terms ‘distribute’ and ‘dispense’ have been broadly interpreted, and physicians may be found in violation of federal law for writing a prescription for a substance, such as marijuana, for which federal law has no recognized value. Violation of federal laws can bring significant penalties, including imprisonment and fines. In addition, violating federal law (or aid and abet in its violation) may result in other federal sanction, such as a revocation of a physician’s DEA registration.¹⁷³

The Marijuana Policy Project considers these laws “symbolic measures” because they recognize the therapeutic value of marijuana but do not provide access without a policy change at the federal level.¹⁷⁴ The U.S. Supreme Court upheld the 2002 Ninth Circuit Court of Appeals decision, *Conant v. Walters*, recognizing the right of doctors to *recommend* marijuana.¹⁷⁵

State Rescheduling

A small number of states have rescheduled marijuana at the state level. According to Marijuana Policy Project, Alaska, Iowa, Montana, Tennessee, and the District of Columbia have current laws rescheduling marijuana for medical reasons.¹⁷⁶ New Mexico recently rescheduled marijuana for patients in therapeutic research programs or registered with the state medical

¹⁷¹ Pacula et al., p. 426.

¹⁷² Marijuana Policy Project, p. 10.

¹⁷³ Washington State Medical Association, "Medical Marijuana," accessed January 28, 2008, http://www.wsma.org/practice_resource_center/medical-marijuana.cfm.

¹⁷⁴ Marijuana Policy Project, p. 11.

¹⁷⁵ "Medical Marijuana Cases: Conant v. Walters," Drug Policy.org, accessed January 23, 2007, <http://www.drugpolicy.org/marijuana/medical/challenges/cases/conant/>

¹⁷⁶ Marijuana Policy Project, p. 11.

marijuana program.¹⁷⁷ Often, these rescheduling laws include conditions. For example, rescheduling may be contingent on federal rescheduling. In Washington, marijuana is placed in a less restrictive schedule for patients enrolled in a therapeutic research program.¹⁷⁸ This program is no longer operational.

In theory, these laws generally allow doctors to prescribe marijuana to patients for medical reasons.¹⁷⁹ A recent congressional report confirms the right of states to do this, saying, “States can statutorily create a medical use exception for botanical cannabis and its derivatives under their own, state-level controlled substance laws.”¹⁸⁰ Reportedly, these laws have not improved patient access. The Marijuana Policy Project says these laws have “little or no practical significance...because the federal schedules supersede state schedules and the federal government does not permit marijuana prescriptions.”¹⁸¹

Therapeutic Research Programs (TRPs)

States have also passed laws allowing therapeutic research programs for medical marijuana. Very few programs were operational. Gaining federal approval for a marijuana research program is very complex. Researchers “must obtain a special license from the DEA to handle the substance, FDA approval of the research protocol (if experimenting with human subjects), and a legal supply of the substance from the only federally approved source – the National Institute on Drug Abuse (NIDA).”¹⁸² Many states were unable to meet these strict standards.

Washington passed the Controlled Substances Therapeutic Research Act in 1979.¹⁸³ This law called for the Department of Health to administer the program and the Board of Pharmacy to develop the program rules.¹⁸⁴ The program researched the therapeutic potential of THC. The department was successful in obtaining marijuana in rolled and capsule form from the National Institute of Drug Abuse. The research program lasted approximately

¹⁷⁷ New Mexico Senate Bill 523 § 9(A)(e), “The Lynn and Erin Compassionate Use Act,” 2007, accessed August 24, 2007, <http://legis.state.nm.us/Sessions/07%20Regular/final/SB0523.pdf>.

¹⁷⁸ Chapter RCW 69.51.080, <http://apps.leg.wa.gov/RCW/default.aspx?cite=69.51.080>.

¹⁷⁹ Pacula et al., p. 423.

¹⁸⁰ Eddy, p. 4.

¹⁸¹ Marijuana Policy Project, p. 11.

¹⁸² Ibid., p. J-1.

¹⁸³ R.A. Roffman, Abstract of “The Controlled Substances Therapeutic Research Act in the State of Washington,” 1981, *Journal of Clinical Psychology*, Vol. 21(133S-140S), accessed on January 29, 2008, http://jcp.sagepub.com/cgi/content/abstract/21/8_suppl/133S.

¹⁸⁴ “Controlled Substances Therapeutic Research Act,” RCW 69.51, accessed January 28, 2008, <http://apps.leg.wa.gov/RCW/default.aspx?cite=69.51&full=true>.

two years.¹⁸⁵ Results from this research helped lead to the approval of THC pills (dronabinol) in 1981.¹⁸⁶

Currently, only California has a functioning therapeutic research program for medical marijuana. The Center for Medicinal Cannabis Research, part of the University of California, was established in August of 2000 with the intent of conducting clinical research on the safety and efficacy of medicinal marijuana. As of December 2007, 11 studies have been completed. Six studies have been discontinued. There are no studies being conducted at this point but two are under review.¹⁸⁷

¹⁸⁵ Lisa Salmi, Washington State Department of Health, Health Professions Quality Assurance, personal conversation, Jan. 29, 2008.

¹⁸⁶ Wells, Steve, Priscilla Lisicich, Carol Owens, "Governor's Council on Substance Abuse Report: Implementation of Initiative 692: The Washington Medical Use of Marijuana Act," Washington State Department of Community, Trade and Economic Development, January 2000, accessed December 10, 2007, http://mfiles.org/whitepaper/white_paper.html.

¹⁸⁷ "CMCR Studies," Center for Medicinal Cannabis Research, University of California, accessed Dec. 20, 2007, <http://www.cmcr.ucsd.edu/geninfo/research.htm>.

Operational Medical Marijuana Laws by State

State	Legal Protection	Patient / Caregiver Ratio	Explicitly Legal Sources	Registry	Comments
Alaska	affirmative defense	1 patient / 2 caregivers	patient & caregiver growing	yes - required	
California	protection from arrest and prosecution with registry ID card; exemption from prosecution without ID card	caregivers can have more than 1 patient	patient & caregiver growing, cooperative and collective growing, dispensaries (in some areas)	yes - optional; currently offered by 35 counties	caregivers can be compensated for expenses
Colorado	exemption from criminal laws with registry ID card; affirmative defense without ID card	not specified in law	patient & caregiver growing	yes - optional and only for patients	criminal penalties for breaching registry confidentiality
Hawaii	affirmative defense with registry ID card; may claim medical necessity defense without ID card under separate court ruling	1 patient / 1 caregiver	patient & caregiver growing	yes	
Maine	affirmative defense	not specified in law	patient & caregiver growing	no registry	
Maryland	medical necessity defense	not specified in law	not specified in law	no registry	patients still face arrest, fine of \$100, and possible related court costs
Montana	protection from arrest and prosecution with registry ID card; affirmative defense without ID card	patients may only have 1 caregiver at a time; caregivers can assist more than 1 patient	patient & caregiver growing	yes	fine and/or jail time for the unauthorized release of confidential registry information; registry ID cards or their equivalent from other states are accepted
Nevada	exemption from prosecution with registry ID card; affirmative defense for those over supply limits or without ID card	caregiver may only assist 1 patient; patients may not be caregivers for other patients	patient & caregiver growing	yes	

State	Legal Protection	Patient / Caregiver Ratio	Explicitly Legal Sources	Registry	Comments
New Mexico	protection from arrest, prosecution, and penalty	caregivers can assist up to 4 patients	licensed producers - may include patients, caregivers, private entities, associations of persons, and state agencies	yes - required	
Oregon	exemption from marijuana criminal laws with registry ID card; affirmative defense without ID card	patients may only have 1 caregiver at a time	patient & caregiver growing, registered growers may grow for up to 4 patients, patients may donate excess marijuana to other registered patients	yes	patients and caregivers may compensate growers for expenses
Rhode Island	protection from arrest, prosecution, and penalty with registry ID card; affirmative defense without ID card or when exceeding amount limits	patients may have up to 2 caregivers, caregiver may assist no more than 5 patients	patient & caregiver growing	yes	caregivers may be compensated for expenses; registry ID cards or equivalent from other states are accepted; penalties for unauthorized breach of registry confidentiality
Vermont	exemption from criminal penalties with registry ID card	1 caregiver / 1 patient	patient & caregiver growing	yes - required	marijuana must be grown in a secure, indoor, registered facility; physicians <i>certify</i> patient has qualifying condition; physician certifications from nearby states are accepted
Washington	affirmative defense	1 caregiver / 1 patient	patient & caregiver growing	no registry	

Alaska

History:	Ballot Measure 8, allowing the limited medical use of marijuana, was passed on November 3, 1998 by 58% of voters. It became effective on March 4, 1999. Senate Bill 94 became effective June 2, 1999 and required patients and caregivers to register.
Defense:	Affirmative defense against state criminal charges
Participants:	Qualified patients Primary caregivers Alternate caregivers
Patient / Caregiver Ratio:	1 patient / 2 caregivers (1 primary, 1 alternate) Primary and alternate caregivers may only assist 1 patient unless related by blood or marriage
Allowed Supply & Distribution Activities:	Acquire, cultivate, transport, manufacture, deliver, display
Additional Sources:	Not specified in law
Other Features:	Property is protected from seizure and forfeiture
Issues / Feedback:	The short growing season requires indoor growing for most participants, which is more expensive than outdoor growing, according to the Marijuana Policy Project.
Sources:	Alaska Department of Health and Social Services, Division of Public Health, Bureau of Vital Statistics, "Marijuana Application Packet," accessed August 23, 2007, http://www.hss.state.ak.us/dph/bvs/PDFs/Marijuana%20Application%20Packet.pdf "Medical Uses of Marijuana for Persons Suffering From Debilitating Conditions Act," Alaska Statute 17.37, Legislature Textual Infobases, accessed August 23, 2007, http://www.legis.state.ak.us/cgi-bin/folioisa.dll/statx99/query=*/doc/{@6909}? "State-by-State Medical Marijuana Laws: How to Remove the Threat of Arrest," Marijuana Policy Project, 2007, p. F-11, accessed December 18, 2007, http://www.mpp.org/assets/pdfs/pdf/SBSR_2007.pdf

California

History:	<p>Ballot Proposition 215, known as the "Compassionate Use Act", was approved by 56% of the voters on November 5, 1996. It became effective on November 6, 1996. It allows the limited medical use of marijuana.</p> <p>Senate Bill 420, the "Medical Marijuana Program Act", was passed in 2003 with the intent of clarifying the medical marijuana law. It allows the cooperative and collective growing of marijuana. It also requires a statewide ID registry.</p>
Defense:	<p>Protection from arrest and prosecution with registry ID card Exemption from prosecution without ID card</p>
Participants:	<p>Qualified patients Primary caregivers</p>
Patient / Caregiver Ratio:	<p>Primary caregivers can care for more than 1 patient as long as everyone resides in the same county; a caregiver for a patient living in a different county may only assist 1 patient</p>
Allowed Supply & Distribution Activities:	<p>Transport, deliver, or cultivate; cooperative and collective cultivation is allowed</p>
Additional Sources:	<p>Cooperative and collective production of marijuana is allowed; dispensaries exist in some cities and counties</p>
Other Features:	<p>Caregivers may be compensated for services and expenses.</p>
Issues / Feedback:	<p>Collectives and cooperatives are not clearly defined in the medical marijuana law. Cooperative dispensaries have opened in many areas.</p> <p>Some cities and counties regulated dispensaries; some cities and counties ban dispensaries; other cities and counties have no regulations for dispensaries.</p> <p>The DEA has raided dispensaries. The DEA has also sent letters warning landlords leasing to dispensaries that they may have their property seized.</p> <p>The crime surrounding dispensaries and the indoor grows that supply them are a big problem, according to the Executive Director of the California Police Chiefs Association.</p>

California's model of regulated dispensaries and voluntary registration and ID is very successful, according to Zach Rinser of the Cannabis Club Network. He would encourage sanctuary resolutions at the local level to prevent the DEA from working with local police on medical marijuana raids. He says dozens of cities in California have done this.

The Medical Marijuana Program Chief says feedback from law enforcement is mixed. They either support the county programs and medical marijuana patients or they support the federal law and consider marijuana illegal.

Patients living in counties that have chosen not to offer IDs have expressed disappointment to the Medical Marijuana Program chief.

- Sources:** California Health and Safety Code, Section 11357-11362.9
<http://info.sen.ca.gov/cgi-bin/displaycode?section=hsc&group=11001-12000&file=11357-11362.9>
- California Senate Bill 420, "The Medical Marijuana Program Act," 2003, accessed December 21, 2007,
http://www.dhs.ca.gov/mmp/Legislative_History/Links/SB420_Chaptered.htm
- California Department of Public Health, Department of Health Care Services, Office of County Health Care Services, "California Medical Marijuana Program," 2007, accessed February 13, 2008,
<http://www.dhs.ca.gov/mmp/>
- Karen Parr, Chief of Medically Indigent Services Section, Office of County Health Services, California Department of Public Health, "Medical Marijuana Survey," e-mail message, November 14, 2007.
- Leslie McGill, Executive Director, California Police Chiefs Association, "Medical Marijuana Dispensaries Task Force," e-mail message, November 13, 2007.
- Zach Rinser, California Cannabis Clubs, "Contact San Francisco Cannabis Clubs," e-mail message, November 14, 2007.

Colorado

- History:** Ballot Amendment 20 was approved on November 7, 2000 by 54% of voters. It allowed the limited medical use of marijuana. This law became effective on June 1, 2001.
- Defense:** Exemption from state prosecution if patient or caregiver is in possession of registry ID card

Affirmative defense against criminal penalties for qualifying patients and caregivers not in possession of ID card

Participants: Patient
Primary caregiver

**Patient /
Caregiver
Ratio:** Not specified in law

**Allowed
Supply &
Distribution
Activities:** Acquire, produce, or transport

**Additional
Sources:** Not specified in law

**Other
Features:** Protection against harm and forfeiture of property included in law;
police are required to keep confiscated marijuana plants alive

**Issues /
Feedback:** The Medical Marijuana Registry Program reports numerous
questions regarding the law, including whether "marijuana plants
may be grown or if two or more patients and/or caregivers may
share one growing space."

The Medical Marijuana Registry Program also notes that law
enforcement must keep seized plants alive under the law, creating
a burden for them.

Sources: Colorado Ballot History, Initiative 20, "Medical Use of Marijuana,"
2000, accessed August 23, 2007,
<http://www.leg.state.co.us/lcs/ballothistory.nsf/>

Colorado Department of Public Health and Environment, Medical
Marijuana Registry Program, "Medical Marijuana Registry Program
Update," October 31, 2007, accessed February 6, 2008,
<http://www.cdphe.state.co.us/hs/Medicalmarijuana/marijuanaupdate.html>

"Medical Use of Marijuana for Persons Suffering from Debilitating
Medical Conditions," 0-4-287 - Article 18, Section 14, Colorado
Department of Public Health and Environment, accessed August
23, 2007,
<http://www.cdphe.state.co.us/hs/medicalmarijuana/mjamendment.html>

Sue Lindsay, "Denver Judge Increases Safe Access to Medical
Marijuana for Patients," Rocky Mountain News, November 20,
2007, Marijuana Policy Project, accessed on December 18, 2007,
<http://www.mpp.org/news/in-the-news/denver-judge-increases-safe.html>

Hawaii

History:	<p>Senate Bill 862 H.D. 1 was signed into law on June 14, 2000. It became effective December 28, 2000.</p> <p>A 1979 Court decision also allows a medical necessity defense under certain circumstances.</p>
Defense:	<p>Affirmative defense against state criminal charges with registry ID card</p> <p>Medical necessity defense may be claimed without having a registry ID card under a separate court ruling</p>
Participants:	<p>Qualifying patients Primary caregivers</p>
Patient / Caregiver Ratio:	<p>1 patient / 1 caregiver</p>
Allowed Supply & Distribution Activities:	<p>Acquire, cultivate, distribute (only between caregiver and patient), and deliver</p>
Additional Sources:	<p>Not specified in law</p>
Other Features:	<p>Patients and caregivers may grow marijuana at home or at another site approved by the Narcotics Enforcement Division.</p> <p>Marijuana grow sites must be marked with the patient's registry ID number.</p> <p>Limited property protection is included in the law, not including the care of live plants</p>
Issues / Feedback:	<p>According to the Narcotics Enforcement Division (the agency that administers the medical marijuana registry), Hawaii does not allow the sale of marijuana or the development of marijuana buyers clubs.</p>
Sources:	<p>Hawaii Department of Public Safety, Chapter 23-202, Hawaii Administrative Rules, "Medical Use of Marijuana," 2000, accessed August 21, 2007, http://www.hawaii.gov/psd/documents/admin_rules/Chapter_23-202.pdf</p> <p>Hawaii Department of Public Safety, Law Enforcement Division, Narcotics Enforcement Division, "Medical Marijuana Patient Information," June 15, 2005, accessed August 21, 2007, http://kumu.icsd.hawaii.gov/psd/law_home.php</p>

Hawaii Revised Statute, Chapter 329, part IX, accessed December 18, 2007,

http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0121.htm

Hawaii Senate Bill 862, "Medical Use of Marijuana," 1999, Drug Policy Forum of Hawaii, accessed December 18, 2007,

http://www.dpfhi.org/news/sb862_hd1.html

Hawaii Supreme Court, Medical Necessity Court Ruling, 1979, Drug Policy Forum of Hawaii, accessed December 18, 2007,

<http://www.dpfhi.org/Pages/archives/rm1supcrt79.html>

Keith Kamita, Narcotics Enforcement Division, "Medical Marijuana Survey," Hawaii Department of Public Safety, e-mail message, November 13, 2007.

Maine

History: Ballot Question 2 was approved on November 2, 1999 by 61% of voters. It became effective on December 22, 1999. It allows the limited medical use of marijuana.

Senate Bill (L.D.) 611 was signed into law on April 2, 2002 and effective on July 25, 2002. It increases possession amounts for medical marijuana.

Defense: Affirmative defense for state criminal prosecution

Participants: Qualifying patients
Designated caregivers

**Patient /
Caregiver
Ratio:** Law does not specify

**Allowed
Supply &
Distribution
Activities:** Cultivate

**Additional
Sources:** Not specified in law

**Other
Features:** Protection against property forfeiture

No registry

Issues / Feedback:	The Marijuana Policy Project says the legislature considered state government distribution of medical marijuana based on a recommendation from an attorney general task force but abandoned the idea after the U.S. Supreme Court ruling in <i>Oakland Cannabis Buyer's Cooperative</i> case.
Sources:	<p>Citizen Initiated Bill, Chapter 1, I.B. 2 - L.D. 2109, "An Act to Permit the Medical Use of Marijuana," 1999, accessed August 23, 2007, http://janus.stte.me.us/legis/ros/lom/LOM119th/InitBill/IB1.htm</p> <p>Maine Public Law, Chapter 580, S.P. 183 - L.D. 611, "An Act to Aid Implementation of the Maine Medical Marijuana Act of 1998," 2001, accessed September 5, 2007, http://janus.state.me.us/legis/ros/lom/LOM120th/3Pub551-600/Pub551-600-84.htm</p> <p>"State-by-State Medical Marijuana Laws: How to Remove the Threat of Arrest," Marijuana Policy Project, 2007, accessed December 18, 2007, p. F-7. http://www.mpp.org/assets/pdfs/pdf/SBSR_2007.pdf</p>

Montana

History:	Initiative 148 was approved with 62% of the popular vote on November 2, 2004. It allowed the limited medical use of marijuana. It became effective on November 2, 2004.
Defense:	<p>Protection from state level arrest or prosecution for qualified patients and caregivers in possession of a registry ID card</p> <p>Affirmative defense against state criminal penalties available for qualified patients and caregivers without ID cards</p>
Participants:	<p>Qualifying patients</p> <p>Caregivers</p>
Patient / Caregiver Ratio:	<p>Qualifying patients may only have 1 caregiver at a time</p> <p>Caregivers can assist more than 1 patient</p>
Allowed Supply & Distribution Activities:	Acquire, cultivate, manufacture, deliver, transfer, and transport
Additional Sources:	Not specified in law

Other Features: Patients and caregivers with registry ID cards should not be denied any right or privilege, including civil penalties or disciplinary actions by the state labor department.

Property is protected from forfeiture

Issues / Feedback: The head of the medical marijuana program said some patients would like plant counts to be lower and the usable marijuana amounts to be higher. Doctors have said very little. Law enforcement was initially resistant but there is little feedback from them now. At one point, they tried to get the law amended so that patients could have an extra person act as a "transporter" based on the case of a severely ill patient. This was not successful.

Sources: Montana Annotated Code 2005, Title 50, Chapter 46, "Medical Marijuana Act," accessed September 4, 2007,

http://data.opi.state.mt.us/bills/2005/mca_toc/50_46.htm

Montana Department of Public Health and Human Services, Quality Assurance Division, "Montana Medical Marijuana Program," September 14, 2007, accessed February 13, 2008,

<http://www.dphhs.mt.gov/medicalmarijuana/index.shtml>

Montana Department of Public Health and Human Services, Quality Assurance Division, Montana Medical Marijuana Program, "Frequently Asked Questions about the Montana Medical Marijuana Act," accessed September 4, 2007,

<http://www.dphhs.mt.gov/medicalmarijuana/frequentlyaskedquestions1.pdf>

Montana Initiative No. 148, "Montana Medical Marijuana Act," accessed September 4, 2007,

<http://www.dphhs.mt.gov/medicalmarijuana/i148text.pdf>

Roy Kemp, Bureau Chief, Montana Department of Public Health and Human Services, Quality Assurance Division, telephone conversation, November 29, 2007.

Nevada

History: Ballot Question 9 was approved on November 7, 2000 by 65% of voters. It allowed the limited use of medical marijuana.

Assembly Bill 453 became effective on October 1, 2001. It created a state registry for patients.

Defense: Registered patients and caregivers are exempt from state prosecution

Affirmative defense is available for those who are qualified but over the limits or do not have registry ID card

Participants:	Qualifying patient Designated primary caregiver
Patient / Caregiver Ratio:	Patients may only have 1 caregiver at a time Patients may not be caregivers for other patients Caregivers can only provide for 1 patient at a time
Allowed Supply & Distribution Activities:	Deliver and produce
Additional Sources:	Law says the agriculture department should start a seed bank and establish a program to produce and deliver marijuana for medical use. The Program Officer says they have not pursued this and this provision may be written out of the statute next session.
Other Features:	Limited protection against property forfeiture, not including caring for live plants
Issues / Feedback:	None
Sources:	<p>Jennifer Bartlett, Program Officer, Nevada Department of Agriculture, Medical Marijuana Program, telephone conversation, December 18, 2007.</p> <p>Nevada Administrative Code, Chapter 453A, "Medical Use of Marijuana," accessed December 18, 2007, http://www.leg.state.nv.us/nac/nac-453a.html#NAC453ASec150</p> <p>Nevada Department of Agriculture, Medical Marijuana Program, "Program Facts Related to Frequently Asked Questions," March 18, 2007, accessed September 5, 2007, http://agri.nv.gov/ADMIN_MedMarijuana.htm</p> <p>Nevada Revised Statute 453.131, "Uniform Controlled Substances Act," posted July 18, 2006, accessed February 13, 2008, http://bop.nv.gov/LawBook/LawBook-NRS453.pdf</p> <p>Nevada Revised Statutes, Chapter 453A, "Medical Use of Marijuana," accessed August 21, 2007, http://www.leg.state.nv.us/NRS/NRS-453A.html</p>

New Mexico

History: Senate Bill 523, "The Lynn and Erin Compassionate Use Act," was approved on March 13, 2007 allowing the restricted use of medical marijuana. It became effective on July 1, 2007.

Rules have been proposed for the creation of an advisory committee (NMAC 7.34.2), a registry (NMAC 7.34.3), and the licensing of marijuana producers and distributors (NMAC 7.34.4) and are subject to change.

Defense: Protection from arrest, prosecution, and penalties for state marijuana charges

Participants: Qualified patients
Primary caregivers
Licensed producers/distributors

**Patient /
Caregiver
Ratio:** Caregivers can help up to 4 patients

**Allowed
Supply &
Distribution
Activities:** Licensed producers can produce, sell, distribute, dispense and transfer medical marijuana to qualified patients and caregivers only. Licensed producers may be qualified patients, designated caregivers, private entities, associations of persons, or state agencies.

**Additional
Sources:** There are multiple sources in this system (see above)

**Other
Features:** Producers will have to submit a security plan for the grow site

Patients can reimburse caregivers for the cost of supplies or utilities associated with the medical use of marijuana

Property is protected from harm or forfeiture

**Issues /
Feedback:** None

Sources: Proposed 7.34.2 NMAC, "Advisory Board Responsibilities and Duties Public Comment Draft Rule," New Mexico Department of Health, Division of Health Improvement, November 20, 2007, accessed December 4, 2007,
<http://www.nmhealth.org/pdf/Advisory%20Board%20Rules.pdf>

Proposed 7.34.4.8 NMAC, "Internal Draft Licensure Production Rule," New Mexico Department of Health, Division of Health Improvement, accessed December 4, 2007,

<http://www.health.state.nm.us/pdf/Licensure%20Production%20Rule.pdf>

Proposed 7.34.3 NMAC, "Registry Identification Card Public Comment Draft Rule," New Mexico Department of Health, Division of Health Improvement, November 28, 2007, accessed December 4, 2007,

<http://www.nmhealth.org/pdf/ID%20Card%20Rules.pdf>

New Mexico Department of Health, "Medical Cannabis Program - Frequently Asked Questions," accessed February 13, 2008,

<http://www.health.state.nm.us/pdf/MCP-FAQ.pdf>

New Mexico Senate Bill 523, "The Lynn and Erin Compassionate Use Act", 2007, accessed August 24, 2007,

<http://legis.state.nm.us/Sessions/07%20Regular/final/SB0523.pdf>

Oregon

History:	Ballot Measure 67 was approved on November 3, 1998 by 55% of voters. It became effective December 3, 1998. It allowed the limited medical use of marijuana.
	House Bill 3052 became effective on July 21, 1999. It requires each patient to grow marijuana in only one location. It also requires unregistered patients to have a doctor's diagnoses within the past 12 months before claiming an affirmative defense in court. Law enforcement officers who seize marijuana plants are not liable for damages.
	Senate Bill 1085 took effect on January 1, 2006. It raises the possession limits for medical marijuana. People found with more than new possession limits can no longer claim an affirmative defense.
Defense:	Arrest protection for patients, caregivers, and registered growers with registry ID cards
	Affirmative defense for those who qualify but do not have ID cards
	No arrest protection or affirmative defense for those who go over the supply limits
Participants:	Qualifying patient Designated primary caregiver Registered grower
Patient / Caregiver Ratio:	Patients can only have 1 caregiver at a time

	<p>Patients may only have 1 grow site</p> <p>Growers can grow for up to 4 patients</p>
Allowed Supply & Distribution Activities:	Produce and deliver; patients may donate excess marijuana to other qualified patients
Additional Sources:	Patients may share marijuana with other qualified patients
Other Features:	<p>Patients and caregivers may compensate grower for the cost of utilities and supplies</p> <p>Grow sites must be registered with the Oregon Medical Marijuana Program (OMMP) and must be located within the state</p> <p>Limited property protection not including caring for live plants</p>
Issues / Feedback:	<p>According to the Marijuana Policy Project, the Oregon Medical Marijuana Program has been a financial boon to the state. The program is entirely funded by fees and has been so successful that it generated a reserve of funds. This additional revenue was used to lower the registration fee and to help fund the state health department in 2005.</p> <p>The Marijuana Policy Project also notes that the federal government has shown little interest in going after participants in Oregon's program, in contrast to what has been happening in California.</p> <p>The Marijuana Policy Project says Oregon has many physicians participating in recommending medical marijuana.</p> <p>Laird Funk, Vice Chairman of the Oregon Medical Marijuana Program Advisory Committee and registered marijuana grower said there are no clear best practices being used in Oregon. He described their program as "almost adequate." Feedback from patients has depended on their personal situation. Law enforcement feedback is mixed. He says one segment of the law enforcement community insists the program is abused. There have been few prosecutions out of approximately 20,000 registered patients, caregivers, and growers. He describes community feedback as generally supportive. He says there is a need for some sort of dispensary system for those who cannot grow. He suggests non-profits dispensaries licensed and regulated by the state. Other ideas being considered in the state include a state-run research program and dispensary or distributing marijuana through liquor stores.</p>
Sources:	Laird Funk, Vice Chairman of the Oregon Medical Marijuana Advisory Committee, telephone conversation, November 14, 2007.

Oregon Administrative Rules 333-008-0000 - 333-008-0120, January 2006, accessed August 20, 2007,
<http://oregon.gov/DHA/ph/ommp/docs/oar333008.pdf>

Oregon Department of Human Services, "Medical Marijuana Program," accessed August 20, 2007,
<http://oregon.gov/DHS/ph/ommp/index.shtml>

Oregon Revised Statutes (ORS) 475.300 - 475.346, "Oregon Medical Marijuana Act," accessed August 20, 2007,
<http://oregon.gov/DHS/ph/ommp/docs/mmact475.pdf>

"State-by-State Medical Marijuana Laws: How to Remove the Threat of Arrest," Marijuana Policy Project, 2007, p. F-10, accessed December 18, 2007,
http://www.mpp.org/assets/pdfs/pdf/SBSR_2007.pdf

Rhode Island

History: Senate Bill 0710, "The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act", was approved by the state House and Senate and then vetoed by the Governor. The veto was overridden by the Senate on June 30, 2005 and by the House on January 3, 2006. The law became effective January 3, 2006. It allows the limited medical use of marijuana.

Senate Bill 791 was passed on June 21, 2007, making the medical marijuana law permanent.

Defense: Protection from arrest, prosecution, and penalty with a registry ID card

Affirmative defense available for patients without registry ID card or for exceeding limits

Participants: Qualified patients
Primary caregivers

Patient / Caregiver Ratio: Patients may have up to 2 primary caregivers
Caregivers may have up to 5 qualifying patients

Allowed Supply & Distribution Activities: Acquire, grow, manufacture, deliver, transfer, transport

Additional Sources: Not specified in law

Other Features:	<p>Caregivers may be compensated for the cost of assisting patients with medical marijuana use</p> <p>Schools, employers, and landlords may not penalize patients and caregivers</p> <p>Property protection is included in the law</p> <p>There is a voluntary registry for patients and caregivers</p> <p>Registry cards issued by other US jurisdiction medical marijuana programs are accepted</p>
Issues / Feedback:	<p>According to the Marijuana Policy Project, the Rhode Island medical marijuana law is a model bill for effectively providing patients with access to medical marijuana.</p> <p>The medical marijuana program chief shared feedback he has heard. He says patients want a legal way to get marijuana and would like a list of doctors who certify patients. Doctors have been generally supportive but have said little. The community has been generally supportive as well. He says law enforcement does not support the program. One patient and one caregiver arrested since the program began.</p>
Sources:	<p>Charles Alexandre, Chief, Health Professions Regulation, "Medical Marijuana Survey," Rhode Island Department of Health, e-mail message, November 15, 2007.</p> <p>Rhode Island Department of Health, Medical Marijuana Program, "Frequently Asked Questions," June 2006, http://www.health.ri.gov/hsr/mmp/mmp-FAQs.pdf</p> <p>Rhode Island General Laws, Chapter 21-28.6, "The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act," 2007, accessed August 21, 2007, http://www.rilin.state.ri.us/PublicLaws/law05/law05443.htm</p> <p>"State-by-State Medical Marijuana Laws: How to Remove the Threat of Arrest," Marijuana Policy Project, 2007, pp.2-3, accessed December 18, 2007, http://www.mpp.org/assets/pdfs/pdf/SBSR_2007.pdf</p>

Vermont

History:	<p>Senate Bill 76 passed the House and Senate and passed into law without the Governor's signature on May 26, 2004. It became effective on July 1, 2004. It allows the limited medical use of marijuana.</p>
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Senate Bill 7 was passed on May 31, 2007 and effective as of July 1, 2007. It amended the possession amounts and qualifying medical conditions.

Defense:	Exemption from state criminal penalties with registry ID card
Participants:	Qualified patients Caregivers
Patient / Caregiver Ratio:	Patients may only have 1 caregiver at a time Caregivers may only have 1 patient at a time
Allowed Supply & Distribution Activities:	Acquire, grow, transfer, and transport
Additional Sources:	Not specified in law
Other Features:	Marijuana may only be grown in an indoor facility secured with locks or other security devices Physicians licensed in New York, Massachusetts, New Hampshire, or Vermont certify that a patient has a qualifying condition Marijuana grow site must be listed on registry application
Issues / Feedback:	None
Sources:	Vermont Senate Bill 7, "An Act Relating to the Compassionate Use of Marijuana for Medical Purposes," accessed August 21, 2007, http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT058.HTM Vermont Senate Bill 76, "An Act Relating to Marijuana Use by Persons with Severe Illness," 2007, accessed August 21, 2007, http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2004/bills/passed/S-076.HTM

Washington

History: Ballot Initiative 692 was approved on November 3, 1998 by 59% of voters. It allows the limited medical use of marijuana for qualified patients and their caregivers.

Engrossed Substitute Senate Bill 6032 took effect on July 22, 2007. It changed "caregivers" to "providers", clarified procedures for police seizure of medical marijuana, and requested the Department of Health to draft rules defining the 60-day supply and report on options for access to medical marijuana.

Defense: Affirmative defense against state criminal charges

Participants: Qualified patients
Designated providers

**Patient /
Caregiver
Ratio:** Patients can only have 1 caregiver at a time
Providers can only have 1 patient at a time

**Allowed
Supply &
Distribution
Activities:** Produce

**Additional
Sources:** Not specified in law; some dispensaries are currently operating

**Other
Features:** Patients and providers may have a 60-day supply of marijuana. This amount is currently being defined.

Law enforcement may not seize the marijuana of a qualified patient. They may take a sample.

**Issues /
Feedback:** Patients say they would like a legal source for marijuana. Law enforcement would like clear standards on the 60-day supply amount.

Sources: "Medical Marijuana," chapter 69.51A.060 RCW,
<http://apps.leg.wa.gov/RCW/default.aspx?cite=69.51A&full=true>

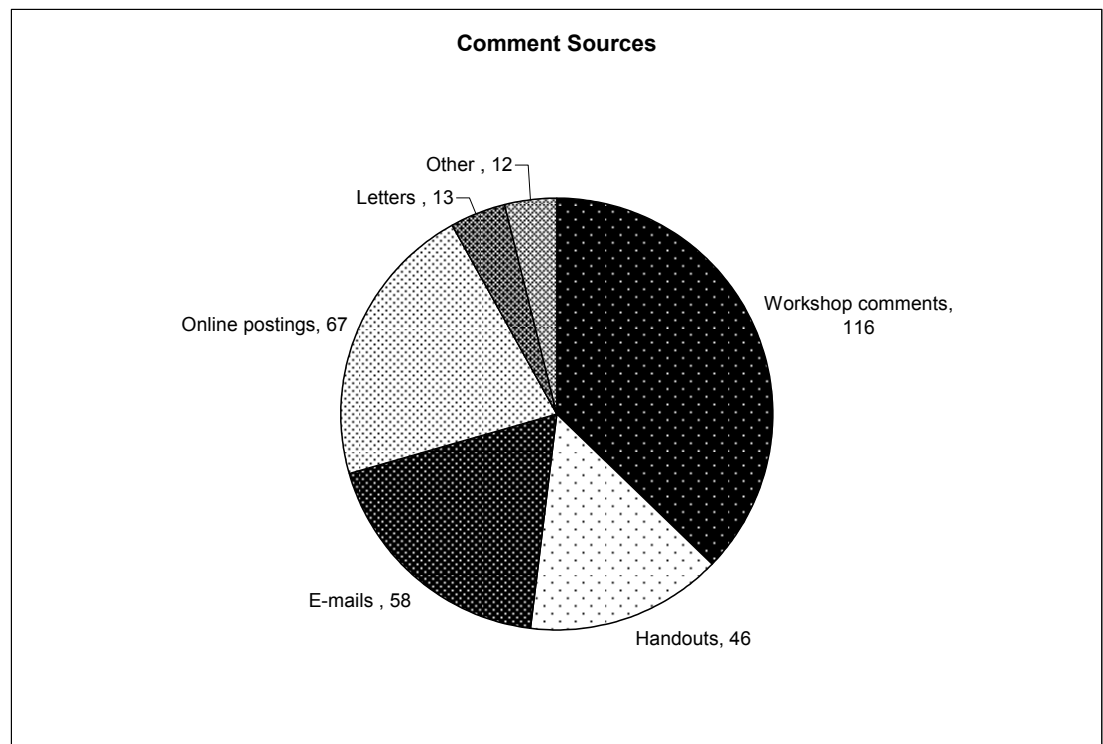
Appendix C

Public Comments Summary Charts

The department reached out to stakeholders to gather input on access to medical marijuana in Washington. Four public workshops were held across the state in September 2007. Hundreds of people shared their opinions about the two projects assigned to the department. People talked about the current means of getting marijuana for medical purposes. They shared suggestions and opinions on possible alternatives. The department also received hundreds of comments via mail, fax, phone, email, and postings to a dedicated Web site.¹⁸⁸ The insights shared by participants were instrumental in identifying barriers to access and assessing alternatives.

As of Dec. 13, 2007, the Washington State Department of Health received 312 public comments related to safe and effective access to medical marijuana. Some people submitted multiple comments for consideration. Although the department asked for comments from all interested parties, most comments came from patients using medical marijuana and their advocates. Social stigma and fear of legal repercussions may have kept some medical marijuana users from participating. In addition, the department received few comments from law enforcement and the medical community.

Figure 1



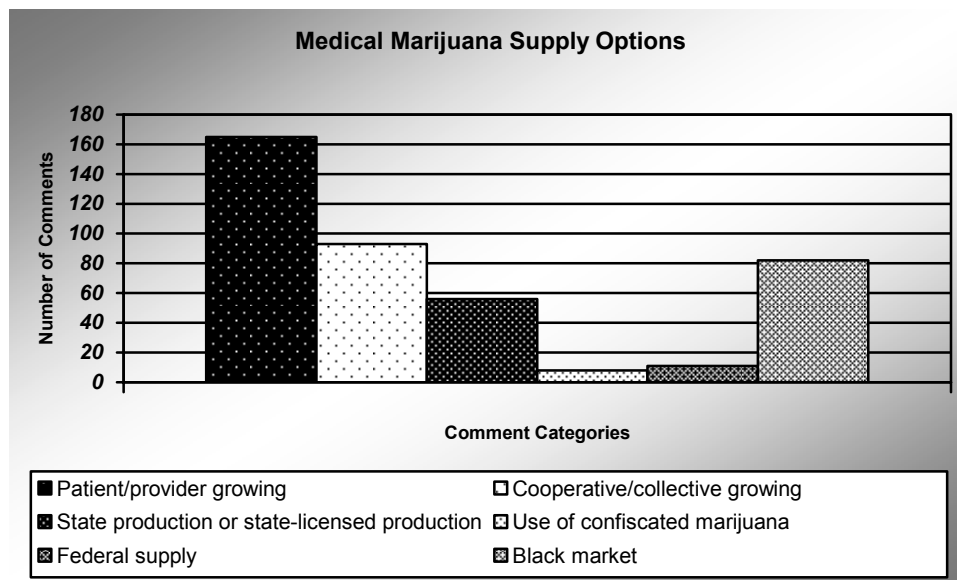
The following charts summarize the themes of the comments. Some comments were in support of a particular distribution method. Other comments were in opposition. Some comments were not clearly in support or opposition of particular supply and distribution methods. Instead, people

¹⁸⁸ See Appendix C for a summary of public comments.

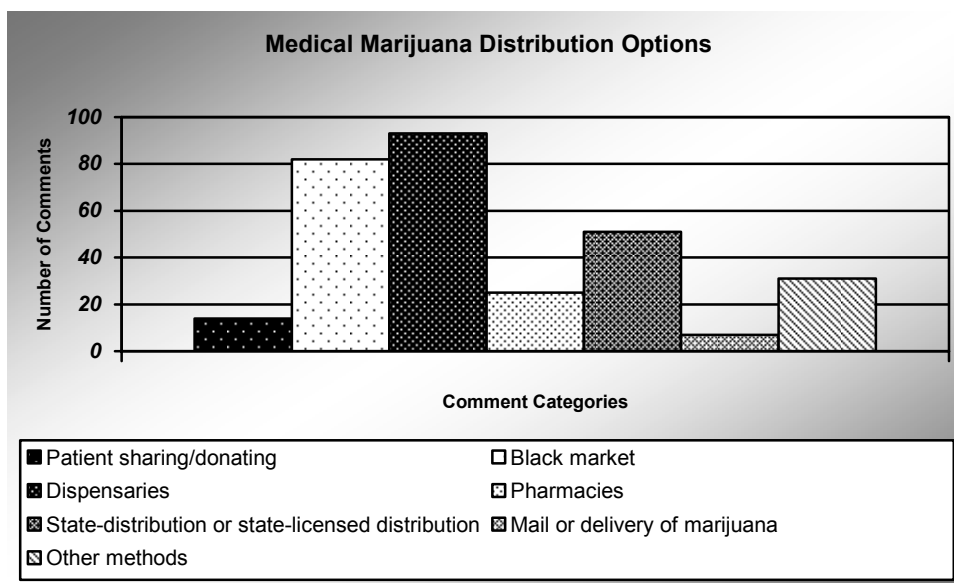
shared the nuances of their experiences. Stakeholder insights are interwoven throughout the text of the report. Their comments highlighted the complexity of this issue and the challenge of finding a workable solution.

The department passed out two questionnaires at each public workshop. One handout asked for responses on the 60-day supply issue. A few people commented on access issues on this handout, as noted in the pie chart (Figure 1.). The second handout asked for opinions on how to ensure the secure, safe, consistent, and adequate supply of medical marijuana to patients. People were asked to provide feedback on a variety of distribution systems. Models included for feedback included patient growing, provider growing, buying from black market suppliers, growing and distribution by non-governmental groups, and growing and distribution by the government. Opinions were also solicited on the topic of a registry. Consequently, it is very likely that these topics received more comments because of this handout.

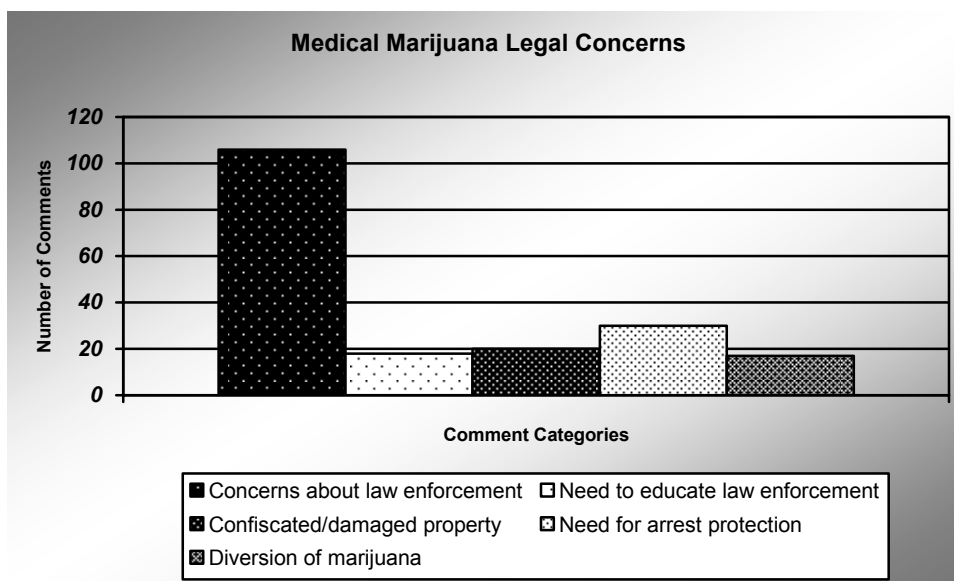
Public Comments on Medical Marijuana Supply Options



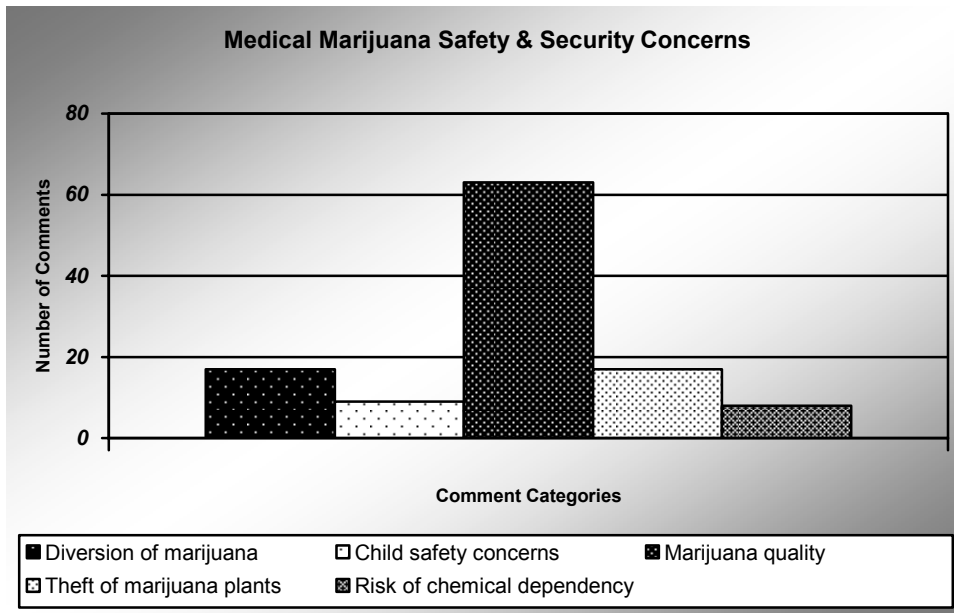
Public Comments on Medical Marijuana Distribution Options



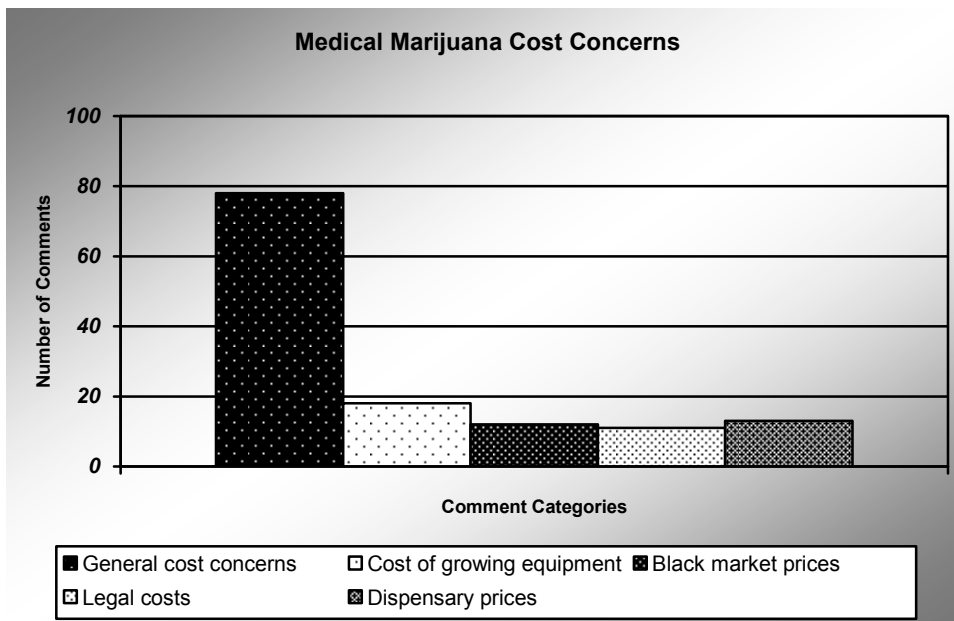
Public Comments on Medical Marijuana Legal Concerns



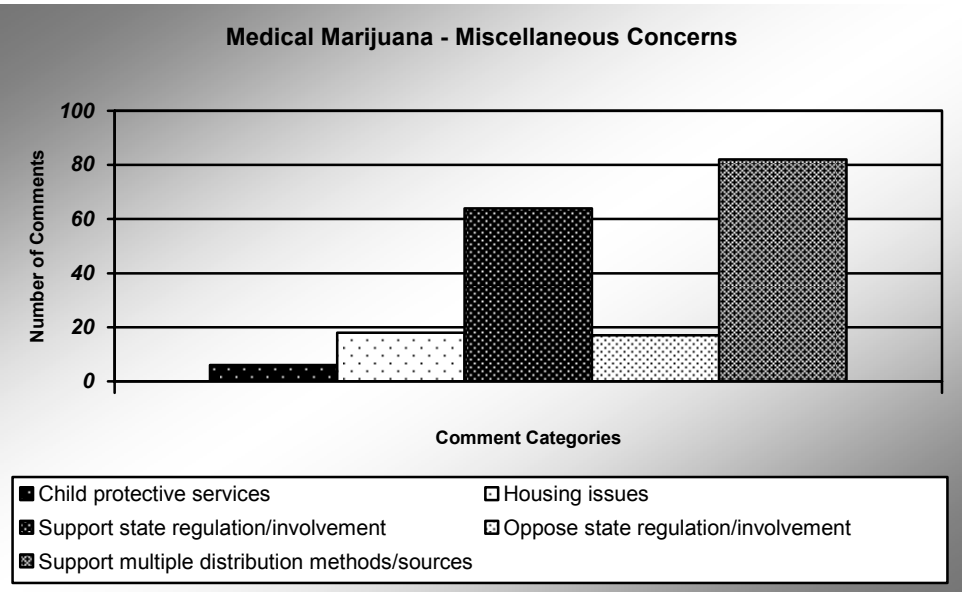
Public Comments on Medical Marijuana Safety & Security Concerns



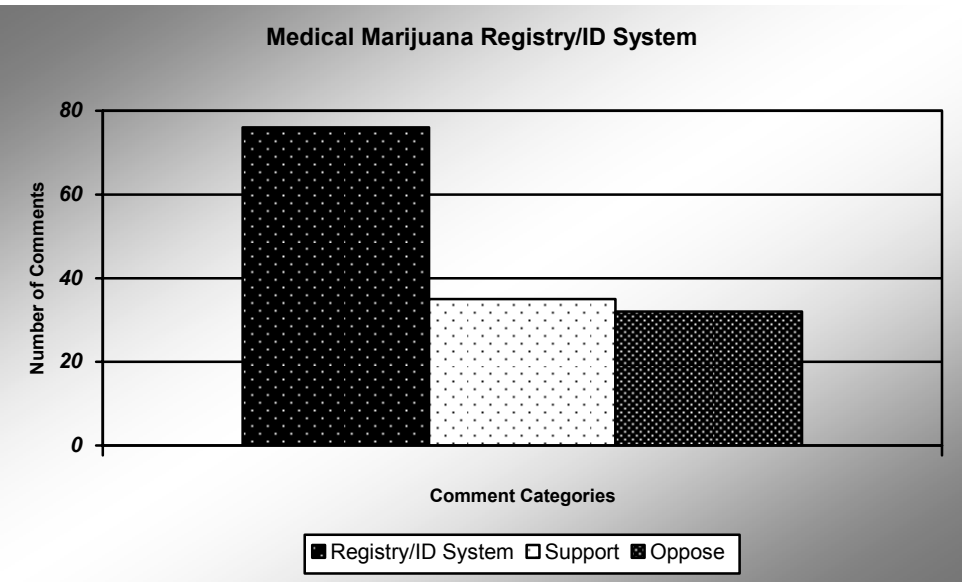
Public Comments on Medical Marijuana Cost Concerns



Public Comments on Medical Marijuana – Miscellaneous Concerns



Public Comments on a Medical Marijuana Registry



Appendix D

Medical Marijuana Registries

Unlike most other medical marijuana states, Washington does not have a medical marijuana registry. States with registries typically provide an identification card for patients and caregivers. Program participants can present the I.D. to law enforcement if the need arises. Law enforcement can then verify the registration status of a patient or caregiver by contacting the state medical marijuana program. Some states require patients to register to receive legal protection. Other states offer optional registration. Washington, Maine, and some counties in California do not have medical marijuana registries.

States with Medical Marijuana Registries

State	Registry	No Registry	Optional	Required
Alaska	X			X
California	X		X	
Colorado	X		X	
Hawaii	X			X
Maine		X		
Maryland	X			
Montana	X			X
Nevada	X		X	
New Mexico	X			X
Oregon	X		X	
Rhode Island	X		X	
Vermont	X			X
Washington		X		

Telling qualified patients and providers from illegal users and dealers is difficult for law enforcement. The Washington State Patrol said, “Task Force Commanders are challenged with enforcement of illicit marijuana growing operations while also respecting legitimate medical marijuana patients and their grow operations.”¹⁸⁹ The state medical marijuana law says that patients and providers must have a doctor’s recommendation or an equivalent note in the patient’s medical record. A photocopy of the recommendation is legally acceptable as well. The Washington State Medical Association has a form available on its Web site.¹⁹⁰ Use of this form is optional. The lack of an easily verified document creates extra work for police. They must try to tell legitimate documents from fakes.

Registries offer police a way to identify legitimate patients and caregivers. For this reason, they may help protect patients and caregivers from arrest. However, they may also put patients and caregivers at risk. In theory, the

¹⁸⁹ Captain Timothy P. Braniff, Investigative Assistance Division, Washington State Patrol, letter to Blake Maresh, Executive Director of Health Professions Quality Assurance Division Five, Washington State Department of Health, Dec. 4, 2007.

¹⁹⁰ "Documentation of Physician Authorization to Engage in the Medical Use of Marijuana in Washington State," July 2007, accessed Jan. 28, 2008, http://www.wsma.org/files/Downloads/PracticeResourceCenter/Med_Mari_authorization.pdf.

federal government could get a hold of patient information on registration forms or in computer databases. Federal prosecutors could possibly use this information to go after patients or providers for violating federal law.¹⁹¹ So far, this has not happened.

A grand jury recently attempted to access patient records from the Oregon Medical Marijuana Program registry. The state went to court to prevent the release of the confidential patient records. Chief U.S. District Judge Robert H. Whaley ruled against giving the grand jury access to the records, finding the request unreasonable.¹⁹² Oregon's medical marijuana law, like the laws in other states with registries, says registry information is confidential and can be released only to authorized parties for verification purposes.

Public opinion in Washington is mixed. Some patients support registries, saying they may help prevent arrest. Other patients say they put patients at greater risk of federal criminal penalties. Some people suggested optional registration or a registry run by a patient advocacy group.

Here are a few innovative practices from medical marijuana states:

- Several states offer stronger legal protection to patients and caregivers who have registered:
 - Medical marijuana laws in California, Montana, and Rhode Island offer arrest protection for registered patients and caregivers who are otherwise in compliance. Patients and caregivers not registered may still cite an affirmative defense in court against state criminal charges. State and local police still arrest patients and caregivers under federal law or if they are in violation of state law.
 - Medical marijuana laws in Colorado, Nevada, and Oregon offer registered patients and caregivers exemption from state prosecution.¹⁹³ Qualified patients and caregivers who do not register may still cite an affirmative defense in court. State and local police still arrest patients and caregivers under federal law or if they are in violation of state law.
- Montana and Rhode Island accept registry IDs or their equivalents from other states with medical marijuana programs.

¹⁹¹ Pacula et al., pp. 413-438.

¹⁹² Anne Saker, "Ruling Protects Pot Patients Privacy," *The Oregonian*, Sept. 6, 2007, accessed on Jan. 9, 2008, <http://www.mpp.org/news/in-the-news/ruling-protects-pot-patients.html>.

¹⁹³ Caregivers in Colorado are no longer issued registry ID cards, according to the Colorado Department of Public Health and Environment.

- Medical marijuana laws in Rhode Island and Montana include penalties for the unauthorized release of confidential registry information.
- California, Rhode Island, and Oregon offer reduced registration fees for qualifying low-income patients. Montana's Web site has a link to a medical marijuana advocacy organization that helps patients pay for registration.
- Oregon registers growers and issues grow site registration cards for to post at grow sites. Patients may only have one grow site and it must be within the state.
- Oregon has a 24/7 law enforcement verification data system.
- Several states, including Montana, Nevada, New Mexico, Oregon, and Vermont, require caregivers to pass criminal background checks.
- Santa Cruz County's Health Services Agency registry protects patient confidentiality by not keeping patient information on file. Instead, they keep a list of valid registry ID numbers. Patients submit proof that they are qualified patients. The agency verifies this and then either returns the documents to the patient.¹⁹⁴ Registry numbers are printed on the IDs. Law enforcement calls the agency to verify that the number is valid.
- Rhode Island, Oregon, and Colorado report statistics on their registries. Reported information may include the number of registrants, the number of physicians recommending marijuana, medical conditions of qualified patients, patient demographic data, program costs, and marijuana-related prosecutions of registered patients and caregivers.

¹⁹⁴ County of Santa Cruz Health Services Agency, Medical Cannabis User Identification Card, "Frequently Asked Questions for Applicants," accessed Feb. 1, 2008, <http://santacruzhealth.net/pdf/mmfaq.pdf>.

Registry Statistics for Selected States

State	Registered Patients	Registered Caregivers	Physicians Recommending	Cost of Registration	Registrant Prosecutions
Colorado	1737	n/a	not reported	\$90	2
Nevada	730	120	not reported	\$150*	not reported
Oregon	15,927	7,735	2782	\$100**	not reported
Rhode Island	192	173	119	\$75**	1

Sources:

Colorado Medical Marijuana Registry Program, "Medical Marijuana Registry Program Update," October 31, 2007, accessed February 6, 2008, <http://www.cdphe.state.co.us/hs/Medicalmarijuana/marijuanaupdate.html>.

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Oregon Medical Marijuana Program, "Oregon Medical Marijuana Program Data," January 1, 2008, accessed February 6, 2008, <http://www.oregon.gov/DHS/ph/ommp/data.shtml>.

Rhode Island Medical Marijuana Program, "Annual Report," December 29, 2006, accessed August 21, 2007, http://www.health.ri.gov/hsr/mmp/MMP_2006_Annual_Report.pdf.

Notes:

* Additional costs for fingerprinting, I.D. card, and initial application packet

** Reduced fee available for low-income individuals

Rhode Island also reported the cost of the program. From May 1, 2006, to December 29, 2006, the costs for equipment and personnel were \$21,361 while registry fees collected were \$8,515.

California's Medical Marijuana Program reports having 18,847 patients and caregivers with registry I.D. cards as of January 2008. County health departments issue the cards and set the fees. The state public health department maintains a registry database used for verifying patient and caregiver status. The registry program is fee supported. The lack of a reliable revenue stream has led to some difficulties for the state program, including staff reductions.¹⁹⁵ In addition, participation has been lower in some counties, possibly as a result of recent DEA raids on dispensaries.¹⁹⁶ Currently, 36 counties are participating.¹⁹⁷

¹⁹⁵ Parr.

¹⁹⁶ Ibid.

¹⁹⁷ California Department of Public Health.

Appendix E

Sources

"21 States Have Authorized Medical Marijuana Studies, but Only Six Implemented Programs," *The Science of Medical Marijuana*, accessed Oct. 10, 2007, <http://www.medmjscience.org/Pages/science/fact1.html>.

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Aggarwal, Sunil, Gregory Carter, Jeffrey Steinborn, "Clearing the Air: What the Latest Supreme Court Decision Regarding Medical Marijuana Really Means," *American Journal of Hospice & Palliative Medicine*, Vol. 22(5), September/October 2005, pp. 327-329, accessed Oct. 8, 2007, <http://students.washington.edu/sunila/>.

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