ACCESS, DISTRIBUTION, AND SECURITY COMPONENTS OF STATE MEDICAL MARIJUANA PROGRAMS

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FOREWORD

This report was undertaken in response to Act 29, First Special Session Laws of Hawaii 2009 (Senate Bill No. 1058, S.D. 2, H.D. 2, C.D. 1). The Bureau was requested to complete and submit to the Medical Cannabis Task Force "a report on the policies and procedures for access, distribution, security, and other relevant issues related to the medical use of cannabis for all the states that currently have a medical cannabis program."

During the 2000 Regular Session, the Hawaii Legislature enacted the Medical Use of Marijuana law, codified as Part IX of Chapter 329, Hawaii Revised Statutes. Essentially, the medical use of marijuana by qualifying individuals in Hawaii is permitted under certain conditions. However, the law does not provide these individuals with a legal method of obtaining medical marijuana. This study examines medical marijuana distribution systems that are operating or are currently being developed in other states.

FACT SHEET

Thirteen states, including Hawaii, have adopted medical marijuana laws. These laws allow certain individuals to cultivate and use marijuana for medical purposes. These individuals must comply with their respective state's medical marijuana law, including being certified or registered to use marijuana for certain specified medical conditions.

Federal law, however, prohibits the cultivation and any use of marijuana. Creating further difficulty for individuals who use medical marijuana is the fact that the medical marijuana laws of most states do not provide a method of obtaining medical marijuana.

This study examines the policies and procedures of the medical marijuana programs of the other twelve states with regard to issues of access, distribution, and security. Of particular interest are the programs in California, New Mexico, and Rhode Island -- the only three states that currently have policies and procedures in place that address these issues.

California's system of distribution is not mandated by statute or administrative rule. Instead, California's state law allows for the formation of cooperatives and collectives for the purpose of cultivating medical marijuana. Regulation is conducted at the municipal and county levels, rather than at the state level.

New Mexico's system of distribution for medical marijuana is established by statute and provides for the licensing of private non-profit producers of medical marijuana. The New Mexico Department of Health has finalized an extensive set of administrative rules to regulate the licensing and operation of medical marijuana production facilities. New Mexico issued its first license to a private non-profit producer earlier this year, and distribution is anticipated to begin by the end of summer.

Rhode Island's system of distribution for medical marijuana is also established by statute. Like New Mexico, the Rhode Island distribution system allows for the licensing of private non-profit entities, called "compassion centers", to cultivate, distribute, and dispense medical marijuana. The Rhode Island Department of Health is currently drafting the regulations that will govern how their distribution system will be operated.

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Chapter 1

INTRODUCTION

State Medical Marijuana Programs

Act 29, First Special Session Laws of Hawaii 2009 (Senate Bill No. 1058, S.D. 2, H.D. 2, C.D. 1) (hereinafter "Act") -- the measure to which this report responds -- is attached as Appendix A. Specifically, the Act directs the Bureau to "report on the policies and procedures for access, distribution, security, and other relevant issues related to the medical use of cannabis for all the states that currently have a medical cannabis program."

Organization of the Study

Chapter 2 reviews the policies and procedures of the Hawaii medical marijuana program. Chapter 3 discusses the medical marijuana programs of other states. Chapter 4 examines the policies and procedures of states that currently have or are developing systems for distribution of medical marijuana.

Chapter 2

HAWAII MEDICAL MARIJUANA PROGRAM

Hawaii was the first state to establish a medical marijuana program by legislation rather than by ballot initiative.[1] Hawaii's medical marijuana program was authorized by Act 228, Session Laws of Hawaii 2000. Act 228 became effective on June 14, 2000, and is codified as part IX, chapter 329, Hawaii Revised Statutes (HRS) (entitled "Medical Use of Marijuana"). The Department of Public Safety adopted administrative rules to implement the provisions of Act 228 on December 28, 2000.

What the Hawaii Medical Marijuana Program Does

Administered by the Department of Public Safety, the Hawaii Medical Marijuana program affords certain protections to qualifying patients, primary caregivers, and treating physicians. Specifically, section 329-125 provides that a qualifying patient or the primary caregiver of a qualifying patient may assert the medical use of marijuana as an affirmative defense to any prosecution involving marijuana, so long as the qualifying patient or primary caregiver has strictly complied with the requirements of the program. Similarly, section 329-126, HRS, provides that "[n]o physician shall be subject to arrest or prosecution, penalized in any manner, or denied any right or privilege for providing written certification for the medical use of marijuana for a qualifying patient[,]" so long as the physician strictly complies with the requirements of the program. The cumulative effect of these protections is the removal of state-level criminal penalties for the medical use of marijuana by qualifying patients.

Section 329-121, HRS, defines "medical use" as "the acquisition, possession, cultivation, use, distribution, or transportation of marijuana or paraphernalia relating to the administration of marijuana to alleviate the symptoms or effects of a qualifying patient's debilitating medical condition." A qualifying patient is generally allowed to select a primary caregiver, a person of at least eighteen years of age who agrees to undertake the responsibility for managing the well-being of the qualifying patient with respect to the medical use of marijuana.[2] Section 329-121, HRS, also states that "[f]or the purposes of 'medical use', the term distribution is limited to the transfer of marijuana and paraphernalia from the primary caregiver to the qualifying patient."

Under section 329-122, HRS, the medical use of marijuana by a qualifying patient is permitted only so long as the amount of marijuana does not exceed an "adequate supply," which restricts the amount of marijuana jointly possessed between a qualifying patient and a primary caregiver to "not more than is reasonably necessary to assure the uninterrupted availability of marijuana for the purpose of alleviating the symptoms or effects of a qualifying patient's

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[1] Alaska, California, Maine, Oregon, and Washington established medical marijuana programs by ballot initiative prior to the enactment of Act 228.

[2] In the case of a minor or an adult lacking legal capacity, the primary caregiver shall be a parent, guardian, or person having legal custody. Section 329-121, Hawaii Revised Statutes (HRS).

debilitating medical condition[.]"[3] Specifically, this amount must not exceed "three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant."[4]

In order to qualify as a patient under the program, a person must have written certification from a physician, affirming that the person has been diagnosed with a debilitating medical condition and that "the potential benefits of the medical use of marijuana would likely outweigh the health risks for the particular qualifying patient."[5] Section 329-126, HRS, requires a certifying physician to:

(1) Diagnose the patient as having a debilitating medical condition;

(2) Explain the potential risks and benefits of the medical use of marijuana;

(3) Complete a full assessment of the patient's medical history and current medical condition, in the course of a bona fide physician-patient relationship; and

(4) Register information regarding patients who have been issued written certifications with the Department of Public Safety.

Section 329-121, HRS, defines the term "debilitating medical condition" as:

(1) Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, or the treatment of these conditions;

(2) A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:
    - (A) Cachexia or wasting syndrome;
    - (B) Severe pain;
    - (C) Severe nausea;
    - (D) Seizures, including those characteristic of epilepsy; or
    - (E) Severe and persistent muscle spasms, including those characteristic of multiple sclerosis or Crohn's disease; or

(3) Any other medical condition approved by the department of health pursuant to administrative rules in response to a request from a physician or potentially qualifying patient.

Qualifying patients and their primary caregivers are required to provide registration information for a confidential patient registry administered by the Department of Public Safety in order to participate in the medical marijuana program.[6] Upon verification of registration information, the Department issues registry identification certificates. Failure to obtain a registry identification certificate would disqualify a patient or caregiver from participating in the medical marijuana program and could render the person subject to criminal prosecution.

[3] Section 329-121, HRS.
[4] *Ibid.*
[5] Section 329-122, HRS.
[6] Section 23-202-10, Hawaii Administrative Rules (HAR).

What the Hawaii Medical Marijuana Program Does Not Do

It should be noted that although the Hawaii medical marijuana program permits qualifying patients the use of medical marijuana, it does not provide patients with a method of obtaining marijuana. Qualifying patients cannot simply have a prescription for medical marijuana filled at a pharmacy. Under federal law, pharmacies are only permitted to dispense medications that have been prescribed. However, since marijuana is classified under federal law as a Schedule I controlled substance, physicians are not allowed to write prescriptions for its use. Under Hawaii law, a physician does not prescribe marijuana for medical purposes, but merely issues a written certification to a qualifying patient. The law is silent regarding how the qualifying patient is to obtain the marijuana.

While the medical marijuana program permits a qualifying patient and primary caregiver to grow marijuana plants for the patient's medical use, the state government does not provide a source or supply marijuana seeds or plants. Neither does it offer guidance on the cultivation of marijuana. Further, the sale of marijuana in any amount is strictly prohibited under state law.[7] As a result, there is no place within the State where a person, even a qualifying patient with a valid registry identification certificate, can legally purchase marijuana.

After careful review of Hawaii's medical marijuana program, as codified under part IX of chapter 329, the Uniform Controlled Substances Act, and administered under chapter 23-202, Hawaii Administrative Rules, it appears that current state law is essentially silent with regard to issues of access, distribution, and security related to the medical use of marijuana.

[7] Section 712-1247, HRS.

Chapter 3

MEDICAL MARIJUANA PROGRAMS IN OTHER STATES

Hawaii is currently one of thirteen states that have legalized the use of marijuana for medical purposes. The twelve other states with active medical marijuana programs are Alaska, California, Colorado, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington.[1]

The medical marijuana programs of the other states generally approach the issue in a manner similar to the Hawaii medical marijuana program. Like the Hawaii program, the programs of the other states remove state-level criminal penalties for the use of marijuana for medical purposes. All the state programs require that qualifying patients be certified by a physician as having a medical condition that would benefit from the medical use of marijuana. While the lists of actual qualifying medical conditions vary from state to state, each state program specifies the conditions that qualify for legal protection.[2] Each state program also specifies the maximum amount of medical marijuana a qualifying patient and caregiver may possess. Finally, many of the state programs establish, either by statute or administrative rule, confidential patient registries that are administered by a state agency -- often that state's agency responsible for health or human resources. These agencies often issue identification cards to qualifying patients and caregivers who have registered with their state's medical marijuana program.

The following table summarizes major policy components of the medical marijuana programs in the thirteen states.

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[1] The State of Maryland enacted a medical marijuana affirmative defense law that went into effect on October 1, 2003. The Maryland law requires state courts to consider a defendant's use of marijuana for medical purposes as a mitigating factor in marijuana-related prosecutions. If a defendant possesses less than one ounce of marijuana and can prove that he or she used marijuana out of medical necessity and with a doctor's recommendation, the maximum penalty that can be imposed is a fine not to exceed $100.

However, while the Maryland law reduces the penalties that may be imposed, it does not remove state-level criminal penalties for the use of marijuana for medical purposes -- unlike all other active medical marijuana programs. Further, the Maryland law does not establish a means for people to become qualifying patients. No guidance is provided regarding what documentation is necessary to become eligible under the law. There is no system in place whereby patients can register with, or become certified by, the state government. Therefore, for the purposes of this study, it does not appear that Maryland's medical marijuana law constitutes an active medical marijuana program.

[2] Each state has its own list of medical conditions that qualify for legal protection under its respective medical marijuana program. Generally, qualifying medical conditions tend to include chronic or debilitating diseases as well as conditions that involve seizures, muscle spasticity, chronic pain, or severe nausea. Many states also provide that medical conditions not specifically included in their programs' list of qualifying medical conditions may still qualify for legal protection if approved by the appropriate state agency.

Table 3-1

ACTIVE MEDICAL MARIJUANA PROGRAMS: MAJOR POLICY COMPONENTS

State	Removes State-Level Criminal Penalties?	Establishes Patient Registry and Issues ID Cards?	Maximum Marijuana Amount Allowed	Methods of Access and Distribution Specified
Alaska	Yes	Yes	1 ounce, 6 plants (up to 3 mature plants)	None
California	Yes	Yes[3]	8 ounces, 6 mature plants (or 12 immature plants)	Cooperatives and Collectives
Colorado	Yes	Yes	2 ounces, 6 plants (up to 3 mature plants)	None
Hawaii	Yes	Yes	3 ounces, 3 mature plants, 4 immature plants	None
Maine	Yes	No	2.5 ounces, 6 plants (up to 3 mature plants)	None
Michigan	Yes	Yes	2.5 ounces, 12 plants	None
Montana	Yes	Yes	1 ounce, 6 plants	None
Nevada	Yes	Yes	1 ounce, 3 mature plants, 4 immature plants	None
New Mexico	Yes	Yes	6 ounces, 4 mature plants, 12 seedlings	State-licensed Producers
Oregon	Yes	Yes	24 ounces, 6 mature plants, 18 seedlings	None

[3]The California medical marijuana program directs the State Department of Health Services to establish a voluntary patient registry and to issue identification cards to qualifying patients who join the registry. Until recently, several counties had resisted implementing an identification card program by engaging in civil suits, arguing that the provisions of the California medical marijuana program were preempted by the federal Controlled Substances Act and violative of the state constitution. In *County of San Diego v. San Diego NORML*, 165 Cal.App.4th 798, 81 Cal.Rptr.3d 461 (Cal.App. 4 Dist., 2008), *cert denied*, 129 S.Ct. 2380 (2009), the Court of Appeal of the Fourth District of California held that the provisions of the California medical marijuana program were not preempted by federal law, nor in violation of the state constitution. As of this writing, most counties have initiated programs to gather patient information and to issue identification cards to qualifying patients.

State	Removes State-Level Criminal Penalties?	Establishes Patient Registry and Issues ID Cards?	Maximum Marijuana Amount Allowed	Methods of Access and Distribution Specified
Rhode Island	Yes	Yes	2.5 ounces, 12 mature plants, 12 seedlings	State-licensed Compassion Centers
Vermont	Yes	Yes	2 ounces, 2 mature plants, 7 immature plants	None
Washington	Yes	No	24 ounces, 15 plants	None

As the table indicates, most states' medical marijuana programs do not provide qualifying patients with a method of obtaining medical marijuana. Like Hawaii, the laws in most of the other states are silent with regard to issues of access, distribution, or security relating to the medical use of marijuana.[4] The overall vagueness of the programs with regard to these issues likely stems from the fact that, under federal law, the distribution of marijuana for any purpose is generally prohibited.

Under the federal Controlled Substances Act, marijuana is classified as a Schedule I controlled substance.[5] Title 21, United States Code sections 841(a)(1) and 844(a) prohibit the possession, manufacture, distribution, and dispensing of any Schedule I controlled substance.[6] Federal law makes no exemption for the use of marijuana for medical purposes.[7] As a result, of the thirteen states with active medical marijuana programs, only three make provision for a system of distribution that allows qualifying patients to safely and legally gain access to medical marijuana. Chapter 4 examines the policies and procedures of the medical marijuana programs of these three states: California, New Mexico, and Rhode Island.

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[4] The ambiguity regarding issues of access and distribution has led individuals in some states to open dispensaries to facilitate the distribution of medical marijuana. Recently, dispensaries have begun operation in Colorado and Washington, despite the fact that the laws of those states do not explicitly protect such facilities. The owners of these dispensaries claim that the removal of state-level criminal penalties for the use of marijuana for medical purposes has created an implied right to sell medical marijuana to qualifying patients. Whether law enforcement officials will allow such dispensaries to continue to operate, or whether the operation of such dispensaries would be deemed valid by a court of law, remains to be seen.

[5] Title 21 United States Code (U.S.C.) Section 812(c).

[6] Under federal law, the dispensing of Schedule I controlled substances is permitted only as part of federally approved research conducted under Title 21 U.S.C. Section 823(f).

[7] In *Gonzales v. Raich*, 545 U.S. 1 (2005), the United States Supreme Court held that federal law enforcement officials are authorized to prosecute medical marijuana patients, even if they grow their own marijuana and reside in a state where the medical use of marijuana is protected under state law. However, the Supreme Court did not hold that state laws protecting the use of marijuana for medical purposes are unconstitutional or invalid.

Chapter 4

STATES WITH OPERATIVE OR DEVELOPING DISTRIBUTION SYSTEMS

California Medical Marijuana Program

On November 5, 1996, voters in California approved Proposition 215, the Medical Use of Marijuana Initiative Statute, which led to the enactment of the Compassionate Use Act of 1996 in that state. The following summary of Proposition 215 was prepared by California's Attorney General:[1]

- Exempts patients and defined caregivers who possess or cultivate marijuana for medical treatment recommended by a physician from criminal laws which otherwise prohibit possession or cultivation of marijuana.
- Provides physicians who recommend use of marijuana for medical treatment shall not be punished or denied any right or privilege.
- Declares that measure not be construed to supersede prohibitions of conduct endangering others or to condone diversion of marijuana for non-medical purposes.
- Contains severability clause.

The Compassionate Use Act was later amended by Senate Bill No. 420, also known as the Medical Marijuana Program Act, which was enacted in October 2003 and took effect on January 1, 2004. As stated in section 1(b), the legislative intent of the Medical Marijuana Program Act was to:

(1) Clarify the scope of the application of the act and facilitate the prompt identification of qualified patients and their designated primary caregivers in order to avoid unnecessary arrest and prosecution of these individuals and provide needed guidance to law enforcement officers.

(2) Promote uniform and consistent application of the act among the counties within the state.

(3) Enhance the access of patients and caregivers to medical marijuana through collective, cooperative cultivation projects.

The provisions of the Compassionate Use Act and the Medical Marijuana Program Act are codified in sections 11362.5 - 11362.83 of the California Health and Safety Code. Like Hawaii, California's state law is essentially silent regarding qualifying patients' access to medical marijuana. Since marijuana is classified under federal law as a Schedule I controlled substance, patients in California are unable to obtain a prescription for marijuana. Also, like Hawaii, California does not provide qualifying patients with marijuana, seeds, or advice on how to obtain

[1] California, Attorney General. Summary of Medical Use of Marijuana Initiative Statute at http://vote96.sos.ca.gov/Vote96/html/BP/215.htm.

marijuana. Further, California's state law does not explicitly call upon any state agency or other entity to establish a distribution system for medical marijuana. However, certain provisions of the Medical Marijuana Program Act have led to the development of a system of cooperatives and collectives formed by patients and caregivers for the purpose of cultivating medical marijuana.

Although California state law prohibits the cultivation or distribution of medical marijuana for profit, section 11362.765 of the California Health and Safety Code allows a primary caregiver to receive reasonable compensation for services provided to a qualifying patient that enables that patient to use medical marijuana. Section 11362.765 further states that reasonable compensation is permitted to "[a]ny individual who provides assistance to a qualified patient or a person with an identification card, or his or her designated primary caregiver, in administering medical marijuana to the qualified patient or person or acquiring the skills necessary to cultivate or administer marijuana for medical purposes to the qualified patient or person."

In order to "[e]nhance the access of patients and caregivers to medical marijuana[,]" section 11362.775 of the California Health and Safety Code provides that "[q]ualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients and persons with identification cards, 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 . . . ." (emphasis added)

Based on the foregoing language, hundreds of cooperatives and collectives have been established throughout California.[2] In August, 2008, the Attorney General of California issued its " Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use" ("Guidelines").[3] While not having the force and effect of law, the Guidelines provide guidance as to how the Attorney General might choose to proceed with regard to state enforcement. In the Guidelines, the Attorney General differentiates between the terms " cooperatives" and "collectives" as follows:

> 1. **Statutory Cooperatives:** A cooperative must file articles of incorporation with the state and conduct its business for the mutual benefit of its members. No business may call itself a "cooperative" (or "coop") unless it is properly organized and registered as such a corporation under the Corporations or Food and Agricultural Code.

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[2] Since Senate Bill No. 420 -- The Medical Marijuana Program Act -- was enacted in 2003, the number of medical marijuana cooperatives and collectives has grown at a rapid pace, making it difficult to determine the actual number of cooperatives and collectives that currently exist in California. Making estimates even more difficult is the fact that hundreds of storefront dispensaries are operating across the state, and it is unclear how many are being operated as part of a cooperative or collective. It should also be noted that the distribution of these dispensaries is not uniform throughout the state. Some counties have an abundance of dispensaries, while others have relatively few. For example, a recent *Wall Street Journal* article estimated that there were approximately 800 dispensaries in Los Angeles County, while there are only about 30 in San Francisco County. Sabrina Shankman, *L.A. Targets Cannabis Clubs*, WALL ST. J., July 8, 2009 at A5.

[3] California, Attorney General. Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use at:
http://ag.ca.gov/cms_attachments/press/pdfs/n1601_medicalmarijuanaguidelines.pdf.

> Cooperative corporations are "democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons." The earnings and savings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash, property, credits, or services. Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year. Agricultural cooperatives are likewise nonprofit corporate entities "since they are not organized to make profit for themselves, as such, or for their members, as such, but only for their members as producers." Agricultural cooperatives share many characteristics with consumer cooperatives. Cooperatives should not purchase marijuana from, or sell to, non-members; instead, they should only provide a means for facilitating or coordinating transactions between members.
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> 2. **Collectives:** California law does not define collectives, but the dictionary defines them as "a business, farm, etc., jointly owned and operated by the members of a group." Applying this definition, a collective should be an organization that merely facilitates the collaborative efforts of patient and caregiver members – including the allocation of costs and revenues. As such, a collective is not a statutory entity, but as a practical matter it might have to organize as some form of business to carry out its activities. The collective should not purchase marijuana from, or sell to, non-members; instead, it should only provide a means for facilitating or coordinating transactions between members.[4]

While the Attorney General differentiates between cooperatives and collectives, they are essentially treated equally, so long as they are organized with sufficient structure to ensure security, non-diversion of marijuana to illicit markets, and compliance with all state and local laws.[5] To ensure this, the Attorney General makes the following suggestions regarding the operation of a cooperative or collective:[6]

> 1. **Non-Profit Operation**: Nothing in Proposition 215 or the [Medical Marijuana Program Act (MMP)] authorizes collectives, cooperatives, or individuals to profit from the sale or distribution of marijuana . . . .
>
> 2. **Business Licenses, Sales Tax, and Seller's Permits**: The State Board of Equalization has determined that medical marijuana transactions are subject to sales tax, regardless of whether the individual or group makes a profit, and those engaging in transactions involving medical marijuana must obtain a Seller's Permit. Some cities and counties also require dispensing collectives and cooperatives to obtain business licenses.
>
> 3. **Membership Application and Verification**: When a patient or primary caregiver wishes to join a collective or cooperative, the group can help prevent the diversion of marijuana for non-medical use by having potential members complete a written membership application. The following application guidelines should be followed to help ensure that marijuana grown for medical use is not diverted to illicit markets:

[4] *Ibid.* (Citations omitted.)
[5] *See Ibid.*
[6] *See Ibid.*

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

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

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

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

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

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

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

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

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

a) Provided free to qualified patients and primary caregivers who are members of the collective or cooperative;

b) Provided in exchange for services rendered to the entity;

c) Allocated based on fees that are reasonably calculated to cover overhead costs and operating expenses; or

d) Any combination of the above.

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

a) Operating a location for cultivation;

b) Transporting the group's medical marijuana; and

c) Operating a location for distribution to members of the collective or cooperative.

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

It should be noted that there is no statewide regulation of cooperatives and collectives. Rather, many cities and counties have issued ordinances to regulate the operation of medical marijuana dispensaries run by cooperatives and collectives within their respective jurisdictions. As a result, the range of regulatory requirements varies greatly between the various cities and counties.[7] For example, Santa Clara County places zoning restrictions on where a dispensary may be located, prohibits the smoking, ingestion, or consumption of marijuana on the premises, specifies that patients under the age of 18 shall only be allowed to enter the premises when accompanied by a parent or guardian, and specifies the hours of operation.[8] On the other hand, the City of Oakland also places zoning restrictions on where a dispensary may operate, but

[7] As of this writing, Americans for Safe Access lists 32 cities and 8 counties in California that have issued ordinances to regulate medical marijuana dispensaries, 51 cities and 3 counties that have issued moratoriums on medical marijuana dispensaries, and 113 cities and 7 counties that have banned medical marijuana dispensaries. Available at www.safeaccessnow.org/article.php?id=3165.

[8] Sections B26-3 and B26-4 of the County of Santa Clara Ordinance Code.

additionally specifies that no more than four permits to operate a dispensary shall be issued.[9] The City of Oakland imposes the following regulations on the operation of medical marijuana dispensaries:[10]

> A. Dispensaries may possess no more than eight ounces of dried marijuana per qualified patient or caregiver, and maintain no more than six mature and twelve (12) immature marijuana plants per qualified patient.
>
> 1. If a qualified patient or primary caregiver has a doctor's recommendation that this quantity does not meet the qualified patient's medical needs, the qualified patient or primary caregiver may possess an amount of marijuana consistent with the patient's needs.
>
> 2. Only the dried mature processed flowers of female cannabis plant or the plant conversion shall be considered when determining allowable quantities of marijuana under this section.
>
> B. The City Manager shall set forth in her/his administrative regulations the method and manner in which background checks of employees for dispensaries will be conducted, and which shall set forth standards for disqualification of an employee based on their criminal history.
>
> C. No cannabis shall be smoked, ingested or otherwise consumed on the premises.
>
> D. Dispensary shall not hold or maintain a license from the State Department of Alcohol Beverage Control to sell alcoholic beverages, or operate a business that sells alcoholic beverages.
>
> E. Dispensary shall maintain records of all patients and or patient caregivers using only the identification card number issued by the county, or its agent, pursuant to California Health and Safety Code Section 11362.7 et seq., as a protection of the confidentiality of the cardholders, or a copy of the written recommendation.
>
> F. Dispensary shall allow the City Manager or his/her designee to have access to the entities' books, records, accounts, and any and all data relevant to its permitted activities for the purpose of conducting an audit or examination. Books, records, accounts, and any and all relevant data will be produced no later than twenty-four (24) hours after City Manager or his/her designees request. [sic]
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> G. The dispensary shall provide litter removal services twice each day of operation on and in front of the premises and, if necessary, on public sidewalks within hundred (100) feet of the premises.
>
> H. The dispensary shall provide adequate security on the premises, including lighting and alarms, to insure the safety of persons and to protect the premises from theft.

[9] Section 5.80.020 of the Oakland Municipal Code.
[10] Section 5.80.040 of the Oakland Municipal Code.

I. Signage for the establishment shall be limited to one wall sign not to exceed ten square feet in area, and one identifying sign not to exceed two square feet in area; such signs shall not be directly illuminated.

J. The dispensary shall provide City Manager or his/her designee, the chief of police and all neighbors located within fifty (50) feet of the establishment with the name, phone number and facsimile number of an on-site community relations staff person to whom one can provide notice if there are operating problems associated with the establishment. The dispensary shall make every good faith effort to encourage neighbors to call this person to try to solve operating problems, if any, before any calls or complaints are made to the police department or other city officials.

K. The dispensary shall meet any specific, additional operating procedures and measures as may be imposed as conditions of approval by the City Manager or his/her designee in order to insure that the operation of the dispensary is consistent with protection of the health, safety and welfare of the community, qualified patients and caregivers, and will not adversely affect surrounding uses.

New Mexico Medical Marijuana Program

The Lynn and Erin Compassionate Use Act was enacted on April 2, 2007, and took effect on July 1, 2007. The provisions of the Lynn and Erin Compassionate Use Act are codified in chapter 26, article 2B, New Mexico Statutes Annotated (NMSA). As stated in section 26-2B-2, NMSA, the purpose of the Lynn and Erin Compassionate Use Act is "to allow the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments."

New Mexico's medical marijuana program is similar to those in other states in that it removes state-level criminal penalties for the medical use of marijuana. However, the New Mexico program is unique in that it was the first program to establish a state-regulated system for the distribution of medical marijuana. Specifically, the New Mexico program allows medical marijuana to be dispensed by licensed producers. Section 26-2B-3, NMSA, defines the term "licensed producer" as "any person or association of persons within New Mexico that the department [of health] determines to be qualified to produce, possess, distribute and dispense cannabis pursuant to the Lynn and Erin Compassionate Use Act and that is licensed by the department [of health]." Section 26-2B-7, NMSA, directs the New Mexico Department of Health to promulgate rules to "identify requirements for the licensure of producers and cannabis production facilities and set forth procedures to obtain licenses;" and to "develop a distribution system for medical cannabis that provides for: (a) cannabis production facilities within New Mexico housed on secured grounds and operated by licensed producers; and (b) distribution of medical cannabis to qualified patients or their primary caregivers to take place at locations that are designated by the department and that are not within three hundred feet of any school, church or daycare center[.]" The New Mexico Department of Health finalized its rules in Title 7, Chapter 34, New Mexico Administrative Code (NMAC), entitled "Medical Use of Marijuana."

Production Facility Licenses

In addition to qualifying patients who wish to grow marijuana for their personal use, the New Mexico Department of Health may also issue licenses to "a non-profit private entity that operates a facility and, at any one time, is limited to a total of ninety-five (95) mature plants and seedlings and an inventory of usable marijuana that reflects current patient needs, and that shall sell marijuana with a consistent unit price, without volume discounts."[11] Such licenses are valid for a period of one year, are non-transferrable, and automatically expire unless renewed.[12] The number of licenses issued shall be at the discretion of the Secretary of the New Mexico Department of Health.[13] In order to be considered for a license, a non-profit private entity must provide the following:[14]

> **(1)** acknowledgement that, at any time, production shall not exceed ninety-five (95) mature plants and seedlings and an inventory of usable marijuana that reflects current patient needs;
>
> **(2)** proof that the private entity is a non-profit corporation pursuant to, Section 53-8-1 et seq. NMSA 1978;
>
> **(3)** appropriate non-refundable fees;
>
> Chapter Section verification that the board of the non-profit includes, at a minimum, one (1) physician, a nurse or other health care provider, and three (3) patients currently qualified under the Lynn and Erin Compassionate Use Act;
>
> **(5)** a description of the facility that shall be used in the production of marijuana;
>
> **(6)** proof that the facility is not within three hundred (300) feet of any school, church or daycare center;
>
> **(7)** a description of the means the private non-profit shall employ to make qualified patients or the primary caregiver aware of the quality of the product;
>
> **(8)** a description of the means the private non-profit shall employ to safely dispense the marijuana to qualified patients or the qualified patient's primary caregivers;
>
> **(9)** a description of ingestion options of useable marijuana provided by the private non-profit entity;
>
> **(10)** a description of safe smoking techniques that shall be provided to qualified patients;

[11] Section 7.34.4.8(A)(2), New Mexico Administrative Code (NMAC).
[12] Sections 7.34.4.8(H), (J), (K), and (L), NMAC.
[13] Section 7.34.4.8(B)(2), NMAC.
[14] Section 7.34.4.8(F), NMAC.

(11) a description of potential side effects and how this shall be communicated to qualified patients and the qualified patient's primary caregivers;

(12) a description of the private entity's means for educating the qualified patient and the primary caregiver on the limitation of the right to possess and use marijuana;

(13) a description of the packaging of the useable marijuana that the private non-profit entity shall be utilizing, including a label that shall contain the name of the strain, batch, quantity and a statement that the product is for medical use and not for resale;

(14) a description of the private non-profit entity's confidential sale records, ensuring that quantities purchased do not suggest re-distribution; both clients and the department shall have access to this information at any time;

(15) a description of the private non-profit entity's policy on the right of the entity to refuse service;

(16) a description of the device or series of devices that shall be used to provide security;

(17) a written description of the private non-profit entity's security policies, safety and security procedures, personal safety and crime prevention techniques;

(18) copies of the entity's articles of incorporation and by-laws;

(19) a list of all persons or business entities having direct or indirect authority over the management or policies of the facility;

(20) a list of all persons or business entities having five percent or more ownership in the facility, whether direct or indirect and whether the interest is in profits, land or building, including owners of any business entity which owns all or part of the land or building;

(21) the identities of all creditors holding a security interest in the premises, if any;

(22) criminal history screening requirements:

(a) all persons associated with a non-profit private entity production facility must consent to a nationwide and statewide criminal history screening background check; this includes board members, persons having direct or indirect authority over management or policies, and employees; all applicable fees associated with the nationwide and statewide criminal history screening background check shall be paid by the individual or production facility;

(b) individuals convicted of a felony violation of Section 30-31-20 [(trafficking controlled substances)], 30-31-21 [(Distribution to a minor)], or 30-31-22 [(Distribution of controlled or counterfeit substances)] NMSA 1978 are prohibited from participating or being associated with a production facility licensed under this rule; if an

individual has been convicted of a felony violation of Section 30-31-1 et seq. NMSA 1978, other than Sections 30-31-20 through 30-31-22, and the final completion of the entirety of the associated sentence of such felony conviction has been less than five (5) years from the date of the individual's anticipated association with the production facility, then the individual is prohibited from serving in his or her role on the board or for the entity; the individual shall be notified by registered mail of his or her disqualification; if the individual has been convicted of more than one (1) felony violation of Section 30-31-1 et seq. NMSA 1978, the individual shall be notified by registered or certified mail that he or she is permanently prohibited from participating or being associated with a production facility licensed under this rule; any violation of this subsection will result in the immediate revocation of any privilege granted under this rule and the act;

(23) the department may verify information on each application and accompanying documentation by:

(a) contacting the applicant by telephone or by mail;

(b) conducting an on-site visit;

(c) requiring a face-to-face meeting and the production of additional identification materials if proof of identity is uncertain; and

(d) requiring additional relevant information that the department deems necessary;

(24) cooperation with the department upon notice by the department of the intent to review the licensed producer application; failure of the private entity to cooperate with the department's request may result in the application being declared incomplete or denied; and

(25) such other information as the private entity wishes to provide or that the licensing authority shall request.

Required Policies and Procedures

A private non-profit licensed producer is required to develop, implement, and maintain on the premises, policies and procedures relating to the New Mexico medical marijuana program. At a minimum, these policies and procedures must include the following criteria:[15]

(1) develop distribution criteria for qualified patients or primary caregivers appropriate for marijuana services;

(2) qualified patient's or the primary caregiver's distribution criteria shall include a clear identifiable photocopy of all qualified patient's or the primary caregiver's registry identification card served by the private entity; and

[15] Section 7.34.4.8(G), NMAC.

(3) alcohol and drug free work place policy; the private non-profit entity shall develop, implement and maintain on the premises, policies and procedures relating to an alcohol and drug free workplace program;

(4) employee policies and procedures; the private non-profit entity shall develop, implement and maintain on the premises, employee policies and procedures to address the following requirements:

(a) a job description or employment contract developed for all employees, which includes duties, authority, responsibilities, qualifications and supervision; and

(b) training in, and adherence, to state confidentiality laws;

(5) the licensed producer shall maintain a personnel record for each employee that includes an application for employment and a record of any disciplinary action taken; and

(6) the private non-profit entity shall develop, implement and maintain on the premises on-site training curriculum, or enter into contractual relationships with outside resources capable of meeting employee training needs, which includes, but is not limited to, the following topics:

(a) professional conduct, ethics and patient confidentiality; and

(b) informational developments in the field of medical use of marijuana;

(7) employee safety and security training; the private non-profit entity shall provide each employee, at the time of his or her initial appointment, training in the following:

(a) the proper use of security measures and controls that have been adopted; and

(b) specific procedural instructions on how to respond to an emergency, including robbery or a violent accident.

(8) all private non-profit entities shall prepare training documentation for each employee and have employees sign a statement indicating the date, time and place the employee received said training and topics discussed, to include name and title of presenters; the private non-profit entity shall maintain documentation of an employee's training for a period of at least six (6) months after termination of an employee's employment; employee training documentation shall be made available within twenty-four (24) hours of a department representative's request; the twenty-four (24) hour period shall exclude holidays and weekends.

Security Requirements

The New Mexico Department of Health's rules impose the following security requirements on private non-profit licensed producers:[16]

> **SECURITY REQUIREMENTS FOR LICENSED PRODUCERS:** Private entities licensed to produce marijuana shall comply with the following requirements to ensure that production facilities are located on secure grounds. **Security alarm system:** The private non-profit entity shall provide and maintain in each facility a fully operational security alarm system. The private non-profit entity shall:
>
> **A.** conduct a monthly maintenance inspection and make all necessary repairs to ensure the proper operation of the alarm system and, in the event of an extended mechanical malfunction that exceeds an eight (8) hour period, provide alternative security that shall include closure of the premises; and
>
> **B.** maintain documentation for a period of at least twenty-four (24) months of all inspections, servicing, alterations and upgrades performed on the security alarm system; all documentation shall be made available within twenty-four (24) hours of a department representative's request; failure to provide equipment maintenance documentation within the twenty-four (24) hour period shall subject the licensed producer to the sanctions and penalties provided for in this rule; the twenty-four (24) hour period shall not include holidays and weekends.

On March 18, 2009, the New Mexico Department of Health announced that it had approved its first private non-profit licensed producer.[17] Due to safety concerns, the New Mexico Department of Health has not released the name or location of the licensed producer to the public.[18] Instead, the New Mexico Department of Health has notified certified patients concerning how to contact the licensed producer.[19] It is speculated that the licensed producer may begin distribution to qualified patients by the end of summer 2009.[20] As of this writing, no other applications submitted by private non-profit entities to become licensed producers have been approved.[21] Several applications are currently under review by the New Mexico Department of Health, but it appears that staffing issues within the department have caused a delay in the review process.[22] As a result, it is unclear when other private non-profit entities will be approved as licensed producers.[23]

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[16] Section 7.34.4.9, NMAC.
[17] News release dated March 18, 2009 by the New Mexico Department of Health. Available at nmhealth.org/CommunicationsOffice/2009 News Releases/DOH1stCannabisProducer.pdf.
[18] *See Ibid.*
[19] *See Ibid.*
[20] Medical Marijuana Grower to Begin Distribution. KOB-TV, New Mexico. June 3, 2009. Available at www.kob.com/article/stories/S961683.shtml.
[21] Dave Maass, *Pot Plans*, Santa Fe Reporter, June 3, 2009.
[22] *See Ibid.*
[23] *See Ibid.*

Rhode Island Medical Marijuana Program

The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act became effective on January 3, 2006. Like the medical marijuana programs of many other states, the Rhode Island program removed state-level criminal penalties for the use of marijuana for medical purposes, but did not provide a method for qualifying patients to obtain marijuana. However, this latter situation changed on June 16, 2009, when the Rhode Island General Assembly overrode vetoes of the Governor of Rhode Island. Chapters 16 and 17, 2009 Public Laws of Rhode Island and Providence Plantations amended Rhode Island's medical marijuana program by, among other things, calling for the establishment of up to three state-licensed "compassion centers." Compassion centers are defined in section 21-28.6-3, General Laws of Rhode Island (Gen. Laws), as non-profit entities that are licensed by the Rhode Island to acquire, possess, cultivate, manufacture, deliver, transfer, transport, supply, or dispense marijuana, or related supplies and educational materials, to registered qualifying patients and their registered primary caregivers. This makes Rhode Island the third state, including California and New Mexico, to allow the operation of dispensaries for medical marijuana.

Chapters 16 and 17 also amend the medical marijuana program by directing the Rhode Island Department of Health to promulgate regulations to govern the licensing and operation of the compassion centers.[24] The first license for the operation of a compassion center is expected to be granted within the next six months.

Although, as of this writing, the Rhode Island Department of Health has not yet promulgated regulations regarding the operation of compassion centers, Chapters 16 and 17, codified as part of Section 21-28.6-12, Gen. Laws, provides some insight into how a compassion center would be run. The law imposes the following operating requirements on compassion centers.

> (1) A compassion center shall be operated on a not-for-profit basis for the mutual benefit of its patients. A compassion center need not be recognized as a tax-exempt organization by the Internal Revenue Services;
>
> (2) A compassion center may not be located within five hundred feet (500’) of the property line of a preexisting public or private school;
>
> (3) A compassion center shall notify the department within ten (10) days of when a principal officer, board member, agent, volunteer or employee ceases to work at the compassion center. His or her card shall be deemed null and void and the person shall be liable for any other penalties that may apply to the person's nonmedical use of marijuana;
>
> (4) A compassion center shall notify the department in writing of the name, address, and date of birth of any new principal officer, board member, agent, volunteer or

[24] The regulations promulgated by the Rhode Island Department of Health shall address the following areas: (1) the form and content of registration and renewal applications; (2) minimum oversight requirements for compassion centers; (3) minimum record-keeping requirements for compassion centers; (4) minimum security requirements for compassion centers; and (5) procedures for suspending or terminating the registration of compassion centers.

employee and shall submit a fee in an amount established by the department for a new registry identification card before a new agent or employee begins working at the compassion center;

(5) A compassion center shall implement appropriate security measures to deter and prevent the unauthorized entrance into areas containing marijuana and the theft of marijuana and shall insure that each location has an operational security alarm system.

(6) The operating documents of a compassion center shall include procedures for the oversight of the compassion center and procedures to ensure accurate record keeping;

(7) A compassion center is prohibited from acquiring, possessing, cultivating, manufacturing, delivering, transferring, transporting, supplying, or dispensing marijuana for any purpose except to assist registered qualifying patients with the medical use of marijuana directly or through the qualifying patients other primary caregiver;

(8) All principal officers and board members of a compassion center must be residents of the state of Rhode Island;

(9) Each time a new registered qualifying patient visits a compassion center, it shall provide the patient with frequently asked questions designed by the department, which explains the limitations on the right to use medical marijuana under state law;

(10) Each compassion center shall develop, implement, and maintain on the premises employee and agent policies and procedures to address the following requirements:

(i) A job description or employment contract developed for all employees and a volunteer agreement for all volunteers, which includes duties, authority, responsibilities, qualification, and supervision; and

(ii) Training in and adherence to state confidentiality laws.

(11) Each compassion center shall maintain a personnel record for each employee and each volunteer that includes an application for employment or to volunteer and a record of any disciplinary action taken;

(12) Each compassion center shall develop, implement, and maintain on the premises an on-site training curriculum, or enter into contractual relationships with outside resources capable of meeting employee training needs, which includes, but is not limited to, the following topics:

(i) Professional conduct, ethics, and patient confidentiality; and

(ii) Informational developments in the field of medical use of marijuana.

(13) Each compassion center entity shall provide each employee and each volunteer, at the time of his or her initial appointment, training in the following:

(i) The proper use of security measures and controls that have been adopted; and

> (ii) Specific procedural instructions on how to respond to an emergency, including robbery or violent accident;
>
> (14) All compassion centers shall prepare training documentation for each employee and have employees sign a statement indicating the date, time, and place the employee received said training and topics discussed, to include name and title of presenters. The compassion center shall maintain documentation of an employee's and a volunteer's training for a period of at least six (6) months after termination of an employee's employment or the volunteer's volunteering.

It should be noted that the legislation amending Rhode Island's medical marijuana program was enacted only months after statements were made by the United States Attorney General on February 25, 2009, signaling a policy shift regarding medical marijuana dispensaries.[25] The Attorney General subsequently reaffirmed on March 18, 2009, that the United States Department of Justice would no longer target medical marijuana dispensaries that were operating in compliance with state law.[26] The Attorney General went on to state that federal agents would only target medical marijuana dispensaries that violated both state and federal law.

Recent Action in Other States

On June 24, 2009, the New Hampshire General Court passed legislation to allow the use of marijuana for medical purposes. Although vetoed by New Hampshire's governor, the proposed law included provisions for the establishment of compassion centers, similar to those in the Rhode Island legislation.[27] As of this writing, several other states, including Delaware, Illinois, Iowa, Pennsylvania, New Jersey, New York, and North Carolina, are also considering legislation to allow the use of marijuana for medical purposes.

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[25] Drug Trafficking Investigation. C-SPAN, Washington, D.C. 29 Feb. 2009. Available at www.c-spanarchives.org/library/index.php?main_page=product_video_info&products_id=284320-1.

[26] Scott Glover and Josh Meyer, *U.S. Won't Prosecute Medical Pot Sales*, Los Angeles Times, Mar. 19, 2009, at A1.

[27] The legislation, House Bill 648, was vetoed by the Governor of New Hampshire on July 10, 2009. It remains to be seen whether the New Hampshire General Court will override that action.

Chapter 5

CONCLUSION

After careful review of the policies and procedures of all states with active medical marijuana programs, it seems that only three states -- California, New Mexico, and Rhode Island -- have policies and procedures in place that address the issues of access, distribution, and security.

California's system of distribution is not mandated by statute or administrative rule. Instead, California's state law simply allows for the formation of cooperatives and collectives for the purpose of cultivating medical marijuana. Regulation is conducted at the municipal and county levels, which has led to a patchwork of different regulatory schemes across the state. As a result, patients' ability to obtain medical marijuana can vary greatly from one area of California to another.

New Mexico and Rhode Island both have statutes that call for the development of a system of distribution for medical marijuana. The Rhode Island Department of Health is currently drafting the regulations that will govern how their distribution system will operate. The New Mexico Department of Health finalized its regulations in January 2009, and approved its first private non-profit licensed producer of medical marijuana in March 2009. Distribution of medical marijuana in New Mexico, via licensed producer, is anticipated to begin by the end of summer 2009.

Clearly, policies and procedures are being developed to address the issues of access, distribution, and security with regard to the medical use of marijuana. However, these policies and procedures appear to be in a very early stage of development and do not, as yet, provide an established model with a proven ability to successfully address these issues. Nevertheless, observation of these policies and procedures over the next few years -- seeing how they develop, how they approach the obstacles they are likely to encounter, what methods are successful versus what methods prove problematic -- will, no doubt, prove informative and valuable in determining how Hawaii chooses to address the issues of access, distribution, and security with regard to its own medical marijuana program.

Appendix A

VETO

THE SENATE
TWENTY-FIFTH LEGISLATURE, 2009
STATE OF HAWAII

S.B. NO. 1058 S.D. 2 H.D. 2 C.D. 1

A BILL FOR AN ACT

VETO OVERRIDE

ACT No. 29
Approved: [signature]
Dated: July 15, 2009

RELATING TO CONTROLLED SUBSTANCES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 PART I

2 SECTION 1. (a) There is established a medical cannabis
3 task force that shall be placed within the department of public
4 safety for administrative purposes. The purpose of the medical
5 cannabis task force shall be to review issues relating to the
6 medical marijuana program. The director of public safety shall
7 be responsible for administering the work of the medical
8 cannabis task force. The medical cannabis task force shall:
9 (1) Examine current state statutes, state administrative
10 rules, and all county policies and procedures relating
11 to the medical marijuana program;
12 (2) Examine all issues and obstacles that qualifying
13 patients have encountered with the medical marijuana
14 program;
15 (3) Examine all issue and obstacles that state and county
16 law enforcement agencies have encountered with the
17 medical marijuana program;

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1 (4) Compare and contrast Hawaii's medical marijuana
2 program with all other state medical marijuana
3 programs; and
4 (5) Address other issues and perform any other function
5 necessary as the task force deems appropriate,
6 relating to the medical marijuana program.
7 (b) The medical cannabis task force shall consist of
8 thirteen members as follows:
9 (1) The director of public safety or the director's
10 designee;
11 (2) The director of health or the director's designee;
12 (3) The director of transportation or the director's
13 designee;
14 (4) The attorney general or the attorney general's
15 designee;
16 (5) The chairperson of the board of agriculture or the
17 chairperson's designee;
18 (6) The president of the Drug Policy Forum of Hawaii or
19 the president's designee;
20 (7) One medical cannabis advocate who is a patient that
21 uses cannabis in a medically authorized or recommended
22 manner to be appointed by the governor;

1 (8) A physician who authorizes or recommends the use of
2 medical cannabis that is nominated from a list jointly
3 submitted by the senate president and speaker of the
4 house of representatives to be appointed by the
5 governor;
6 (9) A Hawaii-licensed physician who specializes in pain
7 control and has issued a medical cannabis
8 recommendation that is nominated from a list jointly
9 submitted by the senate president and speaker of the
10 house of representatives to be appointed by the
11 governor;
12 (10) The president of West Oahu Hope for a Cure Foundation
13 or the president's designee;
14 (11) The director of Americans for Safe Access - Honolulu
15 Chapter, or the director's designee;
16 (12) One registered caregiver to be appointed by the
17 governor; and
18 (13) One representative of the American Civil Liberties
19 Union.
20 (c) The members of the task force shall select a
21 chairperson from among its members, who, in conjunction with the
22 director of public safety, shall establish task force

1 procedures, including the meeting schedule, voting procedures,
2 and member duties.

3 The members of the task force shall serve without
4 compensation, but shall be reimbursed for necessary expenses,
5 including travel expenses, incurred in the performance of their
6 official duties.

7 (d) No later than August 30, 2009, the legislative
8 reference bureau shall complete and submit to the task force a
9 report on the policies and procedures for access, distribution,
10 security, and other relevant issues related to the medical use
11 of cannabis for all the states that currently have a medical
12 cannabis program.

13 (e) The director of public safety shall submit a report of
14 the medical cannabis task force's findings and recommendations,
15 including any proposed legislation and rules, to the legislature
16 no later than twenty days prior to the convening of the regular
17 session of 2010.

18 (f) The medical cannabis task force shall cease to exist
19 on June 30, 2010.

20 PART II

21 SECTION 2. The legislature finds that *Salvia divinorum*,
22 otherwise known as "diviner's sage" or "magic mint," is not

1 regulated in Hawaii. The legislature further notes that several
2 countries, such as Australia, Belgium, Denmark, Estonia,
3 Finland, Italy, Japan, Spain, and Sweden have passed regulatory
4 laws on *Salvia divinorum* or its primary psychoactive
5 constituent, salvinorin A. In the United States, California,
6 Delaware, Florida, Illinois, Iowa, Kansas, Louisiana, Maine,
7 Michigan, Mississippi, Missouri, New Jersey, North Dakota, Ohio,
8 Oklahoma, Pennsylvania, South Carolina, Tennessee, and Virginia
9 regulate *Salvia divinorum*, with approaches ranging from
10 classification as a Schedule I controlled substance to placing
11 restrictions on its sale. The legislature finds that possible
12 regulation of *Salvia divinorum* and its primary psychoactive
13 constituent, salvinorin A, is worthy of formal examination by
14 the State.
15 SECTION 3. (a) There is established a *Salvia divinorum*
16 task force within the department of public safety for
17 administrative purposes. The purpose of the *Salvia divinorum*
18 task force shall be to review the effects of *Salvia divinorum*
19 and its primary psychoactive constituent, salvinorin A. The
20 director of public safety shall be responsible for administering
21 the work of the salvia divinorum task force. The *Salvia*
22 *divinorum* task force shall:

1 (1) Research the uses and effects of *Salvia divinorum* and
2 salvinorin A on adults and minors;
3 (2) Research all other states' legislation relating to
4 salvia divinorum and salvinorin A;
5 (3) Recommend appropriate legislation resulting from its
6 findings to address the sale and use of *Salvia*
7 *divinorum* and salvinorin A in Hawaii; and
8 (4) Address other issues and perform any other function
9 necessary as the task force deems appropriate,
10 relating to *Salvia divinorum* or salvinorin A.
11 (b) The salvia divinorum task force shall consist of the
12 following members:
13 (1) The director of public safety or the director's
14 designee;
15 (2) The director of health or the director's designee;
16 (3) The administrative director of the judiciary or the
17 administrative director's designee;
18 (4) The attorney general or the attorney general's
19 designee;
20 (5) The president of the Hawaii State Bar Association or
21 the president's designee; and

1 (6) The president of the Drug Policy Forum of Hawaii or
2 the president's designee.
3 (c) The members of the task force shall select a
4 chairperson from among its members, who, in conjunction with the
5 director of public safety, shall establish task force
6 procedures, including the meeting schedule, voting procedures,
7 and member duties.
8 The members of the task force shall serve without
9 compensation, but shall be reimbursed for necessary expenses,
10 including travel expenses, incurred in the performance of their
11 official duties.
12 (d) The director of public safety shall submit a report of
13 the *Salvia divinorum* task force's findings and recommendations,
14 including any proposed legislation or rules, to the legislature
15 no later than twenty days prior to the convening of the regular
16 session of 2010.
17 (e) The *Salvia divinorum* task force shall cease to exist
18 on June 30, 2010.

19 **PART III**

20 SECTION 4. This Act shall take effect upon its approval.