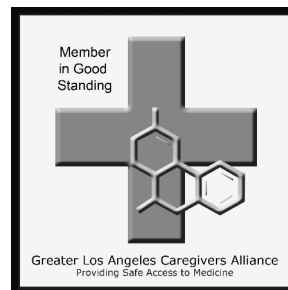


Advancing Medical Cannabis Regulations in Los Angeles

Prepared by
Greater Los Angeles Collective Alliance
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About the Authors

The **Greater Los Angeles Collectives Alliance (GLACA)** is a voluntary association of medical cannabis cooperative and collective operators in Los Angeles who have organized around a shared desire to provide safe access to patients with adherence to a strict code of operational guidelines. GLACA members are working to: (1) protect medical cannabis patients and our community; (2) develop, implement, and monitor compliance with operational and safety protocols for collectives and cooperatives in the Los Angeles area, and (3) educate our community about medical cannabis.

Member collectives conduct a peer-based “secret shopper” program to verify compliance with state law and GLACA operational and safety protocols. Accredited collectives display a GLACA membership logo at their facilities and in printed material to let patients and the community know they uphold the highest possible legal and professional standards in the field.

Visit www.CaregiversAlliance.org for more information about GLACA.



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

ASA provides legal training for and medical information to patients, attorneys, health and medical professionals and policymakers throughout the United States. We also organize media support for court cases, rapid response to law enforcement raids, and capacity-building for advocates. Our successful lobbying, media and legal campaigns have resulted in important court precedents, new sentencing standards, and more compassionate community guidelines.

Visit www.AmericansForSafeAccess.org or call toll free (888) 929-4367 for more information about ASA.

Chapter 1: Federal and State Law

Executive Summary

In 1996, California voters passed the country's first medical cannabis (marijuana) law.¹ One of the most significant developments in California since then is the evolution of a distribution mechanism to ensure safe and affordable access for the more than 300,000 legal patients in the state. While California moved incrementally to implement its law over the last thirteen years, twelve additional states passed medical cannabis laws of their own. Support for medical cannabis grew nationwide as the number of medical cannabis states increased. Medical cannabis enjoys the support of more than 80% of Americans.² This strong support is complemented by ongoing research into the therapeutic properties of cannabis, including findings that clearly show medical efficacy.³

Unfortunately, the federal government still holds that “marijuana has no currently accepted medical use in treatment in the United States,” ignoring well established scientific evidence.⁴ This position, along with a U.S. Supreme Court ruling in June 2005, has given the government the authority to enforce federal laws against cannabis – even in states where its medical use is legal.⁵ At the same time, the U.S. Supreme Court's decision not to overturn or invalidate medical cannabis laws in California or elsewhere allowed the continuing implementation of such laws.

California's 1996 Compassionate Use Act (CUA) calls on local, state, and federal officials to develop a plan for the safe and affordable distribution of cannabis. Although the federal government has shown no interest in cooperating with the State of California to develop an effective distribution mechanism, local and state officials, patients, and advocates have taken the initiative to do so. Since 2004, more than three-dozen cities and counties have developed regulatory ordinances for medical cannabis collective and cooperative associations, sometimes called “dispensaries.”⁶ These facilities have flourished over time with hundreds currently operating across the state. As collectives and cooperatives became well established in California, elected officials and law enforcement realized that sensible regulations reduce crime and complaints, and that neighboring businesses often benefit from collective and cooperative operation.⁷

Collectives began to flourish in the Los Angeles area beginning in 2004. This prompted the Los Angeles County Board of Supervisors in 2006 to adopt a regulatory ordinance covering the

¹ See Proposition 215 or Health & Safety Code Section 11362.5.

² See <http://www.time.com/time/covers/1101021104/story.html>.

³ See <http://www.cannabis-med.org/studies/study.php>.

⁴ See <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2006/ucm108643.htm>.

⁵ *Gonzales v. Raich*, 545 U.S. 1 (2005).

⁶ See <http://AmericansForSafeAccess.org/regulations>.

⁷ See Medical Cannabis Dispensing Collectives and Local Regulations; <http://www.americansforsafeaccess.org/downloads/dispensaries.pdf>.

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unincorporated areas of the county. To address the proliferation of collectives inside Los Angeles city limits, the City Council has been working to develop a regulatory ordinance since 2007. The development of a regulatory ordinance in the City of Los Angeles has been a complicated evolutionary process. Unfortunately, the first draft proposals for a regulatory ordinance did not meet the expectations of patients and advocates, causing confusion, delays, and a further proliferation of collectives in the city.

Advocates are now calling for a prompt conclusion to the development of a regulatory ordinance in the City of Los Angeles. In addition, advocates have made a series of recommendations that should assist the City Council in expeditiously arriving at an ordinance acceptable to all involved. These recommendations include: adopting safety and operational protocols already in use by local collectives, implementing a process for verifying non-for-profit status, requiring security precautions, protecting the confidentiality of membership records, and establishing reasonable location requirements. Advocates are calling on the City Council to finalize development of a regulatory ordinance as soon as possible. This report provides information for local officials and the public to rapidly adopt an ordinance that will avoid further confusion, delays and possible litigation.

National Political Landscape

A substantial majority of Americans support safe and legal access to medical cannabis. Public opinion polls in every part of the country show majority support cutting across political and demographic lines. Among them, a Time/CNN poll in 2002 showed 80% national support,⁸ a survey of AARP members in 2004 showed 72% of older Americans support legal access, with those in the western states polling 82% in favor.⁹

This broad support, contrasted with an intransigent federal government that refuses to acknowledge medical uses for cannabis, led Americans to create state-based solutions. The laws that voters and legislators have adopted are intended to minimize the effects of the federal government's prohibition on medical cannabis by allowing qualified patients to use it without state or local interference. Beginning with California in 1996, voters passed initiatives in eight states plus the District of Columbia -- Alaska, Colorado, Maine, Montana, Nevada, Oregon, and Washington. State legislatures similarly passed laws to protect patients from criminal penalty in Hawaii, Michigan, New Mexico, Rhode Island, and Vermont.¹⁰

Momentum for these state-level provisions for compassionate use and safe access has continued to build as more research on the therapeutic uses of cannabis is published. In addition, the public advocacy of well-known cannabis patients such as the Emmy-winning talk show host Montel

⁸ See <http://www.time.com/time/covers/1101021104/story.html>.

⁹ See <http://medicalmarijuana.procon.org/viewadditionalresource.asp?resourceID=000193>.

¹⁰ See <http://medicalmarijuana.procon.org/viewresource.asp?resourceID=000881>.

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Williams has increased public awareness and created political pressure for state and local solutions around medical cannabis.

Even though the U.S. Supreme Court ruled in June 2005, in *Gonzales v. Raich*, that the federal government had the discretion to enforce such laws it certainly wasn't required to do so.¹¹ In fact, the Supreme Court questioned the wisdom of such enforcement efforts. Furthermore, the Court's decision not to invalidate or overturn California's medical cannabis law points to the ability of federal and state laws to coexist, even when they differ. In the wake of the *Raich* decision, the Attorneys General of California, Hawaii, Oregon, and Colorado all issued legal opinions or statements reaffirming their state's medical cannabis laws.¹² The duty of state and local law enforcement is to the enforcement and implementation of state, not federal, law.

California Law and Federal Interference

In 1996, the voters of California adopted Proposition 215, the Compassionate Use Act (CUA), legalizing the medical use of cannabis with a doctor's approval.¹³ Since then, the twelve additional states that have passed medical cannabis laws were established despite, and arguably because of, a federal policy that refutes the medical efficacy of cannabis.¹⁴ The current federal position is that "marijuana has no currently accepted medical use in treatment in the United States,"¹⁵ which ignores well established and growing scientific evidence of medical efficacy.¹⁶

For years, the Bush Administration attempted to undermine California's medical cannabis law by using the Justice Department and the Drug Enforcement Administration (DEA) to raid, arrest and prosecute people who were otherwise in compliance with state law.¹⁷ As a result, thousands of people have been unnecessarily and adversely impacted by the actions of the Bush Administration.

From the passage of the CUA in 1996, both the Clinton and Bush Administrations ignored the recommendation of California voters "To encourage the federal and state governments to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana."¹⁸ However, in an effort to provide safe access for thousands of California patients who cannot cultivate medical cannabis themselves, a distribution model was

¹¹ *Gonzales v. Raich*, 545 U.S. 1 (2005).

¹² See <http://www.mpp.org/library/gonzales-v-raich-the-impact.html>.

¹³ See Health & Safety Code Section 11362.5.

¹⁴ See <http://medicalmarijuana.procon.org/viewresource.asp?resourceID=000881>.

¹⁵ See <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2006/ucm108643.htm>.

¹⁶ See <http://www.cannabis-med.org/studies/study.php>.

¹⁷ See http://AmericansForSafeAccess.org/downloads/dea_escalation.pdf.

¹⁸ See Health & Safety Code Section 11362.5.

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successfully developed. Collectively and cooperatively run medical cannabis “dispensaries” began to form and take root as a viable method of distribution.¹⁹

After the California legislature passed the Medical Marijuana Program Act (SB 420) in 2003, clarifying the right of patients and their primary caregivers to collectively or cooperatively cultivate, several cities adopted ordinances regulating the dispensation of medical cannabis.²⁰ Then, in 2005, California’s appellate court ruled in *People v. Urziceanu* that as long as patients’ associations operated collectively or cooperatively they should be protected under state law.²¹

Also in 2005, the State of California established a policy of taxing the sale of medical cannabis at storefront collectives.²² In a decision made that year by the Board of Equalization, collectives were required to obtain seller’s permits and remit sales tax revenue to the state. This revenue, which was estimated to total \$100 million in 2007, goes to the state’s general budget and is a significant funding source for a cash-strapped state such as California.²³

In August 2008, further legitimizing storefront medical cannabis collectives, the California Attorney General issued guidelines acknowledging their legality and providing recommendations for complying with state law.²⁴ Some of the Attorney General recommendations included: a) collective or cooperative operation; b) non-profit operation; c) membership application and patient/caregiver verification; d) payment of sales tax to the state; and e) prohibition of sales to non-members.

During the implementation of medical cannabis laws in California and the development of safer methods of access for patients, state courts issued several landmark rulings. Appellate court decisions in *City of Garden Grove v. Superior Court*²⁵ and *County of San Diego v. San Diego NORML*²⁶ found that California’s medical cannabis law held up to scrutiny and, most importantly, that it was not preempted by federal law. Both decisions underscored the obligation of local officials to uphold state law and that “it is not the job of the local police to enforce the federal drug laws.”²⁷ Given refusals by the California Supreme Court and the U.S. Supreme Court to review these cases, they were made binding across the state.

Most recently, the Third District Court of Appeal for California ruled in *Butte County v. Williams* that patients and their primary caregivers have a right to associate collectively and cooperatively and can file suit if that right is violated.²⁸ Another case, *Qualified Patients*

¹⁹ See Medical Cannabis Dispensing Collectives and Local Regulations; <http://www.americansforsafeaccess.org/downloads/dispensaries.pdf>.

²⁰ See Health & Safety Code Section 11362.775.

²¹ *People v. Urziceanu* (3rd Dist 2005) 132 Cal. App. 4th 747.

²² See <http://www.boe.ca.gov/news/pdf/173.pdf>.

²³ See [http:// AmericansForSafeAccess.org/downloads/sales_tax_fact_sheet.pdf](http://AmericansForSafeAccess.org/downloads/sales_tax_fact_sheet.pdf).

²⁴ See http://ag.ca.gov/cms_attachments/press/pdfs/n1601_medicalmarijuanaguidelines.pdf.

²⁵ *City of Garden Grove v. Superior Court* (2007) 157 Cal.App.4th 355.

²⁶ *County of San Diego v. San Diego NORML* (2008) 165 Cal.App.4th 798.

²⁷ See *City of Garden Grove v. Superior Court* (2007) 157 Cal.App.4th 355.

²⁸ See *County of Butte v. Superior Court* (2009).

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Association v. City of Anaheim, which is currently pending before the Fourth District Court of Appeal, addresses whether it is lawful for local governments to establish outright bans on collectives.

Now, with better definition around California's medical cannabis laws and an obligation by local officials to uphold state law, advocates are looking to harmonize federal law with the laws of states like California. As the Bush Administration's attempts to undermine California's medical cannabis law recedes into historical obsolescence, patients and advocates alike are hopeful that a new policy will be developed and implemented under the Obama Administration. Senator Obama made repeated public statements during his presidential election campaign that he was "not going to be using Justice Department resources to try to circumvent state laws on this issue."²⁹ Since taking office, President Obama and his Administration have continued to make declarative statements signaling a new federal policy regarding medical cannabis.³⁰

Risk of Federal Interference Still Remains

Although the Obama Administration has indicated a willingness to change federal medical cannabis policy, patients, providers and advocates are cautiously optimistic. Reasons for such caution include years of DEA raids and Justice Department prosecutions that have resulted in harsh penalties for people complying with state law. Despite repeated statements by the new Administration, more than a half-dozen DEA raids have occurred since President Obama took office.

While many believe that the DEA raids under the Obama Administration are the result of Bush Administration holdovers, the risk of federal interference still remains. The U.S. Attorney General has made public statements, which still reserve the right to enforce federal law against those medical cannabis providers that violate both federal *and* state law.³¹ Such statements offer significant consolation to collective and cooperative operators who comply with state law. However, according to advocates and legal experts, Justice Department officials have misinterpreted state law issues in several pending federal cases.³² Such misinterpretations have left medical cannabis providers wary of how the federal government may enforce the law and rightfully concerned about future DEA actions.

²⁹ See <http://www.washingtontimes.com/news/2009/feb/05/dea-led-by-bush-continues-pot-raids/>.

³⁰ *Ibid.*

³¹ See <http://www.foxnews.com/politics/first100days/2009/03/18/holder-signals-administration-relax-enforcement-policy-medical-marijuana/>.

³² One such case is that of Charles C. Lynch; See <http://friendsofcl.com>.

Chapter 2: Medical Cannabis Collectives and Cooperatives

What Are Medical Cannabis Dispensing Collectives and Why Are They Needed?

A majority of medical cannabis patients are not able to cultivate medicine themselves and cannot find a caregiver to grow it for them. Most of California's estimated 300,000 patients obtain their medicine from Medical Cannabis Dispensing Collectives or Cooperatives (MCDC), sometimes referred to as "dispensaries." MCDCs are typically storefront facilities that provide medical cannabis grown by their legally qualified members to other patient-members in need.³³ MCDCs do not obtain cannabis from the illicit market, nor do they provide it to anyone who is not a member.

There are currently hundreds of storefront MCDCs operating in California with closed memberships allowing only qualified patients and primary caregivers to obtain cannabis and only after memberships are approved (upon verification of patient documentation). Some facilities offer on-site consumption, providing a safe and comfortable place where patients can medicate. An increasing number offer additional services for their patient membership, including massage, acupuncture, legal trainings, free meals, and counseling. MCDCs also provide important social benefits for patients according to research published by the University of California at Berkeley.³⁴

Medical Cannabis Dispensing Collectives Are Legal

The California legislature adopted Senate Bill 420 (SB 420) in 2004, which expressly states that Qualified Patients and Primary Caregivers may associate collectively or cooperatively to cultivate cannabis for medical purposes.³⁵ The courts have interpreted this statute to mean that Medical Cannabis Dispensing Collectives and Cooperatives (MCDC), where patients may buy their medicine, are legal entities under state law. California's Third District Court of Appeal affirmed the legality of collectives and cooperatives in 2005 in the case of *People v. Urziceanu*, which held that SB 420, otherwise known as the Medical Marijuana Program Act (MMPA), provides MCDCs a defense to cannabis distribution charges. Drawing from the voter's directive in Proposition 215 to implement a plan for the safe and affordable distribution of medical cannabis, the court found that the MMPA and its legalization of MCDCs represented the state government's initial response to this mandate.³⁶

³³ See Medical Cannabis Dispensing Collectives and Local Regulations; <http://www.americansforsafeaccess.org/downloads/dispensaries.pdf>.

³⁴ *Ibid.*

³⁵ California Health and Safety Code Section 11362.775.

³⁶ *People v. Urziceanu* (2005) 132 Cal.App.4th 747, 33 Cal.Rptr.2d 859, 881.

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In August of 2008, the California Attorney General published “Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use” designed to help clarify the laws surrounding medical cannabis. These guidelines make it clear that patients’ associations authorized under California Health and Safety Code 11362.775 are legal, and as such, are not subject legal sanctions for possession with intent to sell or sales of cannabis under Sections 11359 and 11360, respectively. Part of the function of a patients’ association is to allocate the costs and benefits of the collective cultivation effort, and in this context, buying and selling cannabis within the membership of the MCDC is legal.

Section IV(C)(1) of the Attorney General’s guidelines specifically recognize that legal collectives and cooperatives may maintain storefronts to provide medicine to members:

*“Although medical marijuana “dispensaries” have been operating in California for years, dispensaries, as such, are not recognized under the law. As noted above, the only recognized group entities are cooperatives and collectives. (Section 11362.775). **It is the opinion of this Office that a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law [emphasis added],** but that dispensaries that do not substantially comply with the guidelines set forth in Section IV(A) and (B), above, are likely operating outside the protections of Proposition 215 and MMP, and that individuals operating such entities may be subject to arrest and criminal prosecution under California law. For example, dispensaries that merely require patients to complete a form summarily designating the business owner as their primary caregiver – and then offering marijuana in exchange for cash “donations” – are likely unlawful.”*

It is unreasonable to arbitrarily label all of the storefront MCDCs operating in Los Angeles with the Attorney General’s term “dispensaries,” while ignoring the clear fact that the state’s highest ranking law enforcement official specifically concedes that lawful collectives and cooperatives may maintain storefronts.

What *People v. Mentch* Means for Medical Cannabis Dispensing Collectives

Lobbyists representing law enforcement interests and some medical cannabis opponents wrongly assert that the 2009 California Supreme Court decision in *People v. Mentch* makes Medical Cannabis Dispensing Collectives and Cooperatives (MCDC) illegal.³⁷ This is a clear misreading of the decision, and in some cases, the argument may be propagated to intentionally confuse the issue of legal access under California law. While it is true that the *Mentch* decision upholds a narrow definition of the term “Primary Caregiver” in Proposition 215, the ruling only concerns *an individual’s* claim to be a Primary Caregiver under state law; it does not address the legality of patients’ collectives and cooperatives. The *Lungren v. Peron* decision from 1997 already stated

³⁷ *People v. Mentch* (2008) 45 Cal.4th 274, 283.

that MCDCs could not be caregivers.³⁸ So, applying *Mentch* to MCDCs, including those that maintain storefront facilities in Los Angeles, is misguided and not legally valid.

Medical Cannabis Dispensing Collective Regulations

There are more than three-dozen cities and counties in California that have adopted local laws regulating the operation of Medical Cannabis Dispensing Collectives and Cooperatives (MCDC).³⁹ The City of Los Angeles is among many additional cities that are currently deliberating how to implement such laws in their own jurisdictions. Americans for Safe Access (ASA) provides legal and political support for local governments in arriving at the most sensible regulations that will meet the needs of patients and address issues raised by local residents and neighborhood businesses.

Given the number of MCDCs around the state, there is ample evidence that regulations have benefited patients and members of the community alike.⁴⁰ Regulated MCDCs benefit the community by: a) providing access to medical cannabis for our most vulnerable citizens – the sick and injured; b) offering a safer environment for patients than having to obtain their medicine on the illicit market; c) improving the health of patients through a social support network; and d) helping patients with other social services, such as food and housing. Creating MCDC regulations combats crime because: a) security has been shown to reduce crime in the vicinity; b) street sales of cannabis tend to decrease; and c) patients and operators are vigilant in reporting any criminal activity to police. Because of successful regulations, MCDCs are helping revitalize neighborhoods that bring new customers to neighboring businesses and have generally not been a source of community complaints.

Medical Cannabis Dispensing Collectives Reduce Crime and Improve Public Safety

One of the main concerns of residents and community groups about Medical Cannabis Dispensing Collectives and Cooperatives (MCDC) is the perception that criminal activity is more likely to occur in their vicinity. In fact, evidence shows that collectives help to reduce crime and improve public safety. Crime statistics and the accounts of local officials surveyed by Americans for Safe Access indicate that crime is actually reduced by the presence of an MCDC.⁴¹ In addition, complaints from citizens and surrounding businesses are either negligible or are significantly reduced with the implementation of local regulations. After adopting an ordinance regulating MCDCs in 2006, the Kern County Sheriff noted in his staff report that “regulatory oversight at the local levels helps prevent crime directly and indirectly related to illegal operations

³⁸ *Lungren v. Peron* (1997) 59 Cal.App.4th 1383.

³⁹ See <http://AmericansForSafeAccess.org/regulations>.

⁴⁰ See Medical Cannabis Dispensing Collectives and Local Regulations; <http://www.americansforsafeaccess.org/downloads/dispensaries.pdf>.

⁴¹ *Ibid.*

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occurring under the pretense and protection of state laws authorizing Medical Marijuana Dispensaries.” In the year after the Kern regulations took effect, the sheriff specifically pointed out that existing MCDCs have not caused noticeable secondary effects or problems for law enforcement.

The presence of a storefront MCDC in the neighborhood can actually improve public safety and reduce crime. Most MCDCs take security for their members and staff more seriously than other businesses. Security cameras are often used both inside and outside the premises, and security guards are often employed to ensure safety. Both cameras and security staff serve as a general deterrent to criminal activity and other problems on the street. Those likely to engage in such activities will tend to move to a less-monitored area, thereby ensuring a safe environment not only for collective or cooperative members and staff but also for neighbors and businesses in the surrounding area. Residents in areas surrounding MCDCs have reported to Americans for Safe Access marked improvements to the neighborhood. Oakland City Administrator Barbara Killey, who oversees that city’s regulatory ordinance, noted, “The areas around the collectives may be some of the most safest areas of Oakland now because of the level of security, surveillance, etc...since the ordinance passed.” Likewise, Santa Rosa Mayor Jane Bender noted that since the city passed its ordinance, there appears to be “a decrease in criminal activity. There certainly has been a decrease in complaints. The city attorney says there have been no complaints either from citizens nor from neighboring businesses.”

Those MCDCs that go through the permitting process or otherwise comply with local ordinances tend, by their very nature, to be those most interested in meeting community standards and being good neighbors. Cities enacting ordinances for the operation of collectives may even require security measures, but it is a matter of good business practice for MCDC operators since it is in their own best interest. Many local officials surveyed by Americans for Safe Access said collectives operating in their communities have presented no problems, or what problems there may have been significantly diminished once an ordinance or other regulation was instituted. Former Santa Cruz Mayor Mike Rotkin said his city’s collectives get cooperation from the local police because they “well run and well regulated and located in an area acceptable to the City. Because they are under strict city regulation, there is less likelihood of theft or violence and less opposition from angry neighbors. It is no longer a controversial issue in our city.”

Chapter 3: Regulating Safe Access in Los Angeles

Medicinal Cannabis Dispensing Collectives in Los Angeles

The first medical cannabis association in Los Angeles started providing medicine to patients suffering from cancer and HIV/AIDS in Venice in 1995, before voters approved Proposition 215. That facility was closed by the Los Angeles County Sheriff's Department, and subsequently relocated to West Hollywood. The Los Angeles Cannabis Resource Center operated with the city's blessing until 2001, when Drug Enforcement Administration (DEA) agents raided and permanently closed the organization.

Medical Cannabis Dispensing Collectives or Cooperatives (MCDC) began to reopen in West Hollywood and Los Angeles in 2004. The City of West Hollywood moved quickly to establish a moratorium on new MCDCs in 2005, and then to adopt an ordinance regulating their operation.

The first MCDC in Los Angeles opened on Wilshire Blvd. in 2004, and was raided and closed by the Los Angeles Police Department in 2005. This early police action did not stop other MCDCs from opening in the city. MCDCs found it easy to open in Los Angeles because the municipal code only required operators to obtain a Tax Registration Certificate. MCDCs were not anticipated by the code, and there was no requirement for a business license or permit, or any mechanism to track the establishment of new MCDCs.

Los Angeles City Councilmember Dennis Zine made a motion to study regulations for MCDCs in 2005, after the number of facilities in the city began to rise. The proliferation of new MCDCs continued until September 2007, when the City Council adopted an Interim Control Ordinance (ICO) establishing a moratorium on new facilities until permanent regulations could be developed and adopted. After a brief pause, however, new facilities began to open again in Los Angeles using a loophole in the ICO, which has now been removed.

One hundred and eighty-six collectives registered with the City Clerk's office under the terms of the ICO. These facilities provided documentation establishing that they were operating legally before the effective date of the moratorium. Since that time, some of these facilities have been forced to relocate as a result of Drug Enforcement Administration (DEA) interference and intimidation in the form of paramilitary-style raids or letters threatening property owners who rent to facilities with prosecution and civil asset forfeiture. Patients' associations that registered under the ICO and subsequently relocated filed hardship applications for their new locations with the City Clerk's office.

The Hardship Exemption for Los Angeles Collectives

Today, approximately one hundred and thirty Medical Cannabis Dispensing Collectives (MCDC) operate at the same address at which they registered with the City Clerk's office before the 2007 Interim Control Ordinance (ICO) established a moratorium on new facilities. As a result of the threatening DEA letters sent to landlords, many MCDCs were forced to close or move. In order to ensure that those MCDCs forced to move would still be legitimate in the eyes of the city, advocates supported the former City Attorney's inclusion of a Hardship Exemption in the ICO. Even though the number of Hardship Exemption Applications pending with the city continued to grow at a steady pace, the PLUM Committee failed to begin reviewing any of them until 2009.

A flaw in the Hardship Exemption enabled collectives that had not registered with the City Clerk's office before the effective date of the ICO to file for the exemption. Having noticed the flaw, hundreds of applicants used the loophole to open new storefront collectives in the city. By the summer of 2009, the number of pending Hardship Applications had surpassed 500. In an attempt stem the tide of a steadily increasing number of MCDCs, City Councilmember Jose Huizar moved to close the loophole in the ordinance.⁴² Just the threat of closing the loophole caused the number of collectives in Los Angeles to increase even further. To this date, hundreds of Hardship Exemption Applications remain pending with the PLUM Committee.

The medical cannabis collectives that complied with the ICO by registering their operations with the city, but were later forced to move due to DEA interference, should promptly be given a thorough and objective evaluation before the PLUM Committee. In reviewing the Hardship Exemptions for these collectives, the PLUM Committee should consider fidelity and compliance in making a recommendation on their applications. In addition, because the city allows for transfers of ownership during the ICO, the PLUM Committee should also properly review which collectives have been sold or otherwise transferred and why. Some applicants that were denied Hardship Exemptions are threatening lawsuits. And, though the merit of such litigation remains unclear, it is important to quickly resolve the Hardship Applications in order to mitigate actions like these and avoid further delay in adopting a permanent regulatory ordinance.

City Attorney's Ordinance Fails to Address the Los Angeles City Council's Request

In 2008, the Planning Department convened a working group with representatives from the patient community and city staff to make recommendations on permanent regulations. This

⁴² See City Council File 05-0872-S1, April 28, 2009.

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working group based its discussions on the existing medical cannabis ordinance adopted by the Los Angeles County Board of Supervisors in 2006.⁴³ City staff terminated the working group meetings in November 2007, saying they had enough input to move forward.

In April of 2008, the Los Angeles City Attorney published an initial draft ordinance for consideration in the Planning and Land Use Management Committee (PLUM).⁴⁴ The draft ordinance was so restrictive that it essentially outlawed the model of storefront Medical Cannabis Dispensing Collectives (MCDC) already operating lawfully in the city. Patients and advocates who served on the Medical Marijuana Working Group, along with other community members, joined City Councilmember Dennis Zine in rejecting the City Attorney's draft and calling on the committee to request a new ordinance based on the existing Los Angeles County model and the working group's input.

In February of 2009, then City Attorney Rocky DelGadillo published a draft ordinance for the City Council's review. Like past versions, this draft failed to address the outline and direction given by City Council. Rather, basic misinterpretations and blatant disregard of input provided by community members led to a draft ordinance that failed to comprehend the reality of the medicinal cannabis community.

In a response to a letter from Councilmember Zine in November 2008, former City Attorney Rocky DelGadillo equated all of the storefront facilities, including those that registered under and complied with the ICO, to that of Attorney General Brown's definition of an illegal "dispensary." While a small fraction of "dispensaries" may run astray of the Attorney General's guidelines the majority operates within the closed circuit, patient organized collective as described and recognized as legal by the California Attorney General.

Provisions for the regulatory process described in the February 2009 draft unnecessarily burdens the overworked city staff by requiring that each collective provide the name, address and other membership information to the City. Providing this personal information would only create more paperwork and time consumed by city staff. Furthermore the February draft requires that each patient cultivator be identified. This presents challenges in patient confidentiality and self-incrimination. It is not wise for collectives to openly identify the patient cultivators given that the LAPD has a history of working in conjunction with the Drug Enforcement Administration (DEA).

Prohibitions on items such as edibles that are discussed in the February 2009 draft are illogical and unreasonable. Edible products are the primary source of non-smoked cannabis for many patients who either cannot or will not intake smoked cannabis. Edible cannabis preparations are a safe way to ingest cannabis.

⁴³ Los Angeles County Code Section 22.08.130.

⁴⁴ See "Report from City Attorney 04/14/2008" for Council; File 08-0923.

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Furthermore, the regulations failed to address issues such as diversion of medication, ways to reduce neighborhood impact and most importantly member screening. The February 2009 draft ordinance was yet another attempt by the former City Attorney to stall the process of permanent regulations being adopted. Unfortunately, the City Attorney refused to change the poorly drafted ordinance and the City Council was forced to wait until a new City Attorney took office in 2009.

Recommendations for Regulating Collectives in the City of Los Angeles

Because of the failure by the former City Attorney's office to develop a draft ordinance that meets the needs of both patients and communities, advocates are urging several improvements to the new draft ordinance. Furthermore, patients and advocates support the Interim Control Ordinance (ICO), but have a strong desire to complete the development of regulations for Medical Cannabis Dispensing Collectives in the City of Los Angeles in the near future. In order to avoid further confusion, costly litigation, and delayed implementation, patients and advocates oppose any further extension of the ICO, and recommend completing the permanent regulations as soon as possible.

The areas of focus for recommended changes to the draft ordinance include, safety and operational protocols, verification of not-for-profit status, security requirements, confidentiality of membership records, and location requirements:

1. Adopt safety and operational protocols already in use at MCDCs in Los Angeles.

Local patients' associations in the Greater Los Angeles Collectives Alliance (GLACA) have already adopted effective safety and operational protocols that should be included in the permanent regulations wherever possible. Protocols that guard against diversion of cannabis to non-patients, ensure proper verification of qualified patients, establish a limit on the amount of cannabis dispensed to each patient, and encourage "good neighbor" policies have well served patients, providers and members of the community. A copy of the GLACA safety and operational protocols is included in the Appendix of this report.

2. Verify that MCDCs operate in a not-for-profit manner.

The Medical Marijuana Program Act (SB 420) and the California Attorney General guidelines indicate that patients' associations must operate in a not-for-profit capacity. As such, the city should require proof that MCDCs are incorporated as statutory cooperatives or bona fide nonprofit corporations; or that they are operated in a not-for-profit manner. Operation in a not-for-profit manner might include reinvesting excess revenue in services for members or patient advocacy, or supporting other beneficial community activity.

3. Require MCDCs to maintain an appropriate level of security.

In order to abate criminal activity in the vicinity of licensed MCDCs, the city should require staff training on security, the employment of professional security personnel, as well as the use of adequate video cameras and alarms. While input by Los Angeles Police Department (LAPD) on the MCDC Security Plan is warranted, requiring LAPD approval may be problematic. LAPD still regards all collectives or cooperatives, no matter how organized or operated pursuant to state law, as illegal. There must be objective standards set, which can be verified by LAPD without a requirement for subjective evaluations.

4. Keep MCDC membership records confidential, including information about those patients who grow cannabis.

Because medical cannabis remains illegal under federal law, there is still considerable risk to divulging personal information about MCDC members and patient-cultivators. Member patient information is susceptible to federal subpoena and access to this information is tantamount to self-incrimination. In addition, there are requirements under the Health Information Portability and Accountability Act (HIPPA) of 1996 that may prevent local and federal officials from legally obtaining certain patient information. As such, membership information should be kept confidential and proprietary.

Each member of a legally organized and operated MCDC is entitled to bring medicine to the associations' storefront facility (or other location) for provision to other members without sufficient amounts of medicine. In this regard, every collective member is a potential cultivator. Requiring disclosure of individual patient-cultivators does not recognize the state of California law, not does it anticipate legal operation. This misguided approach assumes that MCDCs acquire medicine from the illicit market, and seeks to deter, investigate, and prosecute legal medical cannabis patients whose conduct is appropriate under state law.

5. Make MCDC locations requirements reasonable by avoiding large buffer zones around an arbitrary list of "sensitive uses."

Well-operated and regulated storefront MCDCs are good and inconspicuous neighbors, and as such need not be forced to comply with onerous location requirements. Requiring a large buffer zone from a laundry list of arbitrary "sensitive uses" will unintentionally prohibit MCDCs by making legal sites impossible to find. This will have an adverse impact on the safety and wellbeing of legal patients, who rely on these facilities for safe access to medication. This *de facto* ban on storefronts run contrary to the will of voters in Los Angeles and the instructions of the Los Angeles City Council.

Regulated MCDCs belong in commercial and retail zones, just like pharmacies and other health care businesses. Restrictions on these facilities should be at least more lenient than the location regulations required of the city's adult-oriented businesses, which must be located more than 500

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feet from schools, churches, and parks.⁴⁵ While larger buffer zones between MCDCs may be appropriate to prevent clustering in certain neighborhoods, other location requirements should be reasonable and, when warranted, flexible.

Conclusion

It has now been established through legislation and litigation, as well as through guidelines issued by the California Attorney General that Medical Cannabis Dispensing Collectives and Cooperatives (MCDC) are legal under state law. There is also plenty of evidence that MCDCs do not attract crime, but instead decrease crime in surrounding areas and are a benefit to community members and neighboring businesses.

While most patients' associations in the City of Los Angeles have done their best to comply with local requirements, the proliferation of MCDCs has been a source of concern. The evolution in the development of a regulatory ordinance for MCDCs in Los Angeles has brought city officials closer to an ordinance satisfactory to all involved. However, further prompt deliberation is still necessary to complete this effort. Patients and advocates are urging the city to finalize a draft ordinance as soon as possible, and to avoid any additional extension of the ICO.

Fortunately, there are plenty of experienced advocates assisting the city in this effort and their recommendations should guide the city in developing the next draft ordinance. Furthermore, the city should incorporate the suggested language defining safety and operational protocols, verification of non-for-profit status, security requirements, confidentiality of membership records, and location requirements. By choosing to incorporate the recommendations of advocates, the city can keep to a minimum future problems related to regulating MCDCs in Los Angeles.

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⁴⁵ Los Angeles Municipal Code 12.70(c).