

PUBLIC POLICY ASSESSMENT OF LOCAL GOVERNMENT APPROACHES TO
IMPLEMENTING CALIFORNIA'S MEDICAL MARIJUANA LAWS

HUMBOLDT STATE UNIVERSITY

By

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ABSTRACT

Public Policy Assessment of Local Government Approaches to Implementing California's Medical Marijuana Laws

Samantha M. Bryant

As states continue to implement medical marijuana ordinances and laws, it is necessary to conduct assessments of the implementation issues and outcomes of different medical marijuana regulations now in place. And as local governments scramble to deal with issues stemming from the cultivation, production and distribution of medical marijuana, it is necessary to provide guidance for them. This project involves using data to understand: (1) how ordinances are developed; (2) intended goals and effectiveness of marijuana ordinances; (3) how ordinances are implemented; and (4) legal avenues used to grow medical marijuana. The data will contribute to the analysis of medical marijuana ordinances and hopes to assist in future policy creation. Furthermore it will contribute to the California League of Cities' assessment of medical marijuana ordinances, by providing an analysis of the intended and unintended consequences of these laws.

Keywords: marijuana, marijuana policy, medical marijuana, California marijuana history, policy analysis, marijuana regulation, dispensary regulation, ordinance analysis

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CHAPTER ONE: INTRODUCTION

“Of all the plants men have ever grown, none has been praised and denounced as often as marihuana (*Cannabis sativa*)” (Abel 1980: ix).

Background

It is estimated that marijuana is California’s largest cash crop. It is estimated to be worth between ten and fourteen billion dollars annually (Mallery 2011: 4). The Marijuana Industry has become rampant and in response all levels of government have attempted to regulate the cultivation, distribution, possession, and enforcement of the crop. In this paper I will explore current legislation at the federal, state, county, and local levels. Then after analyzing existing and gathered data, I will develop a discussion around the intended goals and unintended outcomes of current legislation.

To begin I want to describe what marijuana is, how and why it is used, and take a glance at why it has become so widespread in media and discussion nationally. The plant goes by many names including: marijuana, marihuana, cannabis, hashish, pot, chronic, ganja, loco-weed, dope, aunt Mary, BC Bud, blunts, gangster, hash, herb, hydro, indo, kif, Mary Jane, Mota, reefer, skunk, smoke, yerba, sinsemilla, hash oil, green, and Thai sticks (Drug Enforcement agency 2012); however, for the remainder of the report this plant shall be referred to as marijuana.

Marijuana refers to the dried leaves and female flowers of the *Cannabis sativa* plant (Dictionary.com, Marijuana 2012). It is an annual plant that grows from seed or

clone. It can be grown on a range of soils, but tends to grow best in tropical climates. Currently marijuana is grown all over the world, specifically in the United States, Canada, Mexico, South America, and Asia. It is cultivated both outdoors and indoors. “The plant contains 460 chemical compounds and 60 of them are called cannabinoids. Cannabinoids are a family of complex compounds in the hemp plant that are responsible for the psychoactive properties of marijuana” (Gilcrest 2011: 2). Marijuana’s chief ingredient is delta-9-tetrahydrocannabinol (THC), and it can have antiemetic, analgesic, appetite-stimulating, anti-anxiety, and sedative effects (Clark 2000). “Marijuana is usually smoked as a cigarette (called a joint) or in a pipe or bong. It is also smoked in blunts. Marijuana is also mixed with foods, brewed as tea,” is juiced, or can even be made into ointments (Drug Enforcement Agency 2012).

It is difficult to gauge the potency levels of THC; however, being able to calculate or determine these levels are essential to using the plant medicinally. Every year the University of Mississippi’s Potency Monitoring Project tests thousands of marijuana samples. While most have THC levels ranging from five to twenty percent, they have found THC levels exceeding thirty percent (Meserve and Ahlers 2009). In addition “the average potency of marijuana, which has risen steadily for three decades, has exceeded ten percent for the first time” (Meserve and Ahlers 2009). Stronger potency levels correspond to greater drug effects, similar to alcohol.

Due to the current scheduling of marijuana, it is difficult to conduct research that would improve the medicinal properties, health impact, and psychoactive effects of the drug. For this reason marijuana contributes to the uneasiness of policy makers. Without a

reliable system for monitoring potency levels, it is difficult to regulate dosage amounts. In this way it is different than alcohol and other legal pharmaceuticals, which include potency amounts on their labels.

Marijuana's uses vary from medicinal to spiritual to economical. Humans have had a long history with marijuana, and as a result marijuana has had a long legal history. By the 1850's marijuana was considered a "fashionable narcotic" (Our Fashionable, 1854). The earliest uses of marijuana were medicinal and the earliest laws regulating the use of the plant looped marijuana with other narcotic poisons and prohibited the use or sale of marijuana without a doctor's prescription (Ayers 1907). A few decades later, debates over marijuana use and the availability of narcotics pushed the U.S. government to address "loopholes" in poison laws and Congress passed the Pure Food and Drug Act in 1906. The Act required that nationwide sales of non-prescription marijuana must have proper labels.

Following this act several states passed further laws that regulated marijuana sales and consumption (Ayers 1907). From this time on policies restricting the manufacture, distribution, and use of marijuana, along with other drugs like opium, alcohol, tobacco, "Indian hemp" or hashish, hemp, and other "habit-forming drugs" have fluctuated with the attitudes and needs of the government and the public. Furthermore these attitudes were often racist and prohibitions against opium, cocaine, hashish, and marijuana specifically were created to criminalize non-whites, and legitimize the Prison Industrial Complex that currently exists. Marijuana has long been linked to Hispanics,

Latinos, and jazz musicians, just as opium has been linked to those of Chinese descent (Hamaji 2010: 2).

Statement of the Problem

As of 2012, seventeen states¹ and the District of Columbia had legalized medical marijuana (Medical Marijuana 2011). Laws vary by state: some require a registry and identification cards for patients (Cohen 2010: 662). Sixteen of the fifteen states have a registry, excluding DC and Washington State, and in many of these states it is mandatory to enlist with this registry if you wish to use medical marijuana. Some states protect patients with identification cards from arrest and prosecution; however, in other states these cards will only protect patients during prosecution (Cohen 2010: 662).

Currently there are not any national discussions of marijuana regulations, as a result each state has served as an experiment in order to decipher which laws work, which laws do not, and what was overlooked when current legislation was created. States, counties, and local governments need guidance and to participate in discussions if marijuana regulation in the United States is ever going to become profitable and useful to the nation and its' citizens. Therefore ordinances surrounding medical marijuana are essential.

Marijuana is one of the most widely produced, sold, and used drugs in the world. In many places marijuana use is normalized within the culture. The more that marijuana is seen as positively contributing to society medicinally, economically, and

¹These states include: Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Maine, Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington.

recreationally, the greater the need for assessments of its affects on communities. Laws must address cultivation, production, distribution, dosage, and ecological outcomes of these processes to properly regulate this growing industry.

After examining and evaluating current legislation, stakeholders should plan for needed changes and implementation of these regulations. The stakeholders that need to be involved in creating these regulations include physicians, California Department of Health, patients, caregivers, dispensary owners, community members, social and natural scientists, County Board of Supervisors, law enforcement, and other policy-making sectors of local and state-wide governments. Without the insight and shared experiences of all of these individuals, the laws will never adequately serve people.

Introduction to Theoretical Lens

This paper contributes to the assessment of medical marijuana ordinances by providing an analysis of the intended goals and unintended consequences of these ordinances. This paper will analyze whether or not marijuana ordinances solve the problems they were designed to address. The propositions and ordinances will be assessed based on social, environmental, and economic outcomes. For example, current laws that prohibit recreational use of marijuana have increased the economic value of the product, and have not in any way reduced usage, which was the problem these laws were designed to address. In addition, the environmental costs of these ordinances, while unintended, have become devastating to ecological habitats.

Significance of the Study

Medical marijuana has become an issue that must be reconciled. As states continue to implement medical marijuana ordinances and laws, regardless of federal law, it is necessary to conduct assessments of the implementation issues and outcomes of local laws in place. To begin this process it is essential to look at ordinances that have already been implemented in order to understand the social, economical, and environmental impacts they wish to solve and those they ignore. Socially, fears prevail that the loosening of marijuana laws will increase crime and create a culture that is dependent on drugs. Economically there is hope that this medicine could be used to help relieve financial tensions at the local, state, and federal level. Environmentally it is feared that this industry could destroy many public land facilities, primarily national parks and preserves. In response to these concerns cultivation and distribution are limited to non-youth districts or zones, taxes and fees have been implemented, and task forces have been established. Current laws attempt to address the social, economical, and environmental issues that arise as a result of marijuana. In order to have a better understanding of whether current laws are accomplishing the goals they intended to and in order to determine what issues have risen as a result of implemented legislation research must be conducted.

This project involves using data to pursue an understanding of: (1) how ordinances are developed; (2) the intended goals and effectiveness of marijuana ordinances; (3) the ways that ordinances are implemented; and (4) issues of legal avenues

used to grow medical marijuana. The literature review highlights the history of marijuana, the social control of marijuana, and the medicalization of marijuana use.

Analyses such as this are necessary because as local governments scramble to deal with issues stemming from the cultivation, production, and distribution of medical marijuana, it is necessary to provide guidance for them. A 2005 Gallup poll shows that seventy-five percent of United States citizens support legalizing marijuana (The Gallup Organization, Inc. 2009: 1). However this plant remains a Schedule I drug. After the Controlled Substance Act of 1970 was implemented, marijuana was officially placed in the Schedule I classification in the United States. “ A Schedule I classification in the Controlled Substance Act of 1970 designated marijuana as a harmful drug with a potential for abuse, and therefore makes it illegal to manufacture, distribute, or dispense marijuana regardless of any reason” (Gilcrest 2011: 12).

However, given that marijuana cultivation and use are unlikely to disappear, developing guidelines that benefit the entire medical marijuana community but protect local communities is a must. After the examination of the strengths and weaknesses of policies regarding the regulation, production, distribution, and possession of medical marijuana, this study will dissect ordinances and explore the manifest and latent functions of these ordinances. The objective of this research is to provide policy makers with a guide to assess the needs of the medical marijuana community and society as a whole in regards to medical marijuana regulation.

CHAPTER TWO: LITERATURE REVIEW

This literature review begins by discussing a theoretical lens often used in analyzing drug policy: manifest and latent functions. It continues by exploring the roles of international and national marijuana policy influencing state and local policymaking. Next, the history of California medical marijuana will be explored. Finally, the role of dispensaries and marijuana ordinances will be discussed. Combined these sections will contextualize the current medical marijuana debate.

Theoretical Lens

When drug policy is explored, it is essential to investigate the obvious intent of policies and compare those overt goals to hidden or unexpected outcomes. Merton coined the terms manifest and latent functions to address this common social phenomenon (Merton 1968). “The distinction between manifest and latent functions was devised to preclude the inadvertent confusion, often found in the sociological literature, between conscious motivations for social behavior and its objective consequences” (Merton 1968: 144). He further explains that manifest functions are subjective and consist of desired outcomes and purposes of legislation; latent functions are usually unrecognizable initially and consist of objective functional consequences that are often revealed only after policy implementation has occurred (Merton 1968: 145).

Merton believes “only such detailed information will enable us to move from the plane of broad approximations to intensive and well-grounded analyses of intellectuals’

relations to social policy” (Merton 1968: 263). He goes on by declaring that policies must be questioned by exploring their consequences and by examining ways of implementing alternative policies. Therefore it is essential to explore the different methods that all levels of government use to create and implement policy. More importantly, it is necessary to compare these policies at each level to decipher what is working, what isn’t working, and what hasn’t even been addressed (Merton 1968: 272).

Medicinal marijuana policies were designed to allow patients access to medication, to create clarity for those enforcing and abiding by these policies, and to introduce more uniform regulations. Unintended consequences that have prevailed in regards to medicinal marijuana policies include environmental destruction, issues with land use or zoning requirements, and an overall confusion by law enforcement due to vague and arbitrary verbiage in current legislation.

While it is necessary to explore the physical unintended consequences of policies, social injustices must also be explored. Social injustices can be carried out intentionally and unintentionally. An example of intentional social injustices is the policing and targeting of certain races for drug and violent crime convictions. An example of unintentional social injustices is disparate incarceration rates. The difference is that “unintentional forms of injustice and oppression are commonly manifested when individuals in privileged groups disregard the negative impact that systematic forms of discrimination and inequities have on millions of persons in marginalized groups in contemporary society” (Crethar et. all 2008: 270).

Some authors address the ways that institutionalized racism, ecological racism, and systematic injustices perpetuate an oppressive system in the United States. Wise (2008) argues that there are several prevalent privileges held by white people. The first privilege is that whites often can ignore the realities of people of color, because it doesn't affect them; whereas people of color must understand the dominant group's perceptions because it affects them daily. For example, in newspaper articles immigrants are framed as being associated with drug use and criminal activity and, after being blamed for ecological destruction, are associated with lacking respect for nature. Often times they are also referred to as "armed foreign nationals" with stories about how guns and military type methods are used to protect cultivation sites. "This new connection creates a major sense of fear and urgency in the articles" (Hamaji 2010: 10). The second privilege he points out is that racism is real and continues to exist, overtly and discretely. The third and final privilege that Wise points out is that whites are not burdened by their race.

Wise is also critical of the war on communities of color. He believes that as long as these stigmas continue, the War on Drugs is a tool for racial discrimination, and as a result U.S. prisons will continue to be filled with people of color. "Because [Caucasians] are not suspected, therefore [Caucasians] are not detected. Therefore [as Caucasians, they] are not punished" (2008:4). The goal of this research is not to suggest that whites should be incarcerated at higher rates for drug crimes, instead it is suggesting that racial profiling and targeting specific communities contributes to an increased proportion of minority groups being incarcerated. Because enforcement is such a large part of regulating a drug there must be ordinances written that protect patients and prohibit law

enforcement officers from targeting certain neighborhoods and dispensaries. Therefore marijuana regulations should not enable disproportionate targeting of some groups over others. Wise gives the example of police targeting minority motorists rather than their Caucasian counterparts. “According to the department of justice, in a study released in 2004, black and Latino males are three times more likely than white males to have their cars stopped and searched for drugs- even though white males are four and a half times more likely to actually have drugs on us on the occasion when we are stopped” (Wise 2008: 3). If police are patrolling the wrong neighborhoods and therefore the wrong people, how will the issue ever be solved?

Drug History in the United States and Internationally

Drugs, especially marijuana, have a long history in the United States. The first instance in which racialized drug laws were created involved the Chinese and opium. The British introduced opium to China in order to addict the Chinese population and gain control of resources such as silk, porcelain, tea, and spices. As a result the Chinese fled British imperialism and came to California, especially cities like San Francisco and Los Angeles (Elisnson and Yogi 2009: 36, 41-53). Then in 1909 President Theodore Roosevelt met with Chinese leaders:

To help China eradicate the problem of opium addiction among its inhabitants. It was with some degree of embarrassment, however, that the United States delegates to the Shanghai convention realized that their own country had no federal laws prohibiting the smoking of opium. To avoid being accused of hypocrisy, Congress quickly enacted such a law. By making the opium user a criminal Congress attempted to suppress opium traffic in America (Abel 1980: 193).

It just so happened to be that opium users were mostly of Chinese descent and were therefore targeted and labeled as drug addicts and criminals.

Also in the early 1900's people began to notice that there was an increasing population of Hispanic workers farming agricultural lands. As people began to believe that Mexicans were taking jobs from American workers, the hatred for Hispanics grew.

Small business and small plot owners started paying attention:

Suspicious and often resentful of these newcomers, the townspeople humiliated, harassed, and abused them to make them feel as unwelcome as possible. When the Mexican lashed back at their tormentors, their actions were often attributed to the influence of marihuana, which to many Americans symbolized the Mexican presence in America. As early as 1914, the town of El Paso passed a local ordinance outlawing the sale or possession of marihuana. Like the outlawing of opium, the ordinance was meant to annoy and harass a class of people. The pretext for the law was said to have been a fight started by a Mexican who was allegedly under the influence of the drug, but the real reason was dislike, if not hatred, of the foreigners from across the Rio Grande (Abel 1980: 205).

In 1915, as a result of fear and public outcry over job loss, states began outlawing cannabis. They implemented their own state legislation, and passed prohibition of marijuana unless prescribed by a doctor. California was the first to pass this law in 1915, and was followed by Utah (1915), Wyoming (1915), Texas (1919), Iowa (1923), Nevada (1923), Oregon (1923), Washington (1923), Arkansas (1923), and Nebraska (1927) (Abel 1980: 203). It is important to note that "references in the newspapers to the adoption of these laws, clearly show that the marihuana was relatively unknown, even in states with considerable Mexican populations" (Abel 1980: 203). It then becomes apparent that this new legislation was created purely to target a group that was thought to be benefitting more than its' Caucasian counterpart.

During this time, in New Orleans, another class of people was targeted as marijuana smokers. This city had a raucous Red Light district in which ladies of the night and jazz musicians entertained sailors, traders, and other visitors. “It was in these bordellos, where music provided the background and not the primary focus of attention, that marihuana became an integral part of the jazz era” (Abel 1980: 214). Similar to their Hispanic counterparts, African American jazz musicians began to be noticed, stigmatized, and targeted because of their marijuana use.

Historically anti-marijuana propaganda emphasized that marijuana users were often not white, and were always lazy, psychotic, and uncontrollable, conducted “degenerate sex attacks”, and were violent (Anslinger 1937: 1). Examples of the claimed levels of violence vary from military personnel using it and disobeying orders to others using it to commit rape or murder. As a result a socially constructed relationship was formed linking crime and marijuana and it was reinforced by fear of the drug and the penalties associated with it. In response, in 1930, the Federal Bureau of Narcotics created an independent unit in the Treasury Department for marijuana enforcement and appointed Harry J. Anslinger.

In the 1930’s people were very naïve, “they did not challenge authority. If the news was in print or on the radio, they believed it had to be true” (Yurchey 2010). In the 1930’s petrochemical and timber industries organized to put an end to hemp cultivation because it threatened their financial and industrial interest. Industrialists like William Randolph Hearst began to spread propaganda that linked hemp to marijuana, and claiming that both, as one, were “The Real Public Enemy Number One” (Gasnier 1938).

As a result propaganda like 'Reefer Madness' (1936), 'Marihuana: Assassin of Youth' (1935) and 'Marihuana: The Devil's Weed' (1936) were designed by industrialists like Hearst to create an enemy. Their purpose was to gain public support so that anti-marijuana laws could be passed, and they often used extreme tactics. One example is that Reefer Madness did not end with the usual 'The End.' Instead the film concluded with these words: "Tell your children" (Yurchey 2010). Interestingly at the same time "Dr. Walter Bromberg clearly demonstrated the carelessness of police officers in attributing criminal activity to marihuana" (Abel 1980: 209), but this was not publicized to the extent as the above propaganda.

On April 14, 1937, the Prohibitive Marijuana Tax Law, or the bill that outlawed cannabis, was directly brought to the House Ways and Means Committee. This committee is the only one that can introduce a bill to the House floor without it being debated by other committees. The Chairman of the Ways and Means, Robert Doughton, insured that the bill would pass Congress. Then in September of 1937 Congress passed the Marijuana Tax Act (Yurchey 2010). After being slightly amended it was passed by the Senate, and President Roosevelt signed the bill into law, and marijuana became illegal. "When the Marihuana Tax Act became law in 1937, it called for imprisonment of up to five years and/ or a fine of \$2000 as punishment for breaking each provision of the law. The length of the actual [prison] term and [the] fine [amount] were left to the discretion of the court" (Abel 1980: 254).

Possibly due to the states' prior addressing of marijuana legality, there was little media attention about the new bill when it passed. For example it "merited only a scant

three and a half lines in the *New York Times* on August 3, 1937 [it read]: “President Roosevelt signed today a bill to curb traffic in the narcotic, marihuana, through heavy taxes on transactions”.” (As cited in Abel 1980: 247).

Explanations for the Adoption of the Marihuana Tax Act

There are three common explanations provided for why the Marihuana Tax Act was eventually adopted. The “Anslinger Hypothesis” was proposed by Howard Becker in 1963 and suggests that Anslinger, as a “federal bureaucrat” was responsible for prohibition due to his continuous efforts to create strict laws regulating cannabis nationally. The second is the “Mexican Hypothesis” which proposes that:

The Federal Bureau of Narcotics was prompted to support national anti-marijuana legislation due to local pressures exerted by western and southwestern states. It held that anti-Mexican sentiment in communities in such states as Colorado and Texas was exacerbated by the fact that crime and violence attributed to Mexicans and Mexican Americans there were causally linked to marijuana (Elsner 1994: 34-35).

The final explanation for this phenomenon, the Social Control Hypothesis, explores the Marihuana Tax Act in the larger context of drug control policies and social control:

Through the establishment of the Marihuana Tax Act of 1937, the United States government could exert its influence and establish its political dominance both domestically and abroad. In viewing drug control as social control, U.S. drug control laws can be seen as having served two objectives: (1) they have been used for the purpose of ensuring domestic social control by the dominant culture over ethnic and cultural minorities; and (2) they have been used for the purpose of extending and solidifying U.S. political hegemony in other nations throughout the globe (Elsner 1994: 56-57).

Post Marihuana Tax Act

The Marihuana Tax Act was not the end of cannabis policy in the United States, or internationally, it was only the beginning. In 1948 Anslinger began to urge the United Nations commission to adopt a type of convention that would encompass all international agreements on drugs that existed at the time. The Single Convention was just the beginning, at the same time he began pushing for stricter measures internationally against cannabis and wanted to include cannabis in the Single Convention (Abel 1980: 254). As time passed marijuana became more widely used among the United States youth. As its popularity increased during the 1960s, marijuana became less stigmatized than other illicit drugs like heroin. Shortly thereafter the Comprehensive Drug Abuse Prevention and Control Act of 1970 was implemented (Elsner 1994: 3).

After several years the United Nations finally adopted the Single Convention. As of 1961 this convention stated that each participating country could “adopt such measures as may be necessary to prevent misuse of, and illicit traffic in, the leaves of the cannabis plant” (Abel 1980: 254). Nearly all countries signed the 1961 Conventions that require them “to criminalize production, distribution, use or possession of cannabis....Primarily under urging from US, cannabis was included in the strictest prohibition regime category in the 1961 Single Convention on Narcotic Drugs” (Room et. al 2010: 7). Later these countries also adopted the 1988 Convention which added that production, distribution, possession, or purchase of cannabis was to be a criminal offense punishable under “domestic law” (Room et. al 2010: 7). Furthermore the treaty mandated that countries criminalize the drug user if they have drugs.

It is essential to include medical insight in the development of ordinances. The conventions assigned this technical role to the World Health Organization (WHO), which was also assigned to make decisions regarding the rescheduling of controlled substances. While both conventions note that they included cannabis because it has no medical value, the World Health Organization has disagreed and provided research supporting the need to reschedule marijuana. Unfortunately international control systems do not always follow their recommendations. For example “Dronabinol is prescribed particularly in the USA under the brand name Marinol as an appetite stimulant, primarily for AIDS and chemotherapy patients” (Room et. al 2010: 10). Dronabinol is a pharmaceutical drug that contains THC, the principal psychoactive ingredient in cannabis. Dronabinol was listed under Schedule I of the 1971 Convention, however after reviewing the drug WHO recommended first that it be reclassified to Schedule II and then later in 2002 it recommended it be reclassified to Schedule IV (the least restrictive schedule). While Dronabinol (Marinol) was eventually reclassified as a Schedule II drug, the WHO committee continued to push for reclassification to Schedule III or IV. In 2007 after much debate the US and many other countries agreed that the WHO committee should be commended “for its ‘excellent expert advice’, but did not support rescheduling because it ‘may send a confusing message with regard to the risks associated with cannabis use’” (Room et. al 2010: 11). This scenario highlights the importance of policy developers to not only facilitate the cooperation of physicians with other stakeholders in policy creation, but to acknowledge, consider, and institute the recommendations they provide throughout the process. These drugs are being used medicinally and therefore it is

essential that physicians with completed research on the topic, or knowledge of the topic be invited into the discussions.

The United State's primary drug policy priority should be to reduce harm from drug abuse including:

Lost human capital, workplace accidents, spousal and child abuse, family dissolution, increased medical costs and drug-propelled crime. In order to reduce these harms, we need to focus on what really works in combating drug use and dependency: realistic drug education, linkages between enforcement and treatment, and eliminating street drug markets (Conner 1993).

All in all there is general agreement that the United States has lost its War on Drugs. It was never going to succeed because it violates its own capitalist market mentality. "Illicit drugs are commodities, and powerful economic forces drive the huge illicit drug business" (Gierach 1993: 95). Even media evangelist, ex-Baptist minister and businessman Pat Robertson was quoted saying "I really believe we should treat marijuana the way [we] treat [the] beverage alcohol. I've never used marijuana and I don't intend to, but it's just one of those things that I think: this war on drugs just hasn't succeeded" (New York Times 2012).

History of Marijuana Policy in California

In the 1970's eleven states again led the way with marijuana legislation; this time, however, they wanted reduced criminal sanctions for small possession offenders (Room et. al 2010: 85). Most of these reforms reduced criminal charges for possession of marijuana to a misdemeanor. Different states, in the past, have implemented marijuana

possession charges that range from misdemeanor to ‘civil violation’, and have fine amounts that vary from a \$100 to \$1000, and some states require jail time for offenses. More recently California, along with other states, further legalized marijuana for medical purposes.

Proposition 215

In 1996 California and Arizona became the first states to legalize marijuana for medical use. The voters of California approved Proposition 215 by fifty-six percent, enacting The Compassionate Use Act of 1996. This policy, and others that have followed, have greatly impacted our society, environment and economy. Every law related to medical marijuana forces future regulations to be implemented.

The Compassionate Use Act declared three purposes for the Act (Proposition 215 1996):

(1) to ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person’s health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief; (2) to ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction; (3) 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.

The Attorney General took the position that the term “primary caregiver” does not include dispensaries. They were precluded from asserting the defense that they were caregivers to patients. Peter J. Cohen, a physician and attorney on the East Coast,

identified several other issues with this proposition: that the number of marijuana dispensaries is not limited by statute, there is a lack of criteria listed in which cannabis is ‘deemed appropriate’, and “that the presence of a bona fide doctor-patient relationship is not addressed” (2010: 658). He claims that New Jersey has accomplished this goal with the passing of the Compassionate Use Medical Marijuana Act (S119; A804) in 2010.

This act regulates marijuana under similar conditions that are used to track the distribution of medically prescribed opiates like Oxycotin and Morphine. New Jersey also requires an actual doctor-patient relationship (Cohen 2010: 661). Cohen claims that “reports from across California have revealed problems and uncertainties with Proposition 215 in the ways it has impeded the ability of law enforcement officers to enforce its provisions and have prevented qualified patients and designated primary caregivers from obtaining the protections afforded by the act” (2010: 663).

This California proposition fails to discuss the ways in which a safe and affordable distribution of marijuana will occur. It doesn’t discuss the class and multicultural participation that will be needed to achieve any kind of egalitarian plan for this distribution. For example, people who cannot afford transportation, or caregivers, will have a much more difficult time obtaining medicine unless they live within walking distance of a dispensary. Additionally the proposition and Cohen both ignore the issues that working class people will encounter. For example, people on MediCal will have an easier time affording the doctors’ visits than their counterparts who make too much money to obtain this type of aid and whose employer refuses to provide health care. It is nearly impossible for people in this group to afford a visit to a physician much less have

the fiscal ability to nurture the doctor-patient relationship that Cohen suggests. It is important to note the people who are marginalized by legislation in order to see who is left out, who is included, and who is targeted (Discussion occurred in Interview with a Dispensary Director 2012). It is important to specifically explore these topics and acknowledge issues that are often overlooked by upper and middle class policy makers.

Senate Bill 420

In 2003 the state of California passed California Senate Bill 420 (SB 420). The state wished to address issues that were not included within Proposition 215 and hoped to resolve them to promote a more fair and orderly implementation of the act (California Senate Bill, 2011).

SB 420 was a compromise that considered much input from patients and reformers. It clears up certain implementation issues surrounding Prop 215 (HS11362.5) and formulates a voluntary system to protect patients from arrest. It sets biased and unrealistic standards as the default baseline for protection, but also empowers localities to adopt scientific local medical marijuana guidelines (Vasconcellos and Leno 2003).

This bill proposes that the use of a state identification card program will further the goals of promoting a more uniform and consistent application of the act among counties within the state. “SB 420 creates a wholly voluntary card system that may become ‘de facto’ mandatory legitimizing some patients at a higher level than others (i.e., if you have a card you get more respect” (Vasconcellos and Leno 2003).

Additionally this bill enhances the access of patients and caregivers to medical marijuana through collective, cooperative cultivation projects. Some of the positive effects of SB 420 are that it recognizes all patients’ rights as embodied in Proposition

215, no patient is required to participate in the voluntary complementary ID program, and even without this card the patient is protected under Proposition 215 (California Senate Bill 420 2004). This act declares that medical marijuana is a matter of states' rights, promises confidentiality of records, and criminalizes a breach of confidentiality. In addition patients that are rejected for ID cards can appeal it. SB 420 allows osteopaths and medical doctors to approve this medication, and to grant exemptions for quantities. It also allows agencies and caregivers to provide for more than one patient, gives MediCal patients a fifty percent discount on the purchase of ID cards, and allows caregivers to be reimbursed. SB420 permits agencies to provide marijuana to patients, says that non-governmental agencies can process ID cards, says that caregivers can have more than one patient, and that those patients can live in the same or in a different county than the caregiver. In relation to enforcement SB 420 provides validation of participation in the program when police confront a patient or caregiver, it stops arrests of card-holding individuals, it requires police to comply with these provisions, it codifies the medical use of cannabis flowers rather than leaves, and gives inmates, parolees, defendants, and probates a right to medical marijuana (California Senate Bill, 2011). It also permits the transportation and processing of medical marijuana by patients or their caregivers. SB420 allows for communities to adopt more realistic amounts, but does not allow them to go below the floor amount, and many cities and counties have taken advantage of this as is noted in the analysis.

SB 420 does not permit smoking of marijuana where non-smoking signage is posted, on a school bus, in a motor vehicle that is operating, while driving a boat, or

within 1000 feet of a school, recreation center, or youth center, unless that use is inside a residence. This exempts patients in their homes from penalties associated with using cannabis within 1000 feet of a school. It also states that jails and workplaces don't have to allow medical marijuana use.

An important piece of this legislation that is missing from Proposition 215 is more clear and concise definitions of physician, department, person with ID card, qualified patient, ID card, serious medical condition, written documentation, or excusing physicians from reproducing medical records for patients, and primary caregiver, which doesn't include "the owner or operator, of the clinic, facility, hospice, or home health agency, if designated as a primary caregiver by that qualified patient or person with an identification card" (Vasconcellos and Leno 2003). Finally SB 420 encouraged the University of California, if the Regents approved, to be the principal medical marijuana researchers. The program was supposed to be called the California Marijuana Research Program. The program was designed to conduct studies to understand the general medical safety and efficacy of marijuana and "if found valuable, shall develop medical guidelines for the appropriate administration and use of marijuana. The program may immediately solicit proposals for research projects to be included in the marijuana studies" (Vasconcellos and Leno 2003). It is important to note that while the funding for this research program has dried up they continue to maintain a web-site presence (<http://www.cmcrc.ucsd.edu/>).

Some of the negative effects of SB 420 are that the voluntary card system will remain voluntary and may lead to other issues, and the default guideline limit of eight

ounces of dry cannabis flowers and six mature plants or twelve immature plants, is not scientific or reasonable (California Senate Bill 420 2004).

This bill ignores privilege. Although this bill seeks to assist lower class citizens by serving MediCal patients, it doesn't address the lower working class. More specifically, the people that make too much to apply for this assistance work in places where there are no health care benefits. This makes it difficult for patients in this financial situation to afford medicine that they may need to function. In addition, this law ignores the fact that many patients may not be able to afford or be provided with caregivers, although many patients may need them. For example, many cannabis patients include the elderly, mentally and physically handicapped individuals, and individuals in rural areas with a lack of public transportation. These people all require some kind of assistance in obtaining or consuming their medicine and as long as the state refuses to assist in paying for caregiver services the more difficult these patients' lives are.

Finally, medical marijuana ordinances most directly hinder parents that are patients. The laws do not specifically address parent's rights to cultivate or consume marijuana. For example a couple in Butte County was arrested for marijuana cultivation and their two young children were taken into state custody (Graham 2012, Fendrick 2012). The laws also ignore the fact that there is a lack of affordable child care, especially for low-income families and so designating time to medicate as a parent becomes much more difficult.

Senate Bill 1449

California Senate Bill 1449 (SB 1449) was amended in Senate April 5, 2010. SB 1449, as amended, provides that no person may possess more than twenty-eight and a half grams of marijuana, other than concentrated cannabis. “Existing law provides that under specified conditions (1) the court shall divert and refer the defendant for education, treatment, or rehabilitation, as specified, and (2) an arrested person who gives satisfactory evidence of identity and a written promise to appear in court shall not be subjected to booking” (California Senate Bill 420 2004). If this bill is violated that person is guilty of a misdemeanor and will be punished by fine of no more than one hundred dollars. This penalty is imposed while driving on a highway or on lands, as specified. Those caught with less than one ounce of marijuana may not serve on a jury, but they will not carry a criminal record. According to a report titled “Proposition 36: Five Years Later”, these more lenient policies should decrease the number of people on probation, incarcerated, or on parole for simple drug possession (Ehlers and Zierendenberg 2006: 8-11). These laws will also lessen the amount of charges on future violators’ criminal records (California Senate Bill 420 2004).

When we consider who is actually being arrested, it becomes obvious that class and especially race play a key role in a court’s decision regarding incarceration as compared to who receives rehabilitation programs. In order to lessen the amount of unnecessary law enforcement and increase the legal protection of marijuana patients’, California should incorporate wording from Maine’s LD 1296. “The measure eliminates a 2010 legislative mandate requiring medical marijuana patients to be registered with the state in order to receive legal protection under state law. It also eliminates language

requiring physicians to disclose a patient’s specific medical condition with the Maine Department of Health and Human Services” (Armentano 2011). Maine’s bill limits the ability of law enforcement to seize cannabis from patients within the law, and requires the return of any seized property within a week. Armentano observes that California is one of two additional states that do not require patients to be registered with the state, yet allows their patients to have limited legal protections.

Statewide Enforcement Repercussions

The U.S. Department of Justice estimates that all levels of government combined spend more than \$20 billion per year on drug enforcement (Cussen and Block 2000: 528). As a result, jails are crowded and large sums of tax monies are being used to enforce flawed regulations. As a result in 2000, California passed the Substance Abuse and Crime Prevention Act or Proposition 36. This act changed state law and allowed for qualifying persons convicted of non-violent drug possession offenses to obtain probation in lieu of incarceration. “As a condition of probation, defendants are required to participate in and complete a certified drug treatment program. In cases where incarceration is replaced by treatment—and such treatment is completed—the severity of punishment imposed is considerably reduced, or a de-penalization effect is realized” (Room et. al 2010: 86).

In regards to cultivation, any amount found that is not in the possession of a patient or caregiver is a felony and is punishable by 16 to 36 months in jail. However in one case, “an individual engaged in marijuana growing received a sentence for over 20 years” (Room et. al 2010: 66).

In regards to sale, a “gift” of less than one ounce is a misdemeanor and is punishable by a one hundred dollar fine. However, the law then states that sale of any amount is a felony and is punishable by two to four years in jail. In addition any amount sold to a minor over the age of fourteen is a felony punishable by three to five years in jail, and any amount sold to a minor under the age of fourteen is a felony and is punishable by three to seven years in jail. “Any conviction of a minor under twenty-one years old causes driver’s license suspension for up to one year” (Safe Access Now 2011).

Overall there are very large numbers of arrests, fines, and other penalties that “can cause considerable harm to the individual beyond any formal sanction that may be imposed and which are often in a discriminatory manner” (Room et. al 2010: 7). Furthermore cannabis arrests account for the majority of drug law violations. Looking more specifically at the United States there was an increase in the arrests starting in 1991. The numbers went from 226,000 in 1991 to 735,000 by 2006 (Room et. al 2010:63).

Role of Dispensaries and Marijuana Ordinances

Brief Background of Dispensaries

When California approved Proposition 215 in 1996, the law encouraged state and federal governments to develop facilities or programs for the safe and affordable distribution of medical marijuana (Americans for Safe Access: Medical 2011: 1). Since then medical marijuana dispensaries have opened, had moratoriums placed on them, or have been banned completely, often as a result of federal threats or raids. For example, in 2009, Deputy Attorney General Ogden released a memorandum for selected United

States attorneys. This document was intended by its author to guide the “exercise of investigative and prosecutorial discretion” (2009: 2). It states that federal resources are best spent on “prosecution of commercial enterprises that unlawfully market and sell marijuana for profit continues to be an enforcement priority of the Department” (2009: 2), rather than prosecuting individuals with serious illnesses who use marijuana in compliance with state law. In addition the memo states that “the Department of Justice is committed to the enforcement of the Controlled Substances Act in all States” (2009: 1); and because Congress believes that marijuana is dangerous and illegal, “the illegal distribution and sale of marijuana is a serious crime and provides a significant source of revenue to large-scale criminal enterprises, gangs, and cartels” (2009: 1). Here Ogden has related marijuana to underground organizations that are often linked with racial stereotypes. One timely example is the prosecution of significant marijuana traffickers that he specifically refers to as “Mexican cartels” (1).

Although distribution for dispensaries has been in compliance with the law, and the federal government intends to only target illegal profiteers U.S. Attorney Melinda Haag says that this message is incorrect. “For example, I was hearing from Oakland that it was going to issue licenses and allow large-scale grow operations in warehouses. And I was hearing that everyone believed that would be okay and that my office would not take any action” (Brooks 2012). Oakland had actually approved of the opening of four more dispensaries, which would double the cities current number of dispensaries. While this may have been good news for patients, federal officials thought it may have crossed the

line. Then in response on April 2, 2012 Oaksterdam² got raided. Oaksterdam along with several other facilities was raided by U.S. Marshalls, U.S. Drug Enforcement Agency, and the Internal Revenue Service (Collins 2012).

Many believe the raid was a repercussion for this approval. Some raid “observers said the federal government’s decision to go after Oaksterdam shows it’s not going to back down” (Collin 2012). While the raid was occurring Rebecca Kaplan, City of Oakland City Councilmember At-Large, stated that her constituents approve of the cannabis dispensary, school, and museum and that if the federal government wishes to help they should assist in gun control and other violent behaviors. She also stated that places like Los Angeles and San Diego, who are banning dispensaries, would appreciate the federal government’s assistance more than the City of Oakland has.

As a result many counties and cities have banned dispensaries or introduced new moratoriums on dispensaries, and the patients are the ones who suffer.

Role of Dispensaries

Medical marijuana dispensaries are also known as collectives, clinics, compassion clubs, cannabis centers, and “pot shops”. Dispensaries are organizations that operate “in compliance with state law and are comprised entirely of legally-qualified patients and their primary caregivers that receives medicine exclusively from its members and provides it exclusively to its members” (Americans for Safe Access 2011). Some collectives are comprised of caregivers and cultivators. In these types of dispensaries

²Oaksterdam University is America’s first cannabis college and was founded in 2007. The goal of this university is to provide students with the highest quality training for the cannabis industry (Oaksterdam 2012).

patients can supply the collective, however, the collective sometimes cultivates their own marijuana and dispenses it exclusively to patients. “A cooperative can refer to a grower cooperative or a consumer cooperative as described under California Corporations Code Sections 12201 and 12300. These types of cooperatives are statutory entities which must be duly incorporated as cooperatives and follow strict operational rules” (Americans for Safe Access 2011).

Collectives are legal under state law (California Health and Safety Code 11362.775). This bill authorizes qualified patients and caregivers “who associate within the State of California in order to collectively or cooperatively cultivate marijuana for medical purposes” (California Health and Safety Code 11362.775). Unfortunately, at the time, the law gave no further clarification as to what constituted a collective or cooperative association, how to regulate them, or how to assess their effects on the community. In August 2008, the California Attorney General (AG) produced guidelines for medical marijuana that said that “patient collectives and cooperatives authorized under state law can maintain storefronts to provide medicine to their members” (Americans for Safe Access 2011).

However the definition for primary caregiver given in SB 420 eliminates marijuana dispensaries from filling this position. In *People v. Peron* (1997), the court upheld that “neither a marijuana club nor the marijuana club proprietor in question met the definition of primary caregiver because they did not consistently assume responsibility for the health or safety of the patient, but merely sold marijuana patients on demand” (Orebic 2005: 4). This can be disputed however because many dispensaries do

offer mental health services at their facilities. These vary from yoga to counseling to cooking classes. Some of the health services offered at dispensaries across California include: naturopathic medicine, reiki, ayurvedic medicine, Chinese medicine, chiropractic medicine, acupuncture, massage, cranial sacral therapy, rolfing, group and individual yoga instruction, hypnotherapy, homeopathy, Western herbalists, individual counseling, integrative health counseling, nutrition and diet counseling, limited physical therapy, medication interaction counseling, condition-based support groups (ASA: Medical Cannabis 2011). Even with the above listed medical and physical benefits to marijuana dispensaries and wellness centers, many cities have used *People v. Peron* to uphold dispensary bans.

Also in *People v Peron* (1997) “the court stated that a primary caregiver who grows and supplies physician-approved medical marijuana to a qualified patient can be reimbursed for both supplies and services” (Orebic 2005: 5). In addition California Health and Safety Code Section 11362.765(a) states that the law does not authorize the cultivation of medical marijuana for profit, so collectives generally operate as “not-for-profits”. All collectives are required by law to obtain a seller’s permit, a business license, and pay sales tax to the state; some cities also require a conditional use permit for the building. “A conditional use permit (CUP) is a particular type of land use ordinance that provides communities and local governments control over where certain land uses (e.g., bars, liquor stores, etc) may be located and how they operate” (Community Prevention Initiative 2010: 10). *Pack* determined that dispensary regulation may be pre-empted by federal law and *City of Riverside v. Inland Empire Patient’s Health and Wellness Center*

determined that marijuana distribution was not pre-empted by federal law and that localities could legally ban distribution of medical marijuana altogether. While medical marijuana and medical marijuana dispensaries are protected under state law, they remain illegal under federal law and every time a patient or caregiver purchases marijuana, those who sold the product as well as those purchasing it are committing a criminal act.

This further complicates regulation of profiteering and sales of medical marijuana. For example, “if a primary caregiver characterizes the money he or she receives from a patient as reimbursement for services (or wages); it is lawful, whereas if he or she characterizes it as profit, it is not. This difference is largely semantic” (Orebić 2005: 6). Medical necessity needs to be defined it is not good enough to merely have a doctor’s approval or recommendation under state law. “Here, the Court is saying that although the Controlled Substance Act expressly precludes a medical necessity defense for Schedule I drugs such as marijuana, if the Controlled Substance Act had not done so, the Court would have affirmed the Ninth Circuit’s application of the medical necessity defense” (Orebić 2005: 10). This medical necessity defense is a series of stricter criteria for a patient to use medical marijuana that requires them to have more than a doctor’s approval or recommendation. They include that patients must suffer from a serious medical condition, if the patient doesn’t have cannabis they will suffer harm, cannabis will alleviate the condition associated with their illness, and there is no other legal alternative to cannabis that is considered effective treatment for the patient. These laws are much stricter and make it more difficult to obtain medical marijuana. Since

marijuana is designated as a Schedule I drug it cannot be considered to have any medical value and therefore the medical necessity defense used above cannot be approved.

The California Attorney General believes that enforcement officers should lay out criterion to consider when deciding if a collective or cooperative is legal under state law. For example collective owners should make it a priority to avoid all unlawful operations. This includes but is not limited to the possession of excessive amounts of medicine, plants, or cash; violating local and state laws, including licensing and permitting ordinances and applicable tax laws; the presence of any weapons or illegal drugs; acquiring or providing medicine to anyone who is not a duly registered member; and any inter-state activity acquisition of distribution of medicine (Americans for Safe Access: AG Guidelines 2008). Enforcement, security, and crime increases are all issues around dispensaries that require attention by state policy makers. Several reports attempt to address these issues and recommend solutions for them. “Dispensaries are a cost effective alternative health care delivery option” (Vogel 2011: E650).

The Center for the Community Action and Training (CCAT) in collaboration with the Center for Applied Research Solutions (CARS) explored local land use approaches for the regulation of medical marijuana dispensaries in California as well as analysis of numerous municipalities in California and offered several key findings. After 2005, conflicting differences between California law and federal drug policy seemed to cause investors to hesitate on pursuing this kind of business. Although the conflict persisted it seemed by 2009 that medical marijuana and its dispensaries were declared a reduced drug enforcement priority by the Obama administration and for the Attorney General, Eric

Holder. Furthermore they indicated that raids on marijuana cultivators and dispensaries would cease, as long as they obeyed state law. However by late 2011, the Obama administration had reversed this decision and continued to approve DEA raids on medical marijuana patients, cultivators, and providers. “The move comes a little more than two months after the Obama administration toughened its stand on medical marijuana. For two years before that, federal officials had indicated they would not move aggressively against dispensaries in compliance with laws in the sixteen states where pot is legal for people with doctors’ recommendations” (Leff 2011). Around October 2011, federal prosecutors warned that dispensaries “must shut down in forty-five days or face criminal charges and confiscation of their property even if they are operating legally under the state’s fifteen year old medical marijuana law” (Leff 2011). As a result many counties that allowed collectives to open are now reversing these decisions, and even in counties where dispensaries are allowed to remain open continue to close their doors as a result of fearing federal raids.

The second key finding of the “Medical Marijuana Dispensaries” report was that dispensaries are worrisome to community members because they believe that public safety, crime and neighborhood vitality will be damaged. However the report states that this can be combated with stronger, more targeted regulation and enforcement. The third finding is that “a sample land use ordinance will help standardize a more comprehensive regulatory approach” (Community Prevention Initiative 2010: 4). The final key finding for this analysis was that “flexibility is still needed for municipalities considering

dispensaries” because this is a learning process and it has not be done before therefore room for learning is essential (Community Prevention Initiative 2010: 4).

Furthermore this research found that there are eight core concern areas that medical marijuana municipalities are encountering. These include: safety, nuisance, health, community norms, increase of police resources, unregulated availability of marijuana, additional issues with regulation, and issues that aren’t in one of the above categories. Safety concerns include things like “Medical Marijuana Dispensary robberies, harassment, robberies of persons leaving Dispensary premises and violence associated with illegal drug sales in nearby neighborhoods” (Community Prevention Initiative 2010: 18). Nuisance concerns include loitering, loss of customers by other businesses, vandalism, and closing of nearby businesses. Health concerns related to issues of patients acquiring medical cards without real need, and the distribution and consumption of foods fused with marijuana to unknowing citizens. Community norm concerns included things like youth observing marijuana being smoked that was bought at dispensaries. The concerns for the increased need for police resources are due to the concern of increased burglaries of dispensaries. Unregulated availability of marijuana concerns include fear that people entering dispensaries will use fake ID’s, and smoking marijuana in commercial areas near the dispensary. Additional issues that are regulated include robberies in homes where marijuana cultivation occurs or dispensaries laundering money. Finally issues that are not regulated that are cause for concern include increased number of firearms for protection of marijuana crops, and increased resale of marijuana which was already purchased at the dispensary. At the end of the report the authors provide a

sample ordinance for medical marijuana dispensary regulation. This sample provides examples for the seven concerns and illustrates how to resolve them, as well as proposes performance standards, land use standards, and operational standards.

Others have examined the history of medical marijuana in California, the role of medical marijuana dispensaries, and the impact dispensaries have on communities, crime, the economy, and health. They report three key findings. First, dispensaries actually reduce crime and improve public safety. “Crime statistics and the accounts of local officials surveyed by ASA indicate that crime is actually reduced by the presence of a dispensary. And complaints from citizens and surrounding businesses are either negligible or are significantly reduced the implementation of local regulations” (Americans for Safe Access Medical 2011: 6). However a report by RAND in September 2011 highlighted several of the ways that crime has reduced or increased as a result of dispensaries. Then one month later RAND retracted this study due to the insufficiency of the crime data used in the analysis³.

Second, the report found that diversion of medical cannabis is not typically a problem. “One of the concerns of public officials is that dispensaries make possible or even encourage the resale of cannabis on the street. But the experience of those cities that have instituted ordinances is that such problems, which are rare in the first place, quickly disappear” (Americans for Safe Access Medical 2011: 7). Finally the report notes that dispensaries can be good neighbors. “Like any business that serves a different customer

³More specifically, “the primary issue discovered during the internal review was that the data described as covering the city of Los Angeles and surrounding areas did not include crime data reported by the Los Angeles Police Department” (RAND Retracts 2011).

base than the existing businesses in the area, dispensaries can increase the revenue of other businesses in the surrounding area simply because new people are coming to access services, increasing foot traffic past other establishments. In many communities, the opening of a dispensary has helped revitalize an area” (Americans for Safe Access Medical 2011: 8). These findings, to some extent, ease the concerns presented by the previous report including: safety, nuisance, increased need for police resources, unregulated availability, and community norms. Dispensaries actually have positive effects on these issues and seem to benefit the community as a whole by reducing crime and revitalizing dying business districts.

The report also found several benefits of dispensaries for medical marijuana patients. These include providing benefits to the sick and suffering, and providing health and social services to patients that may not have access to these resources otherwise. Furthermore research supports the dispensary model. A study of 350 medical cannabis patients in the San Francisco Bay Area found that ““medical cannabis patients have created a system of dispensing medical cannabis that also includes services such as counseling, entertainment and support groups, all important components of coping with chronic illness”” (Reiman 2009: 35). In addition the study found that levels of satisfaction with dispensary care were ranked significantly higher than the national health care level of satisfaction. Additionally dispensaries are required by law to label any and all forms of medical marijuana that are sold. Again these findings pacify the concerns from the first report regarding health to some extent and exemplify the benefits of these clinics for

medical patients. Unfortunately, due to the lack of research on medical marijuana, dosage remains a huge issue that must be addressed.

Recommendations for Dispensary Regulations from ASA Report

The report provides recommendations for other counties and cities to consider when implementing dispensary regulations. First, “in order to appropriately resolve conflict in the community and establish a process by which complaints and concerns can be reviewed, it can be helpful to create a community oversight committee” (Americans for Safe Access 2011:13). Many counties and cities have created task forces or advisory panels that are specific to marijuana. The report suggests that these oversight committees are more successful if they include health or planning departments rather than law enforcement agencies.

Another interesting recommendation made by this report is that policy makers do not need to set arbitrary limitations on the number of dispensaries. “Artificially limiting the supply for patients can result in an inability to meet demand, which in turn may lead to unintended and undesirable effects such as lines outside dispensaries, increased prices, and lower quality of medicine, in addition to increased illicit-market activity” (Americans for Safe Access 2011:14). Interestingly, the over-restriction of where dispensaries are located can create unnecessary barriers to patient access.

In addition to having convenient access to medication, patients benefit from on-site consumption when proper ventilation systems are used. “On-site consumption encourages dispensary members to take advantage of the support services that improve

patients' quality of life and, in some cases, even prolong it" (Americans for Safe Access 2011:14). Patients also benefit from access to edibles and medical marijuana consumption devices. Allowing collectives to carry a variety of marijuana medications along with devices that are needed to consume the product would greatly enhance patient benefits.

Finally, cooperatives and collectives are different than dispensaries, so in order to regulate them separately it is important to differentiate them in legislation. Most often collectives or cooperatives are comprised of patients and caregivers that cultivate their own marijuana for personal use. On the other hand, dispensaries are more likely to have store fronts and are run similar to businesses. For a list of cities and counties that are using these recommendations and are having success see Appendix B.

Regulated dispensaries benefit the community by providing access to medicine to seriously ill and injured patients. Regulated dispensaries offer a safer environment for patients than having to use the illicit market, and they often help patients with social services ranging from yoga to cooking classes to support groups.

Role of Marijuana Ordinances

The role of marijuana ordinances at the federal, state, county, and city levels is to regulate the cultivation, distribution, and possession of marijuana that is used by medical patients. These ordinances vary by state, county, and city and address issues that are specific to each region. Due to the many uses of marijuana, ordinances surrounding medical marijuana ordinances are essential to regulating the substance. This analysis

hopes to contribute to the development of laws to address cultivation, production, distribution, dosage, ecological effects, and land use associated with medical marijuana.

CHAPTER THREE: METHODOLOGY AND PROCEDURES

Study Design

This policy assessment was a multi-case study that utilized a mixed method design. A case study involves studying an issue through exploration of one or more cases. This is a good approach when the research wants to provide an in-depth understanding of the cases and/ or compare several specific cases (Creswell 2006: 73-74). This study includes an analysis of medical marijuana ordinances, and explores archival and governmental data, interviews, and field observations.

This policy assessment investigated several jurisdictions in which I analyzed the content of ordinances using existing records. These records were located through legislative searches and conversations with stakeholders. Documentation that was used ranges from Supreme Court rulings to city level ordinances, newspaper articles, and county supervisor meeting minutes as well as interpretations of legislation from groups like Americans for Safe Access, Marijuana Policy Project, NORML, and the California League of Cities.

This research is also based on in-depth interviews with a variety of medical marijuana stakeholders. These interviewees were selected after exploring the different ordinances and then targeting specific counties to discuss their inequities. However, while more interviewees were sought after, few responded and were able to participate in the time allotted for this project. Professionals that were contacted for interviews

included city attorneys , district attorneys, public health officials, and other code enforcement officers.

Stakeholders in this conflict include those involved in the enforcement, distribution, cultivation, or regulation of medical cannabis. There were eight people interviewed for this research between January and April 2012. Due to the interviewees' relaxed views of their identities being revealed, some of the participants identities are not as concealed as they would have been otherwise. Specifically participants included a Cultivation Director from a Dispensary, a Dispensary Director, an Arcata Police Officer, a Newspaper Editor from Humboldt County, a Mendocino County Law Enforcement Official, a Counseling Director for Americans For Safe Access who is on the Board of Directors for Americans For Safe Access in Los Angeles and who has helped found three dispensaries across California, a member of the San Francisco Medical Cannabis Task Force, and a member of the Humboldt Medical Marijuana Advisory Panel (HuMMAP) who is also a Mortgage and Insurance Inspector, as well as a founder of a collective in Southern Humboldt.

The initial goal of the interviews was to determine the manifest and latent functions of medical marijuana ordinances. I wished to understand the intent or goals of ordinances as compared to the unintended consequences of these same ordinances. In addition, I sought to understand how ordinances regarding medical marijuana have been implemented, regulated, and enforced. Finally, in order to assist in developing future legislation, interviews tried to understand the effects of these ordinances on cities and counties, as well as decipher holes in policy that need to be addressed.

Initially I observed two focus groups in a small city in Trinity County in which conversations around marijuana and its societal, economical, and ecological effects took place. Groups were made up of different individuals who were somehow affected by medical marijuana. One group was in favor of legalization and the other was supportive of continuing marijuana prohibition.

Later I observed the Emerald Triangle course at Humboldt State University. It is a single unit course that takes place over a two day period and explores the history and current impacts of the marijuana industry in the Emerald Triangle (Trinity, Humboldt, and Mendocino Counties). The course professor is interested in the ecological impacts of medical marijuana and after sharing his research he invited several guest speakers to attend and speak to the class. These speakers included a local dispensary director, a cultivation director from a local dispensary, an officer from the Arcata Police Department, the Environmental Planner II, Hoopa Tribal Environmental Protection Agency, a representative from the Humboldt County hazardous Materials Unit, the Senior Environmental Scientist from United States Fish and Game, and a representative from Community Challenges and Solutions.

Sampling Procedures and Data Collection

In general, data collection for case studies is typically extensive and draws on sources of information such as interviews, documents, observations, and other materials (Creswell 2006: 75). I obtained a purposeful sample of city and county participants who are responsible for abiding by, drafting, or enforcing policy concerning medical

marijuana. The counties that were specifically sought after were Humboldt, Mendocino, Los Angeles, Orange, San Diego, Sonoma, Alameda, San Francisco, and Marin. These counties varied from other counties in California because they were either unique in their regulations or seemed to be ‘ahead of the curve’ in their legislation creation and implementation. Cities that were specifically sought after included Riverside, San Francisco, Oakland, Berkeley, Sonoma, and Arcata. Similar to the counties chosen, these cities’ ordinances regarding medical marijuana reflected uniqueness or seemed to be ‘ahead of the curve’ in their legislation creation and implementation. Participants included mostly men, only two females were interviewed.

All participants were above the age of eighteen and they are professionally involved with medical marijuana ordinances in California in some way. I selected participants after considering the relevance of their legal or professional duties in relation to medical cannabis. The professionals I chose for interviews were non-elected and elected officials working in the areas of public health, code enforcement, planning, distribution, cultivation, media, and policy development.

Data Analysis Procedures

The process of analyzing case study data involved several steps. Throughout interviews and observations themes emerged within cases and similarities emerged across cases. These similarities were explored and contrasts examined and discussed. Creswell believes that “when multiple cases are chosen, a typical format is to first provide a detailed description of each case and themes within the case, called a *within-case*

analysis, followed by a thematic analysis across the cases, called a *cross-case analysis*, as well as *assertions* or an interpretation of the meaning of the case” (2006: 75). These are the types of analysis that have occurred in this research.

CHAPTER FOUR: DATA AND ANALYSIS

In the last chapter I described the methods used to explore legislation and community reactions to these ordinances. In this chapter I will analyze California's medical marijuana ordinances, compare them statewide and by county, and will explore their manifest and latent functions.

County Marijuana Ordinances

Most marijuana ordinances generally pertain to cultivation, enforcement, and dispensaries. Below is a discussion of these ordinances at the county and city level.

Table 1 County Ordinances Regarding Cultivation

	Number (N)	Percentage (%)
Allow Indoor Cultivation	11	18.9%
Allow Outdoor Cultivation	13	22.4%
Ban Outdoor Cultivation	2	3.4%
Ban All Cultivation	None	None
Follow SB420 Guidelines	40	68.9%

Note: Based on the 58 California counties. Percentages don't total to 100% since counties don't fit into discrete categories.

At the time of this research, eighteen counties had specific regulations for cultivation of marijuana (Table 5). In regards to outdoor cultivation, regulations range

from restricted outdoor cultivation to complete ban of outdoor cultivation. Lassen County and San Bernardino County have banned outdoor cultivation. Counties that have implemented regulations restricting the amount of marijuana that can be cultivated outdoors do so by specifying a plant number, set a limit on the amount of acreage that can be used for growing, or a limit is set on the canopy size of the cultivation site.

Outdoor cultivation in California counties ranged from permitting twelve to ninety-nine plants, or restricted acreage allowing for anywhere from fifty to 360 square feet of cultivation space. El Dorado County permits twenty plants in spring and summer months and ten plants to be cultivated through October. Modoc County has voted to pass a moratorium limiting cultivation to twelve plants per patient, and two patients per parcel. Nevada County permits outdoor cultivation on up to 150 square feet of area. Humboldt and Santa Cruz Counties allow cultivators to use up to one hundred square feet and limit the amount of plants to ninety-nine plants per parcel (Humboldt County's District Attorney 2003). Amador County permits twelve plants per patients to be cultivated outdoors (CA NORML 2012). Trinity County permits cultivation on parcels of more than one acre to less than two and a half acres to cultivate fifty square feet of area, then parcels of two and a half to five acres to have one hundred square feet, parcels of five to ten acres to have 150 square feet of area, and parcels larger than ten acres can only have up to 200 square feet of area (Cole 2012: 2). Similarly Shasta County permits cultivation of up to sixty square feet on less than one acre, up to 240 square feet on two to five acres, and no more than 360 square feet on more than twenty acres (CA NORML 2012). Glenn County permits cultivation of up to one hundred square feet in a fenced yard that is not visible to

neighbors. Kern County permits cultivation of up to twelve plants per parcel outdoors. In Sutter and Tehama counties cultivation is limited to twelve mature or twenty-four immature plants on parcels of twenty acres or less.

Mendocino County permits cultivation of up to twenty-five plants on a single parcel of land. Larger cultivation sites may be used to supply dispensaries or multiple patients for the year these sites are often called cooperatives. Cooperatives work with local officials and law enforcement to maintain an appropriate plant or canopy size compared to the size of the parcel of land that is being used. In Mendocino County large grow sites have been asked to move away from the highway, freeway, and other major roads to avoid theft, violence, or vandalism. Parcels of land used to grow marijuana for one patient are usually smaller and attached to a property with a home on it.

Mendocino County was the most unique, because they have tried to use this industry to their advantage monetarily. For example, in the past they introduced a Marijuana Cooperative Plan. It is described by one Mendocino County Law Enforcement Official below:

The marijuana cooperative plan we had last year (9.31 Exemption) said that if you had four or more people and they have legitimate medical recommendations you could apply at the sheriffs' office [and] pay us \$1500.00 to review your application. If you met the criteria, [meaning] you had more than a ten acre parcel, the marijuana was not going to be visible by the public, you were not stealing water, you were not causing any environmental degradation, and you were not using diesel generators with diesel soaking into the ground. Then you and your cooperative could grow up to ninety-nine plants; you have to pay us once a month to come to your property and make sure that you are still in compliance and that costs you about \$500.00 a month and you have to have each plant marked with a zip tag which has to have each plant... [As a result] last year my budget increased \$600,000.00 because of the 9.31.

In regards to indoor and outdoor cultivation forty counties follow the SB420 guidelines of being permitted to cultivate up to twelve immature or six mature plants and this does not specify whether or not they can cultivate this amount indoors or outdoors.

Indoor cultivation is permitted in many counties and is regulated by a numerical limit on wattage that can be used, the number of plants, square footage used for the cultivation site, or the canopy size. Most counties permit either 1500 watts, anywhere from one to ninety-nine plants, or cultivate on a site that is anywhere from twenty-five to one hundred square feet.

El Dorado County specifically permits indoor cultivation of ten vegetative plants, one mother plant, and ten flowering plants from March 1st to August 31st; Mendocino County permits indoor cultivation up to 100 square feet. Trinity County permits indoor cultivation of parcels of one acre or less in an area of twenty-five square feet of area or one plant (Cole 2012: 2). San Francisco County sets the threshold at twenty-four plants per patient with a twenty-five square foot canopy limit, and Santa Cruz, Madera, and Sonoma counties permit cultivation of up to one hundred square feet of canopy. Humboldt County permits for one hundred square feet of canopy with ninety-nine plants or less and may only use 1500 watts or less of illumination. Nevada County permits indoor cultivation of up to one hundred square feet. Fresno County only permits indoor cultivation to occur in a secure, locked, enclosed structure with a maximum of ninety-nine plants. Similarly Tulare County permits collectives to grow up to ninety-nine plants in an enclosed, locked, and secured area, and permits for patients to have up to twenty-four plants per patient.

County Ordinances Regarding Enforcement

Counties have also implemented regulations pertaining to enforcement. For example, Colusa and San Francisco Counties both impose punishment for marijuana cultivation, possession, or distribution on a case by case basis. Santa Cruz County has established a “physician taskforce proposal” that permits patients to have up to three pounds of medical marijuana per year.

Table 2 County Ordinances Regarding Dispensaries

	Number (N)	Percentage (%)
Have a Dispensary Ordinance	10	17.2%
Provide Definitions in Ordinance	9	15.5%
Permit Dispensaries	11	18.9%
Moratorium on Dispensaries	7	12.1%
Ban on Dispensaries	25	43.1%
Note: Based on the 58 California counties. Percentages don't total to 100% since counties don't fit into discrete categories.		

At least twenty-three counties have banned dispensaries completely (Table 6). Contra Costa County is the only county with a dispensary ban that allows for one dispensary to remain open (Americans for Safe Access 2012). As many as nine counties have created moratoriums on dispensaries (Table 6). Furthermore at least ten counties have created dispensary regulations (Table 6-15).

Looking at county ordinances set forth by Alameda, Calaveras, Modoc, San Diego, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Sonoma, and Stanislaus there are many similarities and differences across ordinances.⁴ Refer to Appendixes B-E for more information on specific ordinances.

County Ordinance Similarities

Similarities across all of these County ordinances include:

- Dispensaries may not employ people under eighteen;
- There is no alcohol permitted for sale or use on-site;
- Security must be up to standards set by the ordinance to assure safety and lessen the likelihood of theft, this includes alarms, locked windows and doors, and lighting;
- There is no on-site consumption of products including ingestion or smoking [this is specifically stated for all except San Diego; and Sonoma County allows it if permitted by the County];
- The dispensary owner, director, or manager must obtain some kind of permit and pay fees for it;

⁴ Alameda (Ordinance No. 0-2005-25 adopted by County Board of Supervisors in 2005), Calaveras (Chapter 17.91 adopted in 2005), Modoc (Chapter 18.170 adopted by County Board of Supervisors in 2005) San Diego (Ordinance No 10061 N.S. adopted in 2010 by County Board of Supervisors), San Luis Obispo (Amending Title 22, the Land Use Ordinance Table 2-2, and Article 4 adopted in 2006 by County Board of Supervisors), San Mateo (Adding Chapter 5.148 to Title 5 adopted in 2009 by County Board of Supervisors), Santa Clara (Division B 26 unsure of adoption year), Santa Cruz (Ordinance Amending Section 13.10.700-M and Section 13.10.332 (B) and adding Section 13.10.670 adopted in 2011 by County Board of Supervisors), Sonoma (Ordinance NO 5715 adopted in 2007 by County Board of Supervisors), and Stanislaus (Chapter 9.86 Medical Marijuana Dispensaries).

- Limits on quantity possession are the cumulative amount needed to satisfy all patients and caregivers, no more is allowed on premises at one time;
- Locations of dispensaries are limited often to non-residential zones, 1000 feet from schools, parks, and other facilities where the primary attendee is under eighteen years old;
- Ordinances require dispensaries to ask patients for ID card or recommendation to be in written form, along with a photo-ID.

Most ordinances also require the dispensary to have limited external signage, do not permit them to advertise that there is medical marijuana inside, they must have adequate parking for patients, caregivers, and employees, have regulated or limited business hours, are not allowed to have anything marijuana related seen from the outside, most ordinances assure violators that they will be committing a misdemeanor and will be punished accordingly, and they are limited to certain “zones”. Some dispensaries are not permitted to sell paraphernalia, nor have it on-site, nor can they hire felons, nor can they deliver product (Table 10).

County Ordinance Differences

However, there are great differences in some of these ordinances as well. They range from on-site cultivation to patient age limitations to edibles being sold or consumed on-site. In regards to on-site cultivation, Calaveras County allows for cultivation on-site, however, Alameda does not. Whereas Modoc demands that collectives receive their

product strictly from members, Santa Cruz strictly requires products to be grown locally. San Diego, Sonoma, and Santa Clara ordinances permit patients to collectively or cooperatively cultivate marijuana on-site. On the other hand, San Mateo's ordinance permits on-site cultivation, storing, processing, and drying of the product. In contrast, San Luis Obispo doesn't permit on-site cultivation (Table 7).

When addressing the environmental impact of marijuana only three of the county ordinances mentioned any regulations. Alameda and Santa Cruz both require litter services at dispensaries to lessen waste and odors at dispensaries. Whereas Sonoma County states "that this ordinance is exempt from environmental review pursuant to State CEQA Guidelines Section 15061 (b) (3) in that there is nothing in this ordinance or its implementation that could foreseeably have a significant effect on the environment" (County Board of Supervisors, Sonoma County 2007: 1).

Contentious Issues in Ordinance Creation

There was a division among County ordinances of whether patients and caregivers under the age of eighteen should be allowed on premises. Calaveras County allows patients and caregivers who are under eighteen year old if they are accompanied by a parent or guardian. However, in Alameda and Modoc Counties no one eighteen or younger can enter the facility.

Another contentious issue was whether dispensaries would sell edibles or marijuana food products to patients. Calaveras allows them with an additional permit, Alameda does not permit the sale of these items, and Modoc doesn't address this issue.

San Diego, Santa Cruz, Sonoma, and San Luis Obispo Counties do not address this issue specifically. San Mateo does not allow for manufacturing or cooking of edibles on-site, but doesn't discuss the sale of these items. Finally, Santa Clara is allowed to distribute these items from dispensaries.

Two of the most discussed and contentious issues regarding dispensaries surround profit or compensation for products, and odor from indoor cultivation. Sonoma and Santa Clara, for example, do not permit the sale of products but then ignore discussion around compensation. Santa Cruz on the other hand permits for cash and in-kind contributions, reimbursements, and reasonable compensation but requires the collective to document these payments. San Mateo allows for compensation of products. In relation to odors, only two counties specifically addressed odor concerns including Santa Cruz and Sonoma. However, Sonoma County takes it one step further requiring proper ventilation or exhaust systems to be used.

Comprehensive County Ordinances on Medical Marijuana

Humboldt, Trinity, and Sonoma Counties are unique in their attempt to write somewhat comprehensive ordinances that address dispensaries, individual cultivation, possession, and other standards. Yet even their ordinances have areas that are not addressed. Neither County ordinance provides definitions for all the terms involved nor do they address environmental degradation that is occurring.

City Marijuana Ordinances

City ordinances have been created by a variety of organizational entities. At the city level many City Councils (Napa, Eureka), City Managers (Citrus Heights, Cotati, Laguna Woods, and Malibu), City Administrators (Angels Camp), Planning Commission (Dunsmuir), Department of Community Development (Eureka), Financial Management (Long Beach), and Building and Safety (Los Angeles) offices along with countless local organizations, have begun to create ordinances guiding cultivation, dispensaries, and possession amounts.

Table 3 City Ordinances Regarding Cultivation

	Number (N)	Percentage (%)
Allow Indoor Cultivation	15	3.1%
Allow Outdoor Cultivation	12	2.5%
Ban Outdoor Cultivation	9	1.9%
Ban All Cultivation	4	0.82%
Note: Based on the 484 California cities and towns. Percentages don't total to 100% since cities and towns don't fit into discrete categories.		

Several cities have limited or banned cultivation. Imperial Beach, Live Oak, Selma, and Lakeport do not permit any cultivation within city limits. Eureka, Corning, Dunsmuir, Elk Grove, Fresno (pending ban), Gridley, Moraga, San Diego, and Willits have completely banned outdoor cultivation. More specifically, Woodland prohibits outdoor cultivation near a residential or school zone, and allows indoor gardens to have

an area up to fifty square feet. San Carlos does not limit the amount grown, it “says a patient may grow medical marijuana for consumption at their residence” (CA NORML 2012). San Diego permits up to twenty four plants to be cultivated indoors if it does not exceed sixty-four square feet. Sebastopol permits up to thirty plants in an area less than 100 square feet at their home but doesn’t specify indoor or outdoor. San Mateo permits cultivation indoors, but does not specify any wattage or square footage limits. Corning, Orland, Shasta Lake, South Lake Tahoe, Yuba, and Elk Grove only permit gardens to be located in a secure detached structure in the rear yard. However, Elk Grove does allow cultivation inside of a dwelling if it is “in a fifty square foot area, excluding bathroom, and kitchen or bedroom” and lights cannot exceed 1200 watts (CA NORML 2012). Elk Grove is unique in that it requires cultivators to obtain a permit that is good for two years, and they prohibit the use of gas products for cultivation. Paradise and Rocklin permit cultivation of up to fifty square feet indoors. Dunsmuir permits an indoor grow of up to 100 square feet, and growing must take place in a garage (CA NORML 2012). Fort Bragg permits up to 100 square feet to be cultivated indoors. Redding permits a maximum of 100 square feet of canopy or ten percent of home or garden area. Moraga only permits growing indoors if it is not observable and Oakland limits indoor cultivation to seventy-two plants in a thirty-two square foot area, and allows for twenty plants to be cultivated outdoors. Chico permits outdoor, residential cultivation of up to fifty square feet per parcel, and permits for indoor cultivation of up to fifty square feet and 1200 watts. Anderson only permits “growing, harvesting and processing of medical marijuana to be in a fifty square foot outbuilding” that is up to city codes and is set with ventilation

and alarm systems (CA NORML 2012). Berkeley allows for outdoor gardens that are observable to be limited to ten plants. Biggs requires that marijuana be cultivated in a fully enclosed and secure location. Arcata permits indoor grows of up to fifty square feet, with a ten foot height requirement, and lighting cannot exceed 1200 watts.

Overall indoor cultivation has been a hot topic in areas that permit it, because these “grow” houses are more likely to catch fire than a house being lived in by a family, usually due to poor wiring. These cultivation houses are also more likely to have mold as a result of constant moisture, and at times have put neighbors at risk because of the increased probability of home invasions (Hoover 2008: A9). These grow houses usually are operated by reclusive strangers and often have increased foot and automobile traffic as well, especially in homes which do not a permanent resident (Hoover 2008: A9).

One City’s Effort to Combat Indoor Cultivation

Arcata, California is similar to counties and other cities in its efforts to limit dispensaries to non-residential areas. The goal is to decrease the number of cultivation homes in residential areas. Patients and caregivers are permitted to cultivate for the patients’ personal use at the patients residence (Diamond 2010: 3-4). The City only permits indoor cultivation if the residence remains intact with a kitchen, bathroom and primary bedrooms for their intended uses (not cultivating marijuana). All residential cultivation areas cannot exceed fifty square feet and neighborhood integrity must be maintained. This part of the ordinance specifies facilities cannot have dust, glare, noise,

odors, or exterior evidence of the cultivation activity as a way to limit home invasions and overall neighborhood disturbances.

Table 4 City Ordinances Regarding Dispensaries

	Number (N)	Percentage (%)
Cities with a Dispensary Ordinance	46	9.5%
Provide Definitions in Ordinance	32	6.6%
Permit Dispensaries	46	9.5%
Moratorium on Dispensaries	76	15.7%
Ban on Dispensaries	177	36.6%
Note: Based on the 484 California cities and towns. Percentages don't total to 100% since cities and towns don't fit into discrete categories.		

Safe distribution of medication is part of the legislation in Proposition 215 and therefore the state is required to allow dispensaries the ability to provide services for patients. However, some cities have banned dispensaries after being intimidated by federal agents. Intimidations consist of sending letter to landlords threatening property seizures, or conducting federal raids of properties. Cities that have banned dispensaries include Long Beach, Riverside, Rancho Mirage, South Lake Tahoe, and Redding to name a few. According to the Americans for Safe Access website there are one hundred and seventy-seven cities in California that have banned dispensaries (Appendix F). Unlike a ban which completely prohibits dispensaries, a moratorium is a delay or suspension in law creation or ban implementation. Some cities have also passed moratoriums, like Eureka, Aliso Viejo, Beverly Hills, Blue Lake, and Half Moon Bay (Appendix G). There

are also some counties that have limited the number of dispensaries, but overall the amount of dispensaries from 1996 to now has fluctuated with political opportunities.

City Ordinances Regarding Collectives and Cooperatives

There are few ordinances that specifically address collectives and cooperatives. Two cities that address these groups are Napa and Arcata. Although it has banned personal outdoor cultivation, Napa has two large scale outdoor grows within city limits that serve as cooperative gardens or collectives for patients in the community.

In Arcata, there are no exceptions made; collectives and cooperatives may not exist in residential zones. Another overarching standard includes limiting to four the total number of permitted cooperatives/ collectives/ dispensaries. However, if they close, the cap will be lowered to two. “After much public testimony and discussion, the decreased cap of two total permitted cooperatives and collectives was decided by recognizing that two pharmacies exist in Arcata, and adequately serve the community’s wide spectrum of pharmacological needs. Therefore, two cooperatives or collectives distributing a single type of “medical” product would adequately service the community’s medical marijuana needs” (Diamond 2010: 5).

All existing cooperatives and collectives must comply with these zoning standards and failure to do so deems the facility as a public nuisance. In Arcata any cooperative or collective or dispensary which is comprised of patients and caregivers for the purpose of cultivating is required by this ordinance to satisfy California’s statutory business forms of cooperatives and collectives. These standards specifically define ‘cultivation’ as

agricultural, and therefore limit collectives, cooperatives, and dispensaries to be located in Agricultural Exclusive and Industrial zoning districts, and require these groups to have a use permit (Diamond 2010: 5). The standards also conclude that these facilities must only cultivate within a self-contained structure that is ventilated and contains a one-hour fire wall, processing (or trimming) and cultivation must operate in conjunction with a permitted facility, there can be no on-site appearance of plants or paraphernalia, and the facility must follow “the City’s environmental regulations for storm water pollution, wastewater diversion, greenhouse gas reduction, and energy efficiency” (Diamond 2010: 5-6).

Distribution of medical marijuana by collectives and cooperatives in Arcata “are allowed only within the City’s Commercial, Industrial, and Public Facility zoning districts, and only with a use permit. The use permit may allow for a limited amount of cultivation at the dispensary site, but the standards anticipate that primary cultivation activity will occur off-site in a properly permitted and otherwise legal cultivation and processing facility” (Diamond 2010:6). However, in March 2012 the City blocked Humboldt Patient Resource Center from obtaining “a conditional use permit for a proposed off-site grow—something the city was pushing for” (Scott-Goforth 2012: A1). The dispensary was attempting to appease local businesses and its patients and cultivate in an off-site facility that would be away from the business district, and residential zones.

In order to appease community members concerned with illegal resale of collective/ cooperative/ dispensary medical marijuana after patients’ purchase it, “the Arcata standards settled on a dispensing limit to any one patient of no more than twice

per day” (Diamond 2010: 6). Collectives/ cooperatives/ dispensaries must also only dispense marijuana to patients with valid physician recommendations.

Case Study in Local Medical Marijuana Regulation

Berkeley is one city that has created specific guidelines to regulate medical marijuana within city limits. They abide by the county level official ID card system, and qualified patients and caregivers with ID cards are exempt from being arrested if they are within legal quantity limits. Officers can only arrest a card holder “if the officer has probable cause to believe that: the ID card is false or falsified; the ID card has been obtained by means of fraud; or the person has violated the quantity limits or other provisions of the medical marijuana laws” (Berkeley 2009: 7). The ordinance gives officers questions to ask to assure that they are dealing with a “qualified medical marijuana patient” (example: are you using medical marijuana for a medical illness?), and a “primary caregiver” (example: what is the name, address, and telephone number of the patient for whom you are the primary caregiver?—this ensures that the patient is a “qualified primary caregiver”) (Berkeley 2009: 8). Improper use of a card is considered a misdemeanor.

Primary caregivers are allowed to have no limit on the amount of patients they have, however, the patient must live in the same county, but this allows the caregiver to have an increased amount of marijuana. Something unique about Berkeley is that the city allows for collective cultivation of marijuana, if permitted. “Collectives, however, do not include third parties such as “club directors”. This is because club directors cannot legally

sell or distribute medical marijuana. However, under the collective model, qualified patients who are unwilling or unable to cultivate marijuana on their own can still have access to marijuana by joining together with qualified patients to form a collective, unless their activity amounts to a “dispensary” and violates the (3) dispensary cap” (Berkeley 2009: 11). Collectives can be made up of patients, caregivers, or some combination of both.

Similar to Arcata’s guidelines, definitions are given for many of the related terms that are not defined clearly in the state legislature such as, collective, and quantity amounts. In Berkeley, patients and caregivers may “possess as much dried marijuana and/or cultivate as many plants as needed for “the personal medical purposes of Qualified Patients” (Berkeley 2009: 4). But if law enforcement believes the patient has more than this they must consider the following before acting:

indications of sales, including scales and style of packaging; total quantity on hand; rate of consumption; whether the marijuana is bought or grown by the person (more would be needed if grown because replenishment is more seldom and tied to a growing cycle); if grown, whether the marijuana is grown indoors or outdoors (more needed if grown outdoors due to single annual harvest); if grown outdoors, the time of year (more on hand after the Fall harvest, less during summer before the Fall harvest); and whether a person is growing marijuana for other members of a collective (Berkeley 2009: 4-5).

The City also addresses seizure of medical marijuana. “Qualified patients and their primary caregivers who come into contact with law enforcement will not have their marijuana seized, if they are in compliance with the provisions of this Bulletin” (Berkeley 2009: 9). When marijuana is seized there are two ways that the court system classifies it as a criminal case or a lawful case. Criminal cases most often lose all seized product,

whereas lawful cases have product returned through court order, or as a result of Special Enforcement Unit's orders.

Berkeley ordinances are similar to Arcata's in that they address paraphernalia. "A qualified patient and the primary caregiver of a qualified patient may possess paraphernalia that the qualified patient needs to smoke or otherwise consume medical marijuana" (Berkeley 2009: 10).

On the other hand something that is unique to Berkeley is that it addresses inmates as medical marijuana patients. "If the person is to be taken into custody and there is a credible claim of medical need for marijuana during the anticipated time of custody, the arrestee should be transported to Santa Rita Jail where custodial medical oversight is available" (Berkeley 2009: 10).

Three medical cannabis clubs are located within the limits of Berkeley. A medical cannabis dispensary is "any person or entity that dispenses, cultivates, stores or uses medical cannabis except where such cultivation, storage or use is by a patient or that patient's care giver, incidental to residential use by such patients, and for the sole use of the patient who resides there" (Berkeley 2009: 12).

Manifest Functions: Accomplishing Intended Goals

After exploring the similarities and differences between county and city ordinances, it is important to discuss commonalities and differences. Following that analysis, this section provides an analysis of the main themes that became apparent in the

interviews related to intended goals and unintended consequences of marijuana ordinances.

The initial outcomes of medical marijuana legislation were positive accomplishments. The primary manifest function that served as positive accomplishments for marijuana ordinances were educating and introducing voters to this issue. Another manifest function was getting a step closer to legalization or rescheduling marijuana on the state and federal levels. Additionally, most interviewees agreed that Proposition 215 and other medical marijuana ordinances gave the patients access to medical marijuana and put the entire pro-cannabis community a step closer to success. The HuMMAAP Representative said: “The criticisms of it are absolutely true and fully justified but I don’t think they detract from its’ value.”

Ambiguities and Contradictions in Regulation: Enforcement Dilemmas

The California appellate decisions in *Claremont v. Kruse* (2009) and *Corona v. Naulls* (2008) both upheld that a city has the authority to develop, implement, and enforce zoning standards that pertain to medical marijuana cultivation, processing, and distribution (Diamond 2012: 2). Part of the manifest function of laws and court cases is to regulate this medicine, while allowing safe and equal access to patients. Unfortunately these laws and court cases are often contradictory and unclear so it is difficult for law enforcement to do their job.

In regards to regulation of medical marijuana, interviews and media revealed that there are a wide variety of organizations and offices that handle the administration and

regulation of marijuana laws. They range from the city to county level and range from the Sheriff to County Board of Supervisors, the Health Department, City Administration, City Managers, Planning Commissions, Department of Community Development, Financial Management, Building and Safety, and City Council members. Regulation includes creating guidelines for taxation, dispensaries, identification cards, cultivation, processing, distribution, profit, among other areas.

While law enforcement is currently involved in the creation of regulations pertaining to medical marijuana, law enforcement's job is to enforce the law, not to create law or to interpret the law, but to serve and protect citizens according to the law. However, law enforcement interviewees noted that there is confusion in enforcing marijuana laws because there are so many vague and conflicting regulations at the various levels of government. A Mendocino County Law Enforcement Officer noted that:

If I catch someone who is illegally using marijuana, then our responsibility, as law enforcement, is to catch them, prove their case, [and] let them have their day in court. And if a judge and a jury agree with us, then they'll be punished for illegally growing, selling, using marijuana. But I don't think law enforcement should say this person has been misusing it so nobody gets to grow marijuana anymore.

Then the Mendocino County Law Enforcement Officer added:

There is not one government agency, one single government agency that says that they are in control of making sure that this is done right. Law enforcement should not be expected to make the laws or interpret the laws. We should be expected to enforce the laws. The role of law enforcement is not to determine whether it's right or wrong, our job is to determine if it's legal or illegal. My job is to make sure that laws are enforced and peoples' rights are protected.

Similarly, an Arcata Police Officer noted: "The city is managing medical marijuana the best that we can because we have competing appellate court decisions, conflicting state

and federal laws, [and] conflicting court cases.” In addition the Arcata Police Officer mentioned: “I’m in the executive branch of government and I truly believe our responsibility is to enforce the laws that the legislative branches of government enact.”

State, county, and city level ordinances are not the only ones that are conflicting. Many noted that the federal prohibition on marijuana was ‘drawing a line in the sand’ that interferes with local ordinances. “Where that line lies, however, is not clear because it is uncertain whether a locality following state law could or would be charged with ‘aiding and abetting’ a federal violation” (Orebic 2005: 15). For example, a Humboldt County Newspaper Editor noted:

The basic problem right now is the conflict between local, county, state, and federal laws. It is impossible for a peaceable cannabis consumer to obey the law. The laws don’t make sense, they are contradictory, we know that due to the supremacy clause the federal laws are the only ones that really matter and they are making that apparent to us now by harassing some of the local cannabis centers.

A representative from the San Francisco’s Medical Cannabis Task Force added:

In San Francisco I think there has been a lot of backlash about the threats that have come in from the federal government. A number of the representatives at the state and local levels have stood up and taken action. For example over a dozen speakers and local officials stood up and expressed their discontent with the conflict between state and federal law [and] until we see these things addressed federally patients are always going to have barriers.

Possession and Cultivation Limits and Regulation Issues

Currently numerical limits regarding possession and cultivation are arbitrary and in some cases are unclear, especially in counties that do not specify numerical cultivation or possession limits. If a more uniform and research-based system of regulating possession and cultivation amounts could be implemented, it would create clarity that is

greatly desired by stakeholders, especially law enforcement and patients. Interviewees discussed that regulations should specifically address limits on the amounts appropriate for personal use, for cultivation, and of converted marijuana as essential to clarifying the law. One Arcata Police Officer noted that it would be preferred if future ordinances would: “Quantify it. I would put limits, you can possess X amount...something very clear about quantities.”

Currently personal possession and cultivation amounts vary by county and city in California, however, most interviewees agreed that there wasn't a reason to have more than one to three pounds for personal use and the three pound limit was over a year, not at a single time. In regards to cultivation, measuring the yield amount could be used to create more uniform laws. Regardless of whether it is indoor or outdoor, the estimated yield can be calculated, and cultivators can pursue reasonable crops while abiding by statewide regulations.

Constructing Legitimate Patients

Law enforcement is not the only group having issues interpreting the law. There are many groups that are impacted by current medical marijuana regulatory schemes. The stakeholders that are involved in this conflict include patients, primary caregivers, dispensaries (or variations of this including cooperatives, delivery systems, and collectives), scientists, researchers, doctors, law enforcement, public health, and the community, including governmental officials.

Patients, however, are most affected by regulations. So when the law is vague and contradictory, it makes it difficult to obey them. This in turn causes issues when trying to gain access to medical marijuana. More specifically, the strict guidelines regarding the distribution or sale and cultivation of marijuana makes it difficult for patients to gain access to the product through legal avenues; unless some kind of dispensary or delivery system is approved by the city, county, or state.

Officials that I interviewed generally thought of dispensary clients as people with serious illnesses however, there are stigmas, stereotypes, and assumptions made by the community and interviewees. These stigmas included recreational users being seen by interviewees as abusing the drug and using Proposition 215 to their advantage, that recreational users may be homeless or of a “hippie” stereotype. A Humboldt County Newspaper Editor noted:

First off you know all this cannabis that is being grown it’s not all hippies that are smoking it. It’s doctors, lawyers, journalists, government people, astronauts, I mean it’s all across the board, people enjoy this drug. That being the case, that millions of people in our populace enjoy this drug and are fully functional people with jobs, families, they pay taxes, they are good American consumers...so why is the government trying to stop these people from doing what they want to?

Interviewees believed the status of being a “legitimate” patient or caregiver was generally seen as being determined by having a serious illness, and some kind of legitimately obtained medical recommendation or identification card. However, in a recent investigative report the evidence on medical marijuana in California suggested that the Marijuana Industry has become:

Close to *de facto* legalization. There are more than 200,000 Californians with a medical letter from a doctor entitling them to cannabis. An owner of one of these

estimated that 40% of her clients suffer from serious illnesses such as cancer, AIDS, glaucoma, epilepsy, and multiple sclerosis. The rest have ailments like anxiety, sleeplessness, attention deficit disorder, and assorted pains (Room et. al 2010: 102).

In 2004, SB420 legislation specifically prohibited police officers from arresting a person with a state-approved ID card, except under certain circumstances. Doctors' recommendations are also permitted to clarify the legitimacy of medical patients; however, this does not require the patient or caregiver to carry an ID card. As a result a Counseling Director for ASA noted:

SB420 created two classes of medical cannabis patients in the state of California. [T]here are those who have ID cards issued by the state, and there are those who don't have ID cards, they just have a doctor's recommendation for medical cannabis. The ID cards are voluntary; you don't have to get it if you don't want it, but it's a good protection to have because if you have a law enforcement encounter, it makes you credible or proves your status.

In regards to the legitimacy of patients, a Mendocino County Law Enforcement Official noted:

I believe there are legitimate patients but I have to say it's a ten percent factor there. Ninety percent of the people who are growing under the auspice of medical marijuana are growing for the purpose of greed or strictly to get high.

Similarly one Arcata Police Officer noted:

My impression of medical marijuana is that if somebody is seriously ill and they benefit from the use of marijuana, I am 100 percent fine with it. I think that's what the people voted for when they passed Proposition 215 back in 1996, was for seriously ill patients to have access to medicinal marijuana. So I'm totally ok with that. Having said that, I don't think that is what we have today. I think that the seriously ill have access to medicinal marijuana, [but] I think that there is a lot of people who use that for recreational use.

These beliefs are not uncommon, interviewees often admitted that there are legitimate patients who need access to medicinal marijuana, but they also agree that many people

are exploiting the implemented regulations for personal gain. Here, the HuMMAP Representative says: “Like every other drug, its medicinal values can be abused for recreation purposes.”

However, not all users are exploiting their access to the drug, nor do they appear to be seriously ill. These people include soldiers with Post Traumatic Stress Disorder who can't sleep due to nightmares, or people with autism who can only control certain ticks with marijuana. As an ASA Counseling Director noted: “It's not just for people who are dying it's for people who are living and healing and getting better.”

It is difficult to regulate and enforce distribution of marijuana without having government approved distribution centers. California cities and counties that allow dispensaries generally create guidelines to regulate them, and the city or county requires the dispensary to obtain licenses and permits prior to opening their doors. Several local enforcement officers work with dispensary owners and conduct ‘walk-through’ investigations of these dispensaries to ensure that they are within the city or county code.

Latent Functions: Experiencing Unintended Consequences

In regards to latent functions of the marijuana ordinances, or unintended consequences of the ordinances, the biggest travesty is the negative consequences for patients. These ordinances were created to serve and protect patients so that they could access medication, and the amount of targeting that they have endured has been overwhelming. Other consequences of the ordinances are related to crime and include discussions around cartels, distribution of marijuana, and robbery. One of the most

prevalent crimes that have prevailed, and must be addressed in future legislation, is ecological damages that are usually a result of cultivators. The final function of marijuana ordinances that was intended by some but has become standard across all levels of government are profits from taxation.

Unforeseen Consequences for Patients

Unfortunately, there have been many negative latent functions that have risen from this ordinance, including discrimination against patients. As Counseling Director for the ASA notes:

There are issues for patients around discrimination for instance people can be terminated from their jobs just for being a medical marijuana patient...[or] facing discrimination in housing, sometimes parental rights', custody hearings, and most tragically I think access to health care. We have people who need organ transplants that are being dropped from the organ transplant list because they are considered drug users.

Minors as Patients: Their Rights and Ability to Access Medication

Another initial impact for patients is confusion in legislation about minors as patients. If a doctor feels that a minor should use medical marijuana, after weighing out the effects of marijuana on a young mind, then this patient is allowed access. An issue with this is that not all dispensaries permit persons under the age of eighteen, even with an adult, to enter the premises. For example while San Luis Obispo, Santa Clara, and San Mateo grant minors' permission to enter with a parent or guardian, Sonoma County does not. When this is the case patient access becomes even more limited, and it may reinforce the illicit market unintentionally. It is therefore necessary that regulations permit minors

to enter a dispensary with a guardian, or that they permit these patients to gain access in some other way. Finally counties that do not address age limits for dispensary entrance, like San Diego and Santa Cruz Counties, cause further confusion for patients and law enforcement because it is unclear who is permitted and who is not.

One unintended consequence appeared as access to dispensaries and limitations around cultivation began to be regulated more strictly. As a result patient access becomes limited. So when federal agents raid a dispensary and it closes, thousands of patients can be displaced at one time. A representative from the San Francisco's Medical Cannabis Task Force noted:

The biggest hurdle that we are dealing with in San Francisco right now is how to protect these dispensaries that have been forced to close, if you don't have a storefront and the process to get one costs about a quarter of a million dollars and let's say eighteen months, [then] you are really putting an unnecessary burden on dispensaries and displacing thousands of patients who lose their access at one time.

Discussions about Crime Related to Marijuana

Another unintended consequence, or latent function of marijuana ordinances, is racial profiling and targeting stigmatized groups, and perpetuating these stigmas in the media. For instance, in communities entrenched in the Marijuana Industry community connections remain, but they have been stretched thin by outside forces and internal divisions. For example, in Garberville, California there is a vast difference between people who have grown up in the area and those that have come from other parts of the nation or world. While some people believe that outsiders are the sole culprits, others believe they are just part of the equation. Overall "my discussions and interactions with

people in Southern Humboldt lead me to believe that we are not talking about organized crime, like the Mafia, but simply organized people. A successful marijuana operation will have to be organized to turn a healthy profit and not get caught” (McCubbrey 2007: 71).

However, if you explore the media, especially in the Emerald Triangle, one would think otherwise. The discussion around cartels dominates public land federal raids and other industrial grows that are raided by local police forces. For example:

Articles [from local media] nearly always refer to the growers as illegal Mexican immigrants, even though it is highly unlikely that the growers are all of Mexican descent, or illegal immigrants. In addition to this, the articles also link these people with Mexican drug cartels even though they rarely state whether or not they know for sure if the cartels are behind the growing...All of these titles place the growers in a very specific niche- illegal Mexican immigrants tied to drug cartels (Hamaji 2010: 10).

I believe scare tactics are used by media and local officials to manipulate public opinion. While authorities have done their best to prove who culprits are, and who they may be affiliated with, there are many unsubstantiated claims which make their way into newspaper coverage. For instance:

Authorities have used the evidence of a salsa garden and food packaging to allege that an outdoor grow as being conducted by Mexicans. On the other hand, one expert in the marijuana field, an ‘officer’ in a leading national pro-marijuana organization, told me he talked with a grower who intentionally planted the tell-tale salsa garden and tortilla packaging at his outdoor grow. In case the grow was busted, the dogs would start off on the wrong trail (McCubbrey 2007: 70).

One recent example is a newspaper article in Arcata that reads “there were written items and food articles located in the campsite that indicated suspects may have been Hispanic” (Times-Standard, Eureka 2012).

When discussing cartels with interviewees the responses varied greatly. A representative from the San Francisco's Medical Cannabis Task Force noted:

For you to go to a cultivation site and find beans and rice on-site just shows that that food is going to last a whole lot longer than anything else you can buy at the grocery store. You know if they come to a site where Mexican Nationals are there it probably means that they're getting paid the same way they are getting paid to go pick grapes or blueberries or whatever it is that they are picking for an agricultural industry. I have never seen any proof or evidence that any cultivation site is tied to an individual cartel. If you look up any information on those cultivation sites that are supposed to be run by cartels it doesn't name the cartel it doesn't name the family or provide any evidence linking it to a cartel. I think that each generation has a new stereotype about what's bad about cannabis and this generations' stereotype is that negative aspect.

One Mendocino County Law Enforcement Official said:

Well I don't have a lot to say about them. I have never arrested a card carrying cartel member in my life. I don't believe we have the high ranking cartel members in Mendocino County...what we do have is the low-end worker bee marijuana growers who are sent up here by organized crime, and I use the term organized crime not cartels, [but] they are sent up here to cultivate the marijuana and then they are paid a lump sum at the end of the year if they have a successful crop. The people we believe are cartel members don't tell us they are cartel members, so it is a very hard thing to prove.

He then described some of the tactics that were used to identify cartel members, and these included: working with federal partners to see if they have the suspect in the national database, investigation and comparison of tattoos of convicted felons known to be associated with cartels and suspected felons, and personal interviews in which they learn what they can to identify the suspect. An Arcata Police Officer stated:

I am [on] the Executive Board for the Humboldt County Drug Task Force, so I am aware of issues that the county recently encountered with the drug cartels and the influence and involvement they have on the illicit side of this issue...[And] they typically have employed low-level laborers to tend and guard outdoor gardens.

Furthermore both officers noted that another latent function of marijuana ordinances is industrial cultivation. The officers infer that large scale cultivators often hire and exploit laborers for the many physical tasks of cultivation such as clear cutting, digging, planting, maintaining plants, and harvesting. While this does not support the claim that cartels are responsible, it does reaffirm the earlier claim that these people are organized and have created a socially organized group of people that is arranged hierarchically similar to other industrial agricultural operations.

One of the perceived outcomes of marijuana policies was that crime would increase. The idea was that as legislation designed to regulate marijuana was lessened, more people would begin to use, cultivate, and distribute it. The crimes people feared would increase were mostly of dispensaries being robbed, youth gaining more exposure and access to medical marijuana, and an increase in the illicit market. In regards to dispensary robberies, Mendocino County and Arcata law enforcement officers disagree. They believe that there has been an influx of homes being converted in whole or in part into marijuana cultivation facilities and then being robbed, and that dispensaries have been left alone. Therefore a latent function of marijuana ordinances was actually an increase in home invasions, rather than all crimes increasing. Often time's ordinances surrounding cultivation put limits on said cultivation and do not specify whether these limits apply to indoor or outdoor areas. As a result when the market demands an indoor product and the process is easier to control inside, cultivators may turn to indoor cultivation and therefore increase the amount of homes that are cultivation sites. Increases in "grow" houses are especially prevalent in cities that have complete bans on

outdoor cultivation. Therefore it can be assumed that areas with increased indoor cultivation may also have an increase in the amount of home invasions in those areas. In regards to this phenomenon one Mendocino County Law Enforcement Official noted:

No one could have predicted the increase of home invasions that we have had. Prior to marijuana exploding in my county we did not have home invasions. Our agriculture at that point was logging and fishing and pears and I never heard of a home invasion, of someone coming in and saying 'I want all your salmon'. They don't do that because there's not a high monetary value for those things, marijuana is a public health concern because of the price and the violence that is very easily connected to it but marijuana itself [is] no more so [a public health concern] than any other strong medication.

And an Arcata Police Officer noted: "The big change that I saw was the growers went from out door to indoor. That was probably the most significant change that 215 brought. Once 215 came in the indoor grows just flourished." As a result: "For Arcata the crime related to this issue hasn't been rampant... what we saw was an increase in the robberies of the residential grows, this is the most significant crime increase." He then shined light on another unintended consequence of indoor cultivation when he mentioned: "This issue of cultivation [also] takes away from affordable housing." Not only has this become an issue for home owners that live out of the area, but this has become an issue for local college students and elderly members of the community when finding a place to live. Therefore another latent function of marijuana ordinances may be increased prices on the rental market.

In regards to the fear of youth having increased exposure and access to marijuana, no increase was mentioned in interviews. Abel notes that the most emotional issue surrounding marijuana was the belief that school children were going to be "seduced into

using it by drug pushers who, more often than not, were identified as foreigners, Mexicans, or blacks” (1980: 225). In regards to youth gaining more access to a drug, one Mendocino County Law Enforcement Official noted:

I haven't seen a huge uptick in young people at school with marijuana. [And] I haven't seen all the crime increase that the neigh-Sayers predict[ed] would happen.

Some minor criminal issues were also noted as latent functions. The “associated problems include pungent marijuana odor, building code violations, fires, threats to neighbors and loss of neighborly community” (Hoover 2008: A9). Residents and officials have begun to identify “grow houses” in their neighborhoods and have reported them to law enforcement, property owners, and property management offices.

These houses typically exhibit one or more of the following characteristics: ‘green’ or ‘skunky’ marijuana odor, house numbers removed, blacked-out windows, rapidly whirling PG&E meter wheels, no residents or non-communicative residents, constant fan noise, ‘No Trespassing’ signs and lots of late-night comings-and-goings, often including rental trucks (Hoover 2008: A9).

In regards to the smell one Mendocino County Law Enforcement Official noted: “The number one social complaint in October is the smell.”

Cannabis odor became a highly discussed topic, not only for residential areas but for dispensaries. Dispensaries can easily be named a public nuisance if not addressed in time. For example in Arcata the dispensary works tirelessly to reduce smells to keep neighbors happy, and down in Mendocino County, smell was one of the most pronounced complaints. In Sonoma and Santa Cruz Counties they have created specific ordinances around ventilation for dispensaries to prevent issues from arising. Therefore smell and odor issues have become a latent function of marijuana ordinances.

Overall crime has not increased in cities with medicinal marijuana ordinances. Unfortunately a final latent function related to crime may be an increase in selling product on the Black Market. One officer believes the amount of people who sell marijuana illegally has increased. He did not mention a specific reason, but this chapter makes several speculations about why increases have occurred. The Mendocino County Law Enforcement Official said: “[While] the number of people selling marijuana illegally has increased... We haven’t doubled in crime, if that’s what you’re asking.” In response to this a Humboldt County Newspaper Editor said:

There is a lot of conflict and strife and nobody knows what to do. The police don’t know which laws to follow...it’s an exercise in futility but there is so much money in it through how can we fault people for being entrepreneurs and wanting to follow the money and wanting to make their own living.

Ecological Impacts

As with any money-making venture, large scale cultivation has transformed the “scale, methods, economic scope, and environmental impact of marijuana growing” (Mallery 2011: 10). An undeniable latent function then becomes environmental degradation. Ecological impacts that were discussed in interviews varied from land alteration and water diversion to killing animals and contaminating water. Necessary elements for marijuana cultivation include access to water sources, adequate sunlight which are often in places with proper humidity levels so that mold doesn’t become introduced into the plant. Industrial sized “sites are created in areas such as logged landscapes, conservation reserves, remote areas of national parks, and other places with

difficult access and visually indistinct features from a birds-eye view” (Mallery 2011: 22).

In many cases these sites must have landscape alterations in order to cultivate the marijuana in the most efficient ways. Issues that arise from these alterations include erosion, transportation of non-native plant species which alter the ability for some native plants to re-grow and cause habitat destruction. In addition to alterations many cultivators use chemicals and soils

To maximize THC content and bud production. These intensive methods change soil dynamics, nutrient levels and chemical makeup, thus creating the opportunity for a new composition of vegetation to emerge...in short, remote Cannabis cultivation forever changes the ecosystems in which it takes place (Mallery 2011: 24).

Cultivation sites can range from half an acre to twenty acres, and according to the National Park Service, “for every acre of forest planted with marijuana, ten acres are damaged” (Mallery 2011: 25).

The amount of water use is another latent function that is highly debated. Mendocino County Sheriff, Tom Allman believes that “one marijuana plant requires approximately one gallon of water per large plant per day”, so if a typical outdoor cultivation site has about ninety-nine plants it can consume approximately ninety-nine gallons of water each day, and a cultivation season lasts for about three to four months. Many industrial cultivation sites are using water from streams, creeks, springs, and other isolated water sources to water their plants and often times diverting entire streams to the crops. This further contributes to habitat destruction and takes away water from species dependent upon it to live and reproduce (e.g., salmon). For example one Mendocino

County Law Enforcement Official noted: “We removed forty miles of black plastic irrigation pipe from the Mendocino County National Forest last year. We removed 57,000 pounds of rubbish, of empty food containers, of clothing, and so forth.”

Cultivators use a variety of methods to exploit water sources in watersheds that range from makeshift dams to cisterns to storage tanks or on-site reservoirs lined with black plastic to gravity based PVC pipe flow systems (Mallery 2011: 26). Some tools are brought up and others are taken from the natural environment at the site, again destroying habitats and causing erosion. Another technique used at cultivation sites is lining a man-made hole with plastic and storing water in it. The plastic is rarely removed and remains at the site even after the cultivation is completed. As a result a latent function is mass littering of plastics that are not easily removed.

Similar to industrial agriculture, marijuana cultivation often includes applying chemicals in order to create plants that are fast growing, or that have a greater yield, or that develop specific traits. This may have been an intended goal of marijuana ordinances, but I believe that it has become an unintended consequence of these ordinances. For marijuana, chemicals are specifically used to maximize bud production, increase THC levels, or prevent rodents or larger animals from damaging the plants. Cultivation sites can contain ecologically damaging poisons, fertilizers, hormones, insecticides, herbicides, and fungicides. “The key difference between industrial agriculture and marijuana cultivation is that Cannabis cultivators are not subject to government or industry regulations” (Mallery 2011: 28). It is essential to explore these chemicals because they are in soil, water, and in the marijuana that is cultivated for

patients. Patients are smoking and eating these products, and they are already seriously ill, so they need to know if they are ingesting more poisons into their bodies. In addition another latent function is that these chemicals are being eaten by wildlife and we don't know what its effects are on them either. As one Mendocino County Law Enforcement Official stated:

If we are going to continue to call marijuana medicine, which I don't see an end in sight from this, I think we are going to have to get to the point of getting inspections done to make sure that medical marijuana is truly as clean of a product as people proclaim it to be.

In addition:

Little can be done to remove the presence of chemicals from the biomass. The high nitrogen and phosphorous fertilizers are both moveable and soluble, thus they are absorbed in and around the site...Insecticides cannot be prevented from dissolving into the air and soil, or the atmosphere (Mallery 2011: 37).

Another latent function occurs primarily with cultivation in remote areas. These sites often use generators and diesel tanks. The generators can be used to run electricity for an indoor cultivation site in a remote area or can serve to create electricity for workers that are living on the properties. These long term inhabitants also can cause wildfires, may use weaponry to protect the site (that disturbs animals and is threatening to human trespassers), spread non-native plants to the area, cause ecological damage through everyday living, and often times leave garbage at the sites after the season is complete. The HuMMAP representative believes that: "Now that the county is pretending to concern itself with environmental issues it will be no more effective in stopping the terrible abuses of the land, undertaken by these industrial growers that are moving into the area."

Profits from Taxation

A manifest function of marijuana ordinances was gaining wealth from the Marijuana Industry through the implementation of taxes and fees. With every substance that influences the local economy, marijuana is taxed. In order to regulate this drug taxation is required. “It is highly desirable that some of this revenue be earmarked for enforcement of the regulations of the cannabis market. Particularly at first, regulation is unlikely to completely eliminate the illicit cannabis market” (Room et al. 2010: 104). Dispensaries must pay permit fees, inspection fees, and sales taxes at the state and local levels, and they are audited by the California Board of Equalization. In addition patients must pay sales taxes, and in some counties where cultivation is permitted the cultivators must pay for permits and inspections. A Counseling Director of the ASA notes: “We always have to remember that money is coming from patients and so we don’t tax prescription medicines because we know it’s a burden and so we would prefer that medical cannabis was treated like a prescription drug in that regard.”

Framing Marijuana

The medical marijuana issue in California has been framed in many ways by the interviewees and in the media. The focus of discussion and concern is informed by themes such as rural versus urban, health versus crime (science versus social), indoor versus outdoor, intent versus outcome, industrial versus personal, and rescheduling versus legalization.

Rural vs. Urban

For a long time in Humboldt County the main industry that supported the local economy was logging. “Without logging, everybody started growing. There are the big time growers investing in sophisticated operations. Overall, the scene has been modified by CAMP⁵ to move indoors, and has remained relatively stable otherwise” (McCubrey 2007: 64). These big time growers are often referred to as industrial growers and they often flourish at large outdoor cultivation sites and then purchase or rent homes to modify into cultivation operations to maintain a flow of money throughout the off season and to have a safe place for cloning.

In regards to ordinances governing rural and urban areas many interviewees agree that they cannot be completely universal. For example a Counseling Director of ASA stated: “I think that ...virtually all the regulations can be consistent on a state level, the exception being the land use policies that are appropriate for urban settings and may not be appropriate for a rural setting.” The member of HuMMAP also has strong views on this debate of rural versus urban. He comes from a rural area and believes that: “SB420, that’s an example of urban written rules that didn’t take into account our existence here, really so it’s effect on us was indirect. We wanted to draw a clear distinction between urban and rural growing requirements.”

⁵The Campaign Against Marijuana Planting, or CAMP, was created in 1983, focusing on both public and private lands. In 1996 with the passage of proposition 215...CAMP shifted its focus away from private lands, and onto public lands. This shift in focus paired with increasing rates of marijuana being grown illegally resulted in an increasing amount of press coverage of the issue” (Hamaji 2010: 4). “CAMP is a unique multi-agency law enforcement task force managed by the Bureau of Narcotic Enforcement and composed of local, state, and federal agencies organized expressly to eradicate illegal marijuana cultivation and trafficking in California. With more than 110 agencies having participated, CAMP is the largest law enforcement task force in the United States” (Mallery 2011: 14-15).

Furthermore he states:

The County is absolutely not interested in talking to rural people on their own level, on their own terms, about their own needs and interests.

Industrial vs. Personal

Although marijuana production is fairly easy to enter into, the combination of capitalism and criminal elements allow for corruption, greed, and exploitation to occur. There is a definite divide in the types of cultivators in this area. The difference between them isn't whether or not they cultivate, but how they cultivate (McCubbrey 2007: 64). The two types mostly include small scale operations and industrial scale operations, but both exist to turn a profit.

Industrial growers are stereotyped as acting distant, being out of town, carrying armory of some kind, owning or renting large lots with over planted sites, using chemicals to increase product weight or size, often using pesticides that are not tested on their effects after long term inhalation of smoke, and being profiteers. Industrial growers were described by one Arcata Police Officer as:

I think the city has the positions the entire time: medicinal cannabis should be accessible to those who need it, and I really believe that's the city's stance, however, we have been dealing with a lot of people who take advantage of the city's position and you have people in the community who are in it for one reason and one reason only, and that's to make money... We still have people able to self-profit who are able to take advantage of the system.

One Mendocino County Law Enforcement Official noted:

The biggest fallacy in 215 is that people, greedy people, try to come in and grow legitimate, or what they say is legitimate medical marijuana but it's not it's a hundred percent for profit... Greedy people are the reason we aren't making progress on this.

Health vs. Crime

In the United States pharmaceutical companies influence rates of prescription drug use. One example is that “the average nursing home patient receives seven different drugs a day, with many being taken up to four times daily” (Ruben 1984: xv). So, “the fact is that America is now, and has always been, a nation of pill poppers” (Abel 1980: 189). Fortunately tides are changing, and patients’ are beginning to realize that they can use marijuana for ailments they may be depending on multiple pharmaceutical drugs to alleviate. The HuMMAP Representative noted: “It’s a more humane drug for many applications, than the artificial non-drugs that we lean on heavily instead.” This can reduce the money patients spend, and may lessen pharmaceutical side affects they experience such as nausea and lack of appetite. One Mendocino County Law Enforcement Official notes in reference to a friend that:

His quality of life, prior to marijuana, was for the most part staying in bed and just getting up out of bed to eat or go to the restroom. [Then] he had a friend have him smoke one marijuana joint in the morning he was able to relax his back muscles and he was able to get out of bed... and that was a watershed moment for me...because now here is a person who was in an accident who I thought was as conservative as me that was telling me about the legitimacy of medical marijuana...[and] I would talk to people who were also very conservative who would say yes ‘I have arthritis I use an ointment made from marijuana and it gives me the relief that no medicine has ever given me before’.

One Humboldt County Newspaper Editor said: “I am very much convinced that in some cases cannabis is the only thing that brings people relief.” And a Representative from the San Francisco Medical Cannabis Task Force noted: “I have tons of patients, as living testimonies, that say they wouldn’t be alive or wouldn’t have the quality of life they have without medical cannabis.”

The change in opinions is also being reflected by physicians. “The California Medical Association has adopted an official policy that recommends the legalization and regulation of cannabis. The board of trustees of the CMA, the largest physician group in California, adopted the policy unanimously at its meeting in Sacramento, according to a statement on the CMA website” (Smith 2011). This may be due to the fact that existing laws put doctors in an uncomfortable position. In addition many physicians believe that without proper research medical knowledge is limited and amounts remain arbitrary.

Furthermore comparative studies reveal that cannabis is less harmful to health than tobacco. “By this criterion, modeling a new cannabis convention of the FCTC can be seen as a relatively conservative option. However, the FCTC is not as strong as public health advocates would wish” (Room et al. 2010: 160). Room et al. provide an example of cannabis control that covers things such as use of terms, education, advertising, legal and illegal trade internationally, economically viable alternatives to cannabis activities, liability, environmental protection, research surrounding cannabis, financial resources needed for enforcement, financial gain from taxation, and ways to amend this Convention.

A large part of the discussion around medical marijuana was public health departments and the lack of participation. An Arcata Police Officer said:

I think that is the lost piece in the political debate of medical marijuana, where has public health been? I mean they have not set a position on this especially in Humboldt County they have been silent about it, I think it is a public health issue, the ingestion mechanism for marijuana is certainly not ideal, smoking anything has health risks associated with it, and public health has been silent on that front.

A representative from the San Francisco Medical Cannabis Task Force believes:

This is not an issue for law enforcement to deal with this is something that is a health matter if there are some negative affects and we don't know what they are just yet because we haven't seen long term research done in the United States then that needs to be dealt with or warn us about a public health concern. This is not something that city council should be dealing with or law enforcement these people are not trained in medical conditions and what is helpful for people who have to deal with medical symptoms, doctors and patients are. Those are the people who should be making these decisions, so hopefully the department of public health will have a little more insight to what those needs would be...Patients, doctors, and scientists aren't even a part of the list right now, and those are the people who know why this is effective and helpful and understand the needs of the patients. So until those people have a seat at the table we are never going to see regulations and laws that make sense.

Finally an ASA Counseling Director noted: "In fact I think we would be doing much better with this issue if it was treated like a public health issue and not a criminal justice issue."

Parent's Rights

Some believe that drug policy reformers and harm reductionists are moving in the same direction "towards the significant lessening or removal of the adverse consequences of the criminalization of cannabis to both the user and society" (Hathaway and Erickson 2003: 465). This includes a variety of things, however, one of the important pieces that needs to be addressed are parental rights as medical marijuana patients. Mothers and fathers can use marijuana as patients as long as they abide by several state laws. First they must abide by the California Child Endangerment Act that allows child protective services to intervene if children are being mentally or physically harmed or neglected. However, in Butte County a woman and her husband were arrested and their children were taken on various charges including consuming cannabis while breastfeeding, and

cultivating medical marijuana. “The couple has since been charged with eight Class A felonies, six relating to cannabis and two charges of child abuse” (Fendrick 2012). Both parents are medical cannabis patients (Elliot 2012). Since then all charges were dropped, and several other residents have come forward with complaints “regarding the misconduct of the BINTF and Child Services Division of Butte County (which leads all of California’s large counties in the percentage rate of permanent removal of children from parents)” (Fendrick 2012).

Many of these incidents occur as a result of “compliance checks”. “A “compliance check” is a mechanism created by local county law enforcement and used solely for the purpose of unlawfully obtaining access to private homes to investigate legal medicinal cannabis gardens for potential arrest and prosecution” (Fendrick 2012). “During this ‘compliance check’ police assured Daisy’s husband that ‘...everything looks okay...good luck with the baby’” (Fendrick 2012). Since they had the appropriate documentation for medical marijuana, the charges did not hold in court. However, the amount of distress caused to the children and parents is everlasting and is another reason there need to be more uniform patients’ rights for parent’s that are patients’.

The Drug-Endangered Children Act is an act that provides provisions for parents that are medical marijuana patients. It has a Risk Assessment that accompanies it that covers the factors that detract “from the safety, security, and well-being of children” (Drug-Endangered Children 1). The assessment asks officers if there is proof a child occupies a residence, if a child has been exposed to indoor cannabis grows, if there are wires exposed and electrical cables overloaded (fire potential), if there is a risk of

poisoning from CO₂, carbon monoxide, black mold, herbicides or pesticides, if drugs were being manufactured or stored in the residence, if the child has been exposed to drug trafficking, weapons, or drug paraphernalia, if the guardian is using illicit drugs, if the child has been exposed to second hand smoke, or if there was general neglect or abuse of the child. An Arcata Police Officer said that they only get involved when kids are living in “sub-standard living conditions or hazardous living conditions”. While a Mendocino County Law Enforcement Official noted that they tend to target large cultivation sites or large possession amounts regardless of the persons’ parental status. A Counseling Director of the ASA said:

We haven’t encountered a case where someone was having a custody issue based on the fact that they just smoked medicinal cannabis, now what we do hear of that happening is when there are divorces and one parent will often use the medical cannabis against another parent.

However, a representative from the San Francisco Medical Cannabis Task Force notes the lack of parental protection when she said: “I wish there were more parents’ rights...The threat is that they can take away our kids for a non-deadly substance...It is unfortunate that there isn’t more protection for parents at this point.”

Indoor vs. Outdoor

Zoning standards are essential to regulate dispensaries and cultivation. The regulations created to guide cultivation and distribution centers “protect a city’s character, stability, and soul” (Diamond 2010: 3). These zoning standards are essential for not permitting indoor cultivation sites to destroy homes, drop neighborhood prices, or become fire safety and electrical hazard areas, and not permitting outdoor cultivation

sites to destroy the environment to the extent that it is being destroyed currently. More specifically something that cities and counties have done in response to residential and ecological degradation is ban gas operated mechanisms, limit cultivation to certain areas, limit the amount of harvests one site can have per year, and limit the amounts that can be cultivated. These regulations help to eliminate degradation, as one HuMMAP

Representative said:

Our community that had created the whole pot economy was being marginalized by evolution [moving] towards indoor growing, towards mass merchandising, with what had always been an informal human scale, very simple agriculture product. So we wanted to advocate for outdoor natural organic sourcing to recreate awareness of the value of reality as opposed to this artificial dangerous toxic shit that contributes to global warming.

However, many counties and cities have arbitrary limits on wattage, square footage, or plant numerical limits that have no medical basis. There has to be some kind of discussion around more uniform, and less arbitrary, numerical limits for cultivation and regulations that address universal environmental degradation like water theft, soil degradation, killing animal and plant species for the better of the crop, and then more specific ones that target emerging area specific problems.

Intent vs. Outcome

The main intent of Proposition 215 was to provide seriously ill patients access to medication that would provide relief. However, several issues have arisen as a result of this law and other legislation. For example there are several terms in medical marijuana legislation that aren't commonly used or known, and that are not well defined. One Mendocino County Law Enforcement Official critiques Proposition 215 by saying:

In my opinion it was a very poorly written law that didn't mention numbers, it didn't mention specific medical conditions, it didn't mention the finality of a doctor putting it in writing, a verbal recommendation was allowed, so there were a lot of loose ends for 215.

The adoption of Proposition 215 was intended to help seriously ill patients similar to pharmaceutical drugs. Unfortunately marijuana remains an expensive commodity that can be cultivated (created) with ease compared to many other substances and is in high demand. This promotes industrialization and profiteering that hurt the medical marijuana movement and its patients. It can also economically harm communities. In rural areas that have a mono-crop economy, or an economy that is based on one resource such as logging, fishing, milling, or cultivating marijuana, a fear is often that youth will become involved in this industry. For all mono-crop economies there are limitations that occur and eventually they may become non-profitable for future generations so falling into these industries may not always be ideal. In the industry of cultivating marijuana there are greater fears for youth because there are still great penalties for profiteering from the crop. Unfortunately the perceived benefits that come from cultivating marijuana, or the 'get rich quick' attraction often overshadows the actual outcomes that occur, like incarceration and property seizures. For example many youth in the Emerald Triangle⁶ grow up in this normalized marijuana culture and bear witness to the great amount of

⁶ The Emerald Triangle is a term often used to describe three counties in Northern California, including Trinity, Mendocino, and Humboldt Counties. This region has been described as the 'Emerald Triangle' because its' location on a map is triangular, and these counties are often known world-wide for their marijuana cultivation. The Emerald Triangle is separated from the rest of California by over ten thousand miles of woody hills between the Pacific Coast and the 'Redwood Curtain' (Mahar 2007). The 'Redwood Curtain' is the forest that protects these counties from the rest of California. "Breaching the Redwood Curtain meant negotiating Highway 101 as it dwindled to a potholed, two-lane road that twisted in and out of river canyons and slalomed around individual redwood trees" (Flinn 2003).

income that comes to marijuana cultivators, and since other industries are struggling in the area, they become intrigued by this up and coming industry. Interviewees noted that youth, especially those in high school, are seeing few options: (1) family business/ entry level positions with minimum wage, limited hours, and no health benefits; (2) college which for most includes mass debt as they come from low-income families; or (3) make the ‘big bucks’ every four to five months, depending on cultivation, and own a home, some property, a vehicle, and live debt free. One source noted:

I taught some of them in high school, and they’d say, ‘why do I need to learn geography or math, I’m just going into growing.’ And as far as accomplishing anything other than dope, to contribute to something to society, they just canceled themselves out. That’s some of the ones that I say, ended up committing suicide or end up in some bad way (McCubbrey 2007: 92).

It is no surprise that some youth choose to work in the marijuana industry given the limited options of other futures in these areas.

Reschedule vs. Legalization

Some believe that anti-drug legislation is reinforced by the concern that the government would be sanctioning immoral and destructive activity, viewed as deviant to the masses. “However, the legalization of drugs does not mean that government and society would sanction their use” (Cussen and Block 2000: 529) A representative from the San Francisco Medical Cannabis Task Force noted:

Right now marijuana is scheduled higher than cocaine and opium, and things of that nature, like it’s less dangerous to do a line of coke than it is to smoke a plant in its natural form. That is the part that doesn’t make sense and that is the part we need to focus on changing.

A Counseling Director for the ASA said:

They are really involved right now in a campaign of intimidation and interference in state medical marijuana laws, all over the country, not just here in California, and I think the preliminary problem we have with the feds is that they're blocking us from moving forward...One of the Supreme Court judges when writing on this issue wrote that the states should be laboratories for social policy, and I think that's the best strategy.

A Humboldt County Newspaper Editor said: "I'm afraid that if it was legalized we would begin to see advertisements associating it with glamour and all the usual things that are dangled before us." An Arcata Police Officer believes:

If I had a choice between the two I would say reclassify it or reschedule, I'm like lukewarm on legalization and you won't find many people in my profession that feel that way, most of them feel like 'absolutely not'. The concern that I have is going back to that kind of public health issue, is you are legalizing another substance that has intoxicating properties, and you know, is that appropriate, well I don't think it necessarily is, but I can also argue that it is so prevalent why not?

One Mendocino County Law Enforcement Official notes: "Now the federal government and the rescheduling is obviously a hurdle in controlling medical marijuana. But if it was rescheduled I think it would ease the concerns of the control." He goes on by asking:

Is alcohol legal in California? No it's not, alcohol is controlled in California, you have to be over twenty-one, you can't have an open container while you are driving down the road, if you are on probation for alcohol you can't have it in possession, if you're a truck driver you can't be above a .05, do you get the point of what I am saying?...alcohol is a controlled substance that the state makes lots of taxes on. So when people ask me if I think marijuana should be legalized I tell them that my opinion is that medical marijuana should be controlled.

There are countless benefits to the rescheduling of marijuana, and health benefits will occur as a result of reclassification or legalization of medical marijuana. "The legalization of drugs would eliminate serious health risks by assuring market-driven high

quality substances” (Cussen and Block 2000: 528). This includes cultivating marijuana with a lessened dependence upon steroids, chemicals, pesticides, and other ‘critter killer’ techniques. “Drugstores, held accountable by customers, would deliver safe products. Brand names would bring competition into the market and assure safer, better products. Doctors would now be able to monitor the drug use of seriously addicted patients” (Cussen and Block 2000: 527).

Societal benefits occur through rescheduling or legalization because illegal drug sales create a destructive atmosphere. “When a criminal culture emerges, a community is torn apart. A booming black market fosters a large criminal presence. Casual recreational users are forced to come in contact with criminals to make their purchases, as prohibition makes it impossible to make a legal transaction” (Cussen and Block 2000: 527).

There are several reasons to reclassify marijuana. As of recent there are three major cases that would be easily avoided if the drug were put in a lower classification (Schedule III or IV for example). The first is the workplace. Seriously ill patients are being forced into using pharmaceuticals because they are legal and do not show up in tox-screenings at the workplace. However, many patients realize that marijuana would alleviate symptoms and lessen the amount of medications in their medicine cabinet, not to mention their monthly medication costs. Another argument for reclassification of marijuana is the September 2011 ATF directive that “firearms dealers in states that allow medical marijuana can’t sell guns or ammunition to registered users of the drug, a policy that marijuana and gun-rights groups say denies Second Amendment rights to individuals who are following state law” (Volz 2011). In addition, dealers can’t sell guns or

ammunition to people who are substance abusers and people who are suspected to be substance abusers (Volz 2011).

The third case concerns drivers' licenses. In 2008 Americans for Safe Access (ASA) filed a lawsuit against California DMV over a patient's driver's license revocation. There have been suspensions or revocations of drivers' licenses for qualified medical marijuana patients in eight California Counties. These counties include Alameda, Butte, Contra Costa, Glenn, Merced, Placer, Sacramento, and Sonoma (Smith 2008). The ASA believes that "the DMV justifies its license revocations of medical marijuana patients by calling them 'drug abusers' despite no evidence to back that claim. The DMV has not taken similar blanket action against people prescribed opiates, barbiturates, sedatives, tranquilizers, and stimulants" (Smith 2008). However, in 2009 the California Department of Motor Vehicles noted, in writing, that qualified patients using marijuana should be treated the same way that other prescription drugs "that may affect safe driving" are treated (Faulkner 2009). So it is still a crime to drive while using medical marijuana or under the influence of medical marijuana, however, other than field sobriety tests there are no way to test the current level of intoxication due to marijuana. Alcohol breathalyzers tell officers the blood alcohol content of the driver however, the closest test for marijuana intoxication levels is a blood test, and because THC stays in your fat cells for up to thirty days the blood test only shows the cumulative amount of THC in a drivers' blood, not the amount of medical marijuana they have used that day, afternoon, or hour. Therefore driving licenses' suspension or revocation is still unclear and should be addressed further.

Overall the Federal Government has the ability to reclassify marijuana and, after allowing research to occur, can regulate medical marijuana dosage and quantity amounts in a more scientific way. As one Mendocino County Law Enforcement official puts it: “There is a smart way to go about this except until federal agencies get on board and allow states to use their temperment authority and states’ rights everything we do is in danger of being overruled or vetoed by the federal government.”

CHAPTER FIVE: CONCLUSIONS

In the last chapter I wrote about data and observations, and provided analysis of medical marijuana ordinances and other existing data. In this chapter I will make recommendations for future legislation based on that analysis. Then I will discuss the research limitations and provide suggestions for future research on this topic.

The implementation of legislation is necessary to regulate the impacts of marijuana fiscally and environmentally, and in order for the state, or nation, to fully incorporate this crop into society. Analysis of manifest and latent functions of laws is crucial in guaranteeing the most beneficial ordinances are being developed. As states begin to implement and amend medical marijuana legislation, they must recognize the ways that laws are interpreted and enforced. Moreover states and counties must explore the intended goals and actual effectiveness of the laws used by other states and counties and compare them to their own intended goals and desired effectiveness.

Throughout California there are a number of different ordinances regulating the possession, cultivation, and distribution of medical marijuana. The changes taking place are a result of the confluence of agendas on the national, state, county, and local levels. Discussions around medical marijuana, local industry, law enforcement, public officials, profits, and damages all need to take place for this issue to be solved, and the people at the table must include patients, caregivers, physicians, researchers, scientists, public health officials, cultivators, law enforcement, and government officials. After assembling a combination of these individuals into a task force or advisory panel a more logical,

egalitarian resolution to this issue can be created. “By coming to know how a destructive policy paradigm replicates a destructive culture and economy, we can better prepare ourselves to develop creative solutions to what amounts to a community development problem... [and] a policy oriented toward influencing the growth of illicit drug economies, rather than destroying them, can encourage economic diversification, while protecting health and the stability of social networks” (McCubbrey 2007: iii). One interviewee noted: “What we need are some good regulations and just some rational policy about this.”

Recommendations for those Writing Marijuana Policy

I will now provide suggestions to be addressed in future legislation regarding medical marijuana. These recommendations are based on interviews and official documents, and an extensive exploration of the manifest and latent functions of medical marijuana ordinances. Key policy elements include: clearer definitions, zoning, land use and environmental issues, quantities, profits, compensation, taxation, patients’ rights, dispensaries, crime and enforcement, and education.

Clearer Definitions

First and foremost there must be clear and logical definitions given for terms in legislation surrounding medical marijuana. Specifically definitions must be given for terms such as ‘doctor’ or ‘physician’: it must be known which doctors’ qualify and which ones do not. Some laws specify these definitions, but others brush over the definitions. When defining ‘indoors’ as compared to ‘outdoors’, for example, is a green house an

‘indoor’ cultivation site? Similarly does an outdoor parcel that is less than .25 acres in a city fall under ‘outdoor’ even though there is no real space for cultivation? Definitions for ‘dispensary’ as compared to a ‘collective’ or ‘cooperative’ must all be distinguishable from the other and each needs its own set of regulations that specifically addresses limitations. In addition, Alameda defines: applicant, county, state, eligible application, identification card, permit, person, permittee, person with an identification card, premises, sheriff, primary caregiver, qualified patient, church, and school. I suggest that these terms be mentioned and defined, if only briefly. For example, while I believe that ‘school’ is a fairly understood and clear term, youth facility or center is not, and that should be defined as well. Finally if there is no mandatory identification card system that is in place ‘doctor’s recommendation’ must be defined and protected from law enforcement.

List of Key Terms That Should Be Defined in Ordinances:

- **Doctor or physician**
- **Outdoor Cultivation**
- **Indoor Cultivation**
- **Dispensary**
- **Collective**
- **Cooperative**
- **Applicant**
- **Eligible Application**
- **Identification Card**

- **Doctor's Recommendation**
- **Permit**
- **Person with identification card**
- **Permitee**
- **Premises**
- **Primary Caregiver**
- **Qualified Patient**
- **Church, Youth Center, or other facilities that are youth related**

Zoning

All participants and regulatory policies suggested that zoning and land use issues have to be addressed in order to provide the general public a healthy and safe environment. More specifically indoor cultivation, outdoor cultivation, and dispensaries are discouraged within 300 to 1000 feet from a school, youth facility, church, or main retail area. Indoor and outdoor cultivation should also be non-visible and as close to unnoticeable as possible from roads and other general public areas, in order to reduce crime and appease sensitive residents. Dispensaries should also conceal on-site cultivation from the general public.

Land Use and Addressing Environmental Impacts

In rural areas, and some urban areas, land degradation, water theft or destruction, habitat protection, and animal protection ordinances must be implemented and enforced or our vices will destroy the land, the water, and the air. In addition, herbicides and

pesticides should not be sold unless they are FDA approved, and the long term effects on the environment and from human consumption should be tested. More importantly dispensaries and other distribution centers should be tested for chemicals and those violating codes restricting these poisons should be punished. The entire mission of medical marijuana ordinances is to get patients medicine that is going to help their ailments, not medicine that introduces more toxins into their bodies.

In order to reduce electricity use, indoor cultivation must limit the amount of lights, ventilation systems, CO2 input systems. In order to reduce fire hazard regulations regarding electricity checks are advised.

Finally, there must be designated dump sites for soils and fertilizers and other wastes, and recycling centers for light bulbs.

Quantities Allowed for Possession and Cultivation

Regulations, that are scientifically supported, must be implemented to control the numerical limits that patients, caregivers, dispensaries, cooperatives, and collectives can possess, cultivate, and distribute. The limits for patients' personal use and cultivation are the most important because that is who is being served. More specifically cultivation must be addressed differently for rural and urban areas. For example, in rural areas where climate is appropriate for outdoor growth, patients and caregivers should be allowed to cultivate more than an outdoor cultivation site in an inner city. In addition these larger sites should have more industry cultivation regulations similar to agriculture so that they are producing an organic product. Indoor limits must also be specified and limited to a

garage or room that is approved by a landlord or property owner. Overall a way to create a more uniform regulatory system on cultivation and possession amounts would be to gauge plant production in such a way that a crop yield could be calculated. If a medically suggested yield was agreed upon the entire state could have more uniform cultivation limits.

Finally, the goal of a dispensary is to create an avenue of access for patients to receive medications. That being said dispensaries must be allowed to cultivate and/ or possess an amount of medication that can serve their patients at any given time.

Compensation, Profits, and Taxes

The most difficult issue to introduce and regulate will be compensation, profiteering, and taxation. Data revealed that it may be easiest to regulate and tax marijuana similar to the way alcohol or tobacco is regulated. That being said this is an industry that many people have profited from, and there must be a way to compensate cultivators and distributors for their efforts and to reimburse them for production costs. In some counties there are fees for permits and inspections and some of these are imposed per plant. These fees must be made uniform, and not take monetarily from the community in which they intend to serve. In addition proceeds need to be returned to medicinal marijuana patients, and used to pay for future research, testing of products that are being sold, and of course regulating and enforcing ordinances.

A large issue that affects the marijuana industry is trade, nationally and internationally. There must be a kind of free trade implemented that does not reinforce

current legislation with negative consequences for the user, producer, or distributor, such as NAFTA.

Patients' Rights

Medical marijuana ordinances were created to serve patients therefore they must address patients' rights. These rights range from having access to a caregiver, and dispensary or distribution center of some kind, to law enforcement honoring doctors' recommendations and ID cards to protections from discrimination in employment, housing, driving, and access to firearms. Furthermore there must be protection of the privacy of patients; there must be a way to detect abuses of ordinances, and ways to allow minors who are patients to have access to their medication.

In regards to dispensary owners and employees Sonoma and Modoc Counties both require the owner or operator to be a patient or caregiver. In addition in Sonoma County the employees must also be patients or caregivers. While this may appear to make sense, medical marijuana being handled solely by patients or caregivers, it is not ideal. Patients are often seriously ill and are unable to cultivate or acquire medication on their own, and caregivers have more responsibilities than cultivation and distribution of medication. For this reason it may be important to retract this requirement.

Furthermore counties have implemented regulations that assist lower income residents in acquiring medicine. Santa Cruz is the only county that specifically mandates dispensaries to participate in an income participation plan, in which product

compensations are determined based on a sliding scale. Ideally all counties would adopt this practice and patients could benefit more from increased access to medical marijuana.

Unfortunately few counties have implemented regulations that protect disabled patients. Calaveras is the only county that specifically requires dispensary facilities to abide by the American Disability Act, although other ordinances do mention that buildings must be up to all building codes. I believe that if more counties included their patients in the creation of medical marijuana ordinances, regulations like this would become more standard. In addition it may benefit counties and cities to follow Santa Clara and Stanislaus County's examples and include Public Health Departments in decision-making groups.

Dispensaries

Dispensary regulations are essential for county and city level ordinances. First and foremost dispensaries must be differentiated in ordinances from cooperatives and collectives. Other laws will indicate the permitted locations for store fronts, provide information regarding signage, security, and ventilation, and must give a list of fees, permits, and inspections that are required. Some locales may choose to limit the number of dispensaries. However, this cannot be an arbitrary limit; it needs to reflect the number of patients that require access. A way to create a less arbitrary limit may be to assess the number of pharmacies that serve an area, including the hours of operation, and then permit a similar amount of facilities with similar hours to serve that same area. In addition dispensaries need to be spread out throughout the county, or they need to

provide delivery systems so that even patients without caregivers can have access to medication.

In regards to regulating dispensaries one suggestion was to “create a medical marijuana dispensary model requiring such things as standardized intake methods, sliding scale charges for a percentage of the clients”, clear and up-to date record keeping of patients, caregivers, and dispensaries, and regular monitoring of operation (Hoover 2008: A9). They are also regulated monetarily by the Board of Equalization in regards to taxation.

In regards to regulating the products sold at dispensaries, there should be guidelines on the amount of medical marijuana allowed at a single location, including cultivation and overall possession of dried marijuana. There should also be guidelines regulating that the product is healthy, and all products should be labeled. Labels should include dispensary name, quantity, CBD and THC levels, and the ailments for which it is recommended. Dispensaries should be permitted to sell edibles, tinctures, ointments, and other forms of concentrated marijuana that benefits patients. On-site consumption of these substances should be permitted if the patient will not be impaired on their way home.

Finally dispensaries often provide social and health services for their patients ranging from yoga and peer counseling to providing their clients with mechanisms that assist in marijuana ingestion. This is a benefit to patients and should be funded, at least partially by the money that is gathered from patients at the dispensary.

Crime and Enforcement

We must monitor the Department of Justice and ensure compliance with new non-interference policies regarding state medical marijuana laws. We must also monitor local law enforcement to ensure that they are pursuing those exploiting the laws. Ideally the states that have legalized medical marijuana should work with the federal government to facilitate rescheduling of marijuana and research regarding the nature of its effects.

Education

First and foremost, anyone that is cultivating medical marijuana must be educated about safe, energy-efficient, and organic cultivation tactics. This includes dispensaries and horticulture supply retail facilities, as well as marijuana media, educating patients and caregivers about tactics that can be used to grow their product without all the added chemicals and energy use. Currently, dispensaries and horticulture supply facilities are rarely informing patients about energy efficient methods or chemical free ones. However, some dispensaries are attempting to use these techniques. When interviewing the director of a dispensary that cultivates marijuana, it was explained to me that the dispensary had consistently tried to work with local horticulture and hydroponic supply facilities in acquiring the most energy efficient and “green” or sustainable equipment that is available for indoor cultivation.

A hearing should be held on the Medical Marijuana Patient Protection Act. “The Medical Marijuana Patient Protection Act (H.R. 2835) would reschedule marijuana, allowing doctors nationwide to prescribe it to patients in need. It would also create

protections in federal law for states that wish to protect medical marijuana patients” (Marijuana Policy Project 2011). After this is completed and research based policy providing patients access to medicinal marijuana is constructed and implemented nationwide, education must take place.

People must be educated about the true effects of cannabis. Especially people who are users and do not intend to stop, but who wish to lower their health risks. For example the book *Cannabis Policy: Moving Beyond Stalemate* offers general guidelines or health advice to users rather than ignoring that fact that this is happening, similar to telling young adults that they should remain abstinent rather than educating them about ways to protect themselves and make intelligent decisions regarding sexual activities, or using the DARE program to teach children to “Just say no”. Some of the general guidelines provided by the *Cannabis Policy: Moving Beyond Stalemate* included not driving while intoxicated, not using marijuana while pregnant, and avoiding using marijuana with other substances to separate the addictions mentally. In an effort to promote user health, *Cannabis Policy: Moving Beyond Stalemate* suggests using methods other than smoking to ingest marijuana (i.e. eating it or vaporizing it), using marijuana with high THC and low CBD levels because CBD is said to cause psychological harms, and not smoking before the age of 17 because it can “significantly increase the likelihood of experiencing adverse effects, both personal and social. Children should therefore be advised of these risks” (2010: 45-46).

Limitations of the Study

In every research project there are challenges and limitations that prohibit the researcher from achieving a complete understanding of their research interest. This research is no different. The most challenging part of this project was that laws and ordinances are constantly changing as a result of fears of repercussions of federal threats and raids. The HuMMAP Representative noted: “The federal terror campaign is effective, it scares people.”

In addition, it felt as though each time I tried to clarify an ordinance or bill the laws had changed or a court case was occurring that addressed it or the Drug Enforcement Agency, IRS, U.S. Marshalls, and other federal agents would conduct a raid on a plot of land, against a certain person, or dispensary. Time will tell if the patterns found in this data will remain consistent. In general I believe that there will always be new arising issues even after everything recommended here has been addressed in legislation.

Obtaining interviews proved to be one of my most difficult challenges. In every county and city a different group of people is in charge of creating guidelines or ordinances related to marijuana. So after understanding who I needed to contact in each city and county, other issues arose. For example issues of time, being overloaded with work, the ‘fear factor’, and a changing political atmosphere made it difficult to obtain interviews at the state, county, and local levels. As a result a limitation to the study is a lack of varying perspectives that would give a more thorough examination of the various

policies in California regulating medical marijuana. Some of the voices that were not intentionally excluded were caregivers, public health officials, and officials from the county board of supervisors or planning departments of individual counties.

There are several limitations of this project that are common among research of this kind. One general limitation of this project is the lack of reliable statistics available to the public. Marijuana has been illegal in the United States for over eighty years. As with any illicit drug, research on it is limited and most information comes from people who have been arrested or incarcerated, excluding a large part of the people associated with this industry. There is an absence of scholarly work that studies patients, cultivators, and long term effects on the environment and human health as a result of the industry. Another general limitation is the ability to obtain peer-reviewed sources around this topic. This is mainly due to the lack of research around environmental, social, and economic outcomes, and the ever changing political atmosphere. A third general limitation for all bodies of research is being aware and noting the bias of authors' of previous studies, in the media, and on organizational websites. As with most research time was limited and with more of it a more thorough collection of interviewees could have been acquired, ideally at least five people per County. The final limitation is subjectivity, which is again inevitable in any research due to the prior knowledge, biases, beliefs, and emotional attachment of the author.

Further Research

In the future I would recommend that at least five people per California County be interviewed. There should be one patient and/ or caregiver, one dispensary owner or operations manager, one researcher, doctor, or scientist knowledgeable about marijuana, and at least one person from each department that contributes to policy creation, reform, and enforcement interviewed. Prior to this data being collected, it is essential to update all ordinances regulating marijuana at the state, county, and city levels from what has been provided here, so that a clear portrait can be painted of legislation regarding medical marijuana, and its' effects on the patient population, and the community at large.

Furthermore if the United States were to reclassify or legalize marijuana several steps would have to occur. First each state would need an analysis, similar to the one described above. Then after ordinances and their effects were determined, there would need to be an assessment of what was successful and what needed to be improved or addressed. At this point it would need to gather stakeholders at a conference and allow opinions to be heard, research to be presented, and explore future legislation. At this point it may be possible to establish and implement universal laws that could regulate the cultivation, distribution, possession, and enforcement of marijuana. These laws would then be specialized by local and state governments as seen fit, or as it applies to their locale. When the states decided to implement more specific regulations it would again need to gather stakeholders and remain conscious of everyone's needs.

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APPENDIX A: DEFINITIONS OF TERMS

1. Drug: “according to the Food, Drug, and Cosmetic Act (1): a substance recognized in an official pharmacopoeia or formulary (2): a substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease (3): a substance other than food intended to affect the structure or function of the body (4): a substance intended for use as a component of a medicine but not a device or a component, part, or accessory of a device” (Merriam- Webster, Drug 2012).
2. Controlled Substance Act (CSA): Enacted into law by Congress in 1972, as Title II of the Comprehensive Drug Abuse Prevention and Control Act. “The Controlled Substance Act (CSA) regulates five classes of drugs: narcotics, depressants, stimulants, hallucinogens, and anabolic steroids. Each class has distinguishing properties, and drugs within each class often produce similar effects. Some induce sleep and others energize” (United States DEA, Drug Classes: 2012). This act also created five schedules of drugs, with varying qualifications for a substance to be included such as potential for abuse and international treaties. The Drug Enforcement and the Food and Drug Administration determine which substances are added to or removed to each schedule. For example, “Schedule I drugs or substances have a high potential for abuse. They have no currently accepted medical use in treatment in the United States, and there is a lack of accepted safety for use of the drug or other substance under medical supervision. Examples of Schedule I substances include heroin, lysergic acid diethylamide (LSD), marijuana, and methaqualone” (Hartney 2012).

And ranges to Schedule V drugs which have relatively lower abuse potential, have been accepted for medical use in the United States, and “abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule IV. Examples of Schedule V drugs are cough medicines with codeine” (Hartney 2012).

3. Controlled Substance: “means a drug or other substance, or immediate precursor, included in schedule I, II, III, IV, or V...The term does not include distilled spirits, wine, malt beverages, or tobacco, as those terms are defined or used in subtitle E of the Internal Revenue Code of 1986” (U.S. Department of Justice 2012).
4. Narcotic: “The term ‘narcotic,’ derived from the Greek word for stupor, originally referred to a variety of substances that dulled the senses and relieved pain. Today, the term is used in a number of ways. Some individuals define narcotics as those substances that bind opiate receptors while others refer to any illicit substance as a narcotic. In a legal context, narcotic refers to opium, opium derivatives, and their semi-synthetic substitutes. Cocaine and coca leaves, which are also classified as ‘narcotics’ in the Controlled Substances Act (CSA), neither bind opiate receptors nor produce morphine-like effects, and are discussed in the section on stimulants” (United States DEA, Narcotics 2012).
5. Marijuana: “A dry, shredded green/brown mix of flowers, stems, seeds, and leaves from the Cannabis sativa plant. The mixture typically is green brown, or gray in color and may resemble tobacco” (Drug Enforcement 2012: 1). “When

marijuana is smoked, the THC passes from the lungs and into the bloodstream, which carries the chemical to the organs throughout the body, including the brain. In the brain, the THC connects to specific sites called cannabinoid receptors on nerve cells and influences the activity of those cells. Many of these receptors are found in the parts of the brain that influence pleasure, memory, thought, concentration, sensory and time perception, and coordinated movement. The short-term effects of marijuana include problems with memory and learning, distorted perception, difficulty in thinking and problem-solving, and loss of coordination. The effect of marijuana on perception and coordination are responsible for serious impairments in driving abilities. High doses of marijuana can result in mental confusion, panic reactions and hallucinations. However, no death from overdose of marijuana has been reported” (Drug Enforcement 2012: 1-2). “Short-term physical effects from marijuana use may include sedation, blood shot eyes, increased heart rate, coughing from lung irritation, increased appetite, and decreased blood pressure” (Drug Enforcement 2012: 1).

6. Medical Marijuana: “whole or parts of the natural marijuana plant and therapeutic products derived, as opposed to drugs synthetically in the laboratory that replicate molecules found in the marijuana plant” (Eddy 2009: 1); and is used to heal numerous ailments including but not limited to: insomnia, chronic pain, lack of appetite, anxiety, and stress.
7. Hashish (“Indian hemp”, Charas): “Hashish (THC content in the range of 2% to 20%) consists of dried cannabis resin and the compressed flowers. Hash oil is an

oil-based extract of hashish that contains between 15% and 50% THC” (Room et al. 2010: 6). Marijuana generally has THC content 20% or lower. “the concentrated resin from the flowering tops of female hemp plants that is smoked, chewed, or drunk for its intoxicating effect” (Merriam-Webster, Hashish 2012); converted marijuana that has been filtered through ice or butane to create bubble hash (ice filtration), hash (butane filtration), or hash oil. This is a type of converted marijuana.

8. Keef: Also known as kif, kef, or kief; “THC crystals from cannabis buds” (urbandictionary.com 2012). These crystals come from any marijuana plant, are extracted through grinders (a device used to break down processed marijuana) or other forms of separating the THC crystals from the buds, and the crystals are combined to create compacted keef. This is a type of converted marijuana.
9. Edibles: Medical marijuana that is converted into butter and said better is used to produce foods, desserts, and beverages. This is a type of converted marijuana.
10. Tinctures: “Until Cannabis was banned in 1937, tinctures were the primary type of cannabis medicines. Tinctures are essentially alcohol extractions of whole cannabis (usually the flowers and trim leaves). Tinctures are easy to make and very inexpensive. Tinctures contain all eighty of the essential cannabinoids” (Patients 2012). This is a type of converted marijuana.
11. Hemp: “From the family Cannabis sativa, a fast growing annual plant cultivated throughout the world for the strong industrial fiber in its stem and oil from its seeds. Although related to marijuana, industrial hemp does not contain the

chemicals that cause marijuana to be classified as an illegal drug, the chemical THC (tetra-hydrocannabinol). Due to the similar leaf shape and although both plants are from the same genus cannabis, hemp is frequently confused with marijuana. However, hemp contains virtually no THC (delta-9-tetrahydrocannabinol), the active ingredient in marijuana and cannot be used as a drug because it produces virtually no THC (less than 0.3%)” (Stemergy 2006).

12. Opium: “A bitter brownish addictive narcotic drug that consists of the dried latex obtained from immature seed capsules of the opium poppy” (Merriam-Webster, Opium 2012).
13. Distribution: “means to deliver (other than by administering or dispensing) a controlled substance or a listed chemical. The term ‘distributor’ means a person who so delivers a controlled substance or a listed chemical” (U.S. Department of Justice 2012).
14. Collective/ Cooperative/ Dispensary: “Medical Marijuana Cooperative or Collect means an affiliation or association of individuals whose collective intent is to provide education, referral or network services and to assist in the lawful acquisition and distribution of medical marijuana in a safe and affordable manner between primary caregivers and qualified patients as permitted in accordance with the Compassionate Use Act of 1996” (Diamond 2010: 20).
15. Processed Marijuana: After cropping the plant the procedure of harvesting the flowers. Usually done by machine or humans, the plant is trimmed down so that leaves, flowers, and stems are separated so that each can be used by medical

patients in their unique way. The end result of the trimmed flowers is known as processed marijuana, and it is ready for immediate use, usually smoking of some kind.

16. Converted or Concentrated Marijuana: “noting anything, formerly of the type specified, that has been converted to something else” (dictionary.com, Converted 2012); in this case the conversion of marijuana through heat or chemicals into from leaves and flowers into hashish, keef, butter, or edibles. Converted marijuana is used for medical purposes and allows the creator to regulate dosage more uniformly.

17. Indoor: The process of cultivating medical marijuana inside of a facility, including anything from a trailer to a house to a greenhouse. This process requires lights, ventilation, fans, heaters, and other ways of regulating temperature and humidity for the crop. This requires the use of electricity and/ or diesel generators.⁷In general people who cultivate inside use soil or hydroponics

⁷October 6, 2011- Evan Mills “The Carbon Footprint of Indoor Cannabis Production” - Dr. Evan Mills is a scientist at the Lawrence Berkeley National Lab, which is managed by the University of California for the U.S. Department of Energy. He has worked as an energy analyst since the early 1980s, specializing in ways to reduce greenhouse gas emissions via improved energy end-use efficiency in buildings. He received a Master’s of Science degree from the Energy and Resources Group (where he is now a Research Affiliate) at U.C. Berkeley in 1987 and a Ph.D. from the Department of Environmental and Energy Systems Studies at the University of Lund in Sweden in 1991. He has over 200 publications in his field. He is a member of the international body of scientists which has worked over the past two decades under the Intergovernmental Panel on Climate Change (IPCC), which collectively shared in the Nobel Peace Prize for 2007 with former U.S. Vice President Al Gore “for their efforts to build up and disseminate greater knowledge about man-made climate change, and to lay the foundations for the measures that are needed to counteract such change.”

(growing using mineral nutrient solutions, in water, without soil). Processed marijuana is used for medical purposes.

18. Moratorium: “A legally authorized period of delay in the performance of legal obligation or the payment of a debt; a waiting period set by an authority” (Merriam-Webster, Moratorium 2012).

19. Outdoor: The process of cultivating medical marijuana outside. This process may require soil and water to be transported to the cultivation site. However, it uses the sun and natural humidity of the site to grow the plant so this requires more attention to temperature and humidity levels prior to cultivation.

20. Immature plant: Marijuana plants with no observable flowers or buds; usually referred to by clones by patients and other participants in the marijuana industry. These plants are often clipped from a donor or “mother plant” and are carefully cultivated until they begin to enter into other growth stages. Often times the amount of immature plants allowed on a property is greater than the number of mature plants allowed on a property.

21. Mature plant: A marijuana plant that has flowers or “buds” that are readily observable without a visual examination. Mature plants are permitted; however, they are often limited. For example SB 420 proposed that there be a limit of twelve immature and six mature plants on a property.

22. Unincorporated area: [for this paper, refers to] The area or region of land in a county that is not under a city’s direct municipality; areas that do not have their own government.

**APPENDIX B: CALIFORNIA CITIES AND COUNTIES WITH
ORDINANCES REGULATING DISPENSARIES**

CITIES WITH DISPENSARY ORDINANCES:

Angels Camp	Los Angeles	Santa Barbara
Arcata	Malibu	Santa Cruz
Berkeley	Mammoth Lakes	Santa Rosa
Citrus Heights	Martinez	Sebastopol
Clearlake	Napa	South El Monte
Cotati	Oakland	South Lake Tahoe
Diamond Bar	Palm Springs	Stockton
Dunsmuir	Placerville	Tulare
El Cajon	Plymouth	Visalia
El Centro	Redding	West Hollywood
Eureka	Richmond	Whittier
Fairfax	Ripon	Yucca Valley
Fort Bragg	Sacramento	
Garden Grove	San Carlos	
Jackson	San Francisco	
Laguna Woods	San Jose	
Long Beach	San Mateo	

COUNTIES WITH DISPENSARY REGULATIONS:

Alameda

San Luis Obispo

Sonoma

Calaveras

San Mateo

Stanislaus

Modoc

Santa Clara

San Diego

Santa Cruz

APPENDIX C: BREAKDOWN OF ALAMEDA COUNTY'S DISPENSARY ORDINANCE

Alameda County passed Ordinance No. 0-2005-25, “An Ordinance Adding Chapter 6.108 to Title 6 of the Ordinance Code of the County of Alameda Relating to Medical Marijuana Dispensaries” that was written by the Alameda County Board of Supervisors (County Board of Supervisors, Alameda 2005: 1). The goal and “intent of this Chapter is to implement State law by providing a means of establishing and regulating the operation of medical marijuana dispensaries in a manner this is consistent with State law and which promotes the health, safety, and general welfare of the residents and businesses within the unincorporated portions of the County” (County Board of Supervisors, Alameda 2005: 2-3). The Chapter then provides a list of definitions for terms such as: applicant, county, state, eligible application, identification card, medical marijuana dispensary, permit, person, permittee, person with an identification card, premises, sheriff, primary caregiver, qualified patient, and school. This Chapter also notes that a residential care facility for elderly patients can be licensed under Chapter 3.2 of Division 2 of the California Health and Safety Code, and a residential hospice or home health agency can be licensed under Chapter 8 of Division 2 of the California Health and Safety Code. The above mentioned permits must be obtained by “the owner, managing partner, officer of a corporation or such other person who shall be primarily responsible for the operation of a proposed medical marijuana dispensary and, if granted, shall maintain the operation of the medical marijuana dispensary in conformity with the terms of this Chapter and of the permit” (County Board of Supervisors, Alameda 2005: 4). These permits expire after two years of issuance and may be renewed by the Sheriff for successive periods of two years upon application submission by the permittee, and it must

be done forty-five days prior to expiration. The applications for permits will be accompanied by a non-refundable fee, and each approved dispensary will pay an annual fee [the amount of which is not stated]. Interestingly this Chapter also notes that “the Board of Supervisors may enact fees to be paid to schools located in the three areas where dispensaries are permitted for reimbursement for drug and alcohol treatment for students” (County Board of Supervisors, Alameda 2005: 8). This ordinance states that the County shall at no time have more than three permits in effect, with a maximum of one permit in each area laid out in Exhibit A of this Chapter. In addition these dispensaries must meet the local standards laid out by this Chapter. This includes not being closer than 1000 ft from any other dispensary, school, park or playground, drug recovery facility or recreation center, or recreation center. Dispensaries must also be located in commercial or industrial zones, and the County is allowed to reduce the location requirement up to fifteen percent of dispensaries near schools if it does not endanger the health and safety of students. Finally a dispensary must comply with County building, zoning, and health codes and permits inspection of the above at any time.

When deciding which applications to approve this Alameda Chapter states “if any area has a number of eligible applications that exceeds the maximum number of dispensaries for such area, the eligible applications to be submitted for final selection shall be designated by drawing or other method that ensures that each eligible application has an equal chance of being selected for the area” (County Board of Supervisors, Alameda 2005: 10). Operating conditions are established by the Sheriff, the Community Development Agency and the Health Care Services Agency, in addition to the standard conditions. These standard conditions address distribution of marijuana to patients or

caregivers with ID card. Each dispensary must maintain records of patients and qualified caregivers, to protect the patient they only require the patients ID card number on record, however, this number is issued pursuant to California Health and Safety Code.

Dispensaries must also maintain a registry of employees, contractors, vendors, or those otherwise engaged with the dispensary [cultivators who distribute to the dispensary].

Dispensary hours are from 9:00am to 9:00pm on any day, and dispensaries within 1000feet of any school shall be closed for one and a half hours after classes are dismissed for the day. “All activities that are undertaken in the operation of the dispensary shall be entirely conducted indoors on the premises” (County Board of Supervisors, Alameda 2005: 11). Marijuana is not permitted to be grown or cultivated on the premises. In relation to quantity the maximum permitted shall be lesser than a) the amount of marijuana equal to eight ounces per patient who has come in the past thirty days or b) a total of twenty pounds. There is no on-site consumption of marijuana [smoking or ingestion], and the dispensary is required to label their products with the name of the dispensary and the weight of the cannabis. In addition edibles must be labeled with ingredients, including the amount of cannabis in the product, and food products that are used. People under the age of eighteen may not work or receive medication from the dispensary. For security purposes no alcohol can be stored, sold, dispensed or used on premise, no person convicted of a felony within ten years may be engaged with the operation of the dispensary, there must be lighting and alarms, and the Sheriff can inspect that all of the listed standards are met. This Chapter also states that litter removal service twice a day must occur up to one hundred feet of the premises. There must be restroom facilities on the premises. In relation to enforcement anyone violating any of the above

standards is guilty of a misdemeanor, and is guilty of a separate offense for each and every day during portion of which any violation is committed, and shall be punished accordingly.

APPENDIX D: BREAKDOWN OF CALAVERAS COUNTY'S DISPENSARY ORDINANCE

Calaveras County created Chapter 17.91 to regulate availability and/ or distribution, by whatever means, of medical marijuana within the unincorporated area of Calaveras. This ordinance defines medical cannabis dispensary, primary caregiver, qualified patient, and person with an identification card. Medical marijuana dispensary is a facility or location where medical marijuana is available or distributed by or to two or more patients or caregivers. Dispensaries may not be a licensed clinic, health care facility, residential care facility, an elderly residential care facility, a residential hospice, or a home agency. The planning director is in charge of enforcement of this chapter. Dispensaries must apply with the planning department for an administrative use permit, which is valid for up to one year. The County has the ability to set terms and conditions on the proposed operations with the public health, safety, and welfare of the community including business hours, parking requirements, lighting, and adequate security. In addition, the planning director and the sheriff may conduct background checks on permittees, or on the dispensary. Dispensaries in this county may be located only in the CP professional office zoning district, and further than one thousand feet of another facility, elementary school, middle school, high school, public library, Public Park, or any youth-oriented establishment. The standard guidelines for dispensaries is that they may possess no more than eight ounces of dried cannabis per patient or caregiver, and maintain no more than six mature or twelve immature plants per patient. "However, 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 dispensary may possess an amount of cannabis consistent with the patient's needs" (Chapter 17.91 2005: 2).

Dispensaries are not permitted to have consumption of marijuana [smoking nor ingestions], inside the building or on its property. Persons under the age of eighteen are only permitted on premises if they are a patient or caregiver. There is no alcoholic beverages allowed on premises, and the dispensary is not allowed to conduct or engage in the commercial sale of any product, good, or service. The dispensary must allow the county to access the dispensary's books, records, accounts, and any other relevant data. There must be adequate security on premises, including lighting and alarms. On-site cultivation must occur in an indoor secured site that the county sheriff deems as not visible or accessible by the public. For edibles or other comestibles to be sold on-site there must be an additional permit with the environmental health department.

Dispensaries are subject to paying fees for both the permit application and the permit. Dispensary regulation violators are subject to revocation of the permit or for nonrenewal. Finally the penalty for violations of this chapter "shall be [a] misdemeanor, punishable by a fine of five hundred dollars and/ or six months imprisonment" (Chapter 17.91 2005: 4).

APPENDIX E: BREAKDOWN OF MODOC COUNTY'S DISPENSARY ORDINANCE

In October 2010 Modoc County adopted Chapter 18.170, the Medical Marijuana Collective Uses ordinance, constructed by the Board of Supervisors of Modoc County. The purpose of the ordinance is to regulate the availability and the distribution of medical marijuana in the unincorporated area of Modoc County. Dispensaries may be located in the Commercial Zoning District with a use permit, and must be up to standards on applicable building codes, and developments standards and requirements, including accessibility requirements. They must also not be located within a residence nor within a hundred feet of a residential zone, nor within one thousand feet of any other dispensary, nor within 1000 feet of any public school park or other establishment that caters primarily to people under eighteen. A dispensary is any facility or location where the primary purpose is to dispense medical marijuana that has been recommended by a physician to a patient or caregiver. Modoc County requires dispensaries to develop an operating plan that addresses security, size of the facility, record keeping, days and times of operation, and anything else that is relevant. Then the facility must obtain a use permit and according to the permit the dispensary must require patients and caregivers to provide a written physician's recommendation, and may not cultivate or distribute for profit [compensation is allowed]. However, later the document states that "collective sales shall be subject to sales tax in a manner required by state law. An operator of a collective shall be required to apply for and obtain a Seller's Permit as required by the State Board of Equalization" (County Board of Supervisors, Modoc 2010: 7).

Furthermore the dispensary may not keep cuttings of the marijuana plan on-site. "the term 'cuttings' shall mean rootless pieces cut from marijuana plants, which are no

more than six inches in length, and which can be used to grow other plants in a different location” (County Board of Supervisors, Modoc 2010: 6). In this case “cuttings” is similar to immature plants or clones that are used to cultivate new crops. The permit expires after one year, unless the dispensary is found to be a public nuisance prior to that. Something unique to Modoc County is that “permits issued for medical marijuana collectives uses shall be exercised only by the applicant, who must be a qualified patient or primary caregiver, and shall expire upon termination of the business” (County Board of Supervisors, Modoc 2010: 4). In addition the permit has fees and must be reapplied for prior to expiration, and the permittee must have a background check. The membership of the dispensaries in Modoc County may not exceed three hundred members at any one time unless permitted by the Planning Commission. There can be no exterior or interior signage or symbols that can display that marijuana is available. Employees or operators must be qualified patients or primary caregivers, which is odd since most patients are seriously or terminally ill. Dispensary members must be a Modoc County resident, a patient or primary caregiver with proper ID, and cannot be under eighteen. The dispensary may have enough medical marijuana at their facility to cumulatively serve each qualified patient or caregiver that is served. There can be no alcohol on-site, nor can they sell drug paraphernalia, products, etc. Business hours are limited to Monday through Saturday from 8:00am to 5:00pm, limiting the amount of time working patients may have to access their medication. Pharmacy hours for example are often Monday to Friday 8:00am to 9:00pm, and Saturday and Sundays from 10:00am to 6:00pm. Patients may not consume marijuana on-site, and the dispensary must acquire marijuana for distribution from the constituent members and distributing to non-members is prohibited. However,

this may limit the strains that patients can have access to. There are very different strains of marijuana that alleviate various types of ailments, to limit where the marijuana comes from may end up hurting the patients.

APPENDIX F: CITIES WITH BANS ON DISPENSARIES

Adelanto	Chino	Emeryville
Alameda	Chula Vista	Escalon
Anaheim	Claremont	Escondido
Arroyo Grande	Cloverdale	Fairfield
Atascadero	Clovis	Folsom
Auburn	Colma	Fontana
Azusa	Concord	Fortuna
Barstow	Corning	Fountain Valley
Beaumont	Corona	Fremont
Benicia	Costa Mesa	Fresno
Blythe	Cypress	Fullerton
Brawley	Danville	Gardena
Brentwood	Davis	Gilroy
Buellton	Desert Hot Springs	Glendale
Buena Park	Dixon	Goleta
Calabasas	Downey	Grand Terrace
Calistoga	Dublin	Grass Valley
Camarillo	East Palo Alto	Grover Beach
Ceres	El Cerrito	Guadalupe
Chico	Elk Grove	Hawthorne

Hayward	Laguna Niguel	Moorpark
Healdsburg	Lake Elsinore	Moraga
Hemet	Lake Forest	Morgan Hill
Hercules	Lawndale	Murrieta
Hermosa Beach	Livermore	Nevada City
Hesperia	Lincoln	Newark
Highland	Lodi	Norco
Hollister	Loma Linda	Oakdale
Holtville	Lompoc	Oakley
Huntington Beach	Los Baños	Ontario
Imperial	Los Gatos	Pacific Grove
Imperial Beach	Manhattan Beach	Palm Desert
Indian Wells	Manteca	Palos Verdes Estates*
Indio	Marina	Paradise
Inglewood	Menifee	Pasadena
Laguna Hills	Merced	Paso Robles
La Canada	Millbrae	Patterson
La Mirada	Mission Viejo	Petaluma
La Palma	Modesto	Pico Rivera
La Puente	Montclair	Pinole
La Quinta	Monterey Park	Pismo Beach

Pittsburgh	San Luis Obispo	Temecula
Placentia	San Marcos	Torrance
Pleasant Hill	San Pablo	Turlock
Pleasanton	San Rafael	Tustin
Poway	Santa Ana	Ukiah
Rancho Mirage	Santa Clarita	Union City
Redondo Beach	Santa Maria	Upland
Redwood City	Santee	Vacaville
Ridgecrest	Scotts Valley	Vista
Rio Vista	Seal Beach	Wildomar
Riverbank	Seaside	Willits
Riverside	Selma	Windsor
Rocklin	Simi Valley	Woodland
Rohnert Park	Solvang	Yountville
Roseville	Sonora	Yreka
San Bernardino	South San Francisco	Yuba City
San Bruno	Sunnyvale	Yucaipa
San Jacinto	Susanville	
San Juan Capistrano	Sutter Creek	

*Ban ordinance allows for one dispensary to remain open.

APPENDIX G: CITIES WITH MORATORIUMS ON DISPENSARIES

Aliso Viejo	Dunsmuir	Mount Shasta
American Canyon	Etna	Mountain View
Anderson	Fairfax	National City
Antioch	Farmington Hills	Novato
Arcata	Fillmore	Oakdale
Atwater	Galt	Orange
Baldwin Park	Greenfield	Orinda
Banning	Half Moon Bay	Orland
Beverly Hills	Ione	Oroville
Blue Lake	La Habra	Perris
Brea	Lafayette	Porterville
Calexico	Laguna Beach	Rancho Cordova
Calimesa	Livingston	Rancho Cucamonga
Carpintaria	Loomis	Rancho Santa
Carson	Los Altos	Margarita
Coachella	Marin City	Red Bluff
Colton	Mill Valley	Redlands
Corte Madera	Monterey	Rio Dell
Daly City	Moreno Valley	Rosemead
Downey	Morro Bay	Salinas

San Dimas

San Fernando

San Juan Bautista

San Ramon

Sausalito

Shasta Lake

Signal Hill

Soledad

South Gate

Tehachapi

Temple City

Victorville

Walnut Creek

Watsonville

West Sacramento

Westlake Village

Wheatland

APPENDIX H: RELEVANT TABLES

TABLE 5 INDOOR AND OUTDOOR CULTIVATION PERMITTED BY COUNTY

County	Outdoor Cultivation Permitted	Indoor Cultivation Permitted
El Dorado	•	•
Humboldt	•	•
Kern	•	
Mendocino	•	•
Nevada	•	
San Francisco		•
Santa Cruz		•
Shasta	•	•
Sonoma		•
Tehama	•	
Trinity	•	

These counties did not have policies that addressed cultivation and therefore are not listed in the table above: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, Fresno, Glenn, Imperial, Inyo, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Merced, Modoc, Mono, Monterey, Napa, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Sierra, Siskiyou, Solano, Stanislaus, Sutter, Tulare, Tuolumne, Ventura, Yolo, and Yuba.

TABLE 6 DISPENSARY ORDINANCES BY COUNTY

County	Dispensaries Permitted with Regulation	Dispensaries Moratorium	Dispensaries Banned
Alameda	•		
Alpine			•
Amador			•
Butte			•
Calaveras	•		
Colusa			•
Contra Costa			**
El Dorado			•
Fresno		•	
Glenn		•	
Humboldt		•	
Kern			•
Kings		•	
Lassen			•
Los Angeles			•
Madera			•
Mendocino			•
Merced			•
Modoc	•		
Nevada			•
Orange			•
Placer			•
Riverside			•
Sacramento			•
San Benito			•
San Bernardino			•
San Diego	•		
San Francisco			•
San Joaquin			•
San Luis Obispo	•		
San Mateo	•		

Santa Barbara			•
Santa Clara	•		
Santa Cruz	•		
Shasta			•
Solano		•	
Sonoma	•		
Stanislaus	•		
Sutter			•
Tehama			•
Trinity		•	
Tulare		•	

**Ban ordinance allows for one dispensary to remain open.

These counties did not have policies that addressed dispensaries and therefore are not listed in the table above: Del Norte, Imperial, Inyo, Lake, Marin, Mariposa, Mono, Monterey, Napa, Plumas, Sierra, Siskiyou, Tuolumne, Ventura, Yolo, and Yuba.

TABLE 7 SPECIFIC DISPENSARY REGULATIONS BY COUNTY

County	Definitions Provided	On- Site Cultivation	Odor Regulations	Compensation for Products
Alameda	•	NP	NA	NA
Calaveras	•	•	NA	NP
Modoc	•	(can sell clones)	NA	•
San Diego	•	•	NA	NA
San Luis Obispo	NA	NP	NA	NA
San Mateo	•	•	NA	(only for caregivers' services)
Santa Clara	•	•	NA	(distribute only)
Santa Cruz*	•	NA	•	(cash, in-kind contributions, reimbursements, and compensation)
Sonoma	•	NA	•	(distribute only)
Stanislaus	•	NP	NA	(distribute only)

Key:

• = permitted

NP= not permitted

NA= not addressed in ordinance

* known as cooperatives in ordinances not dispensaries

TABLE 8 ONSITE DISPENSARY REGULATIONS BY COUNTY

County	Receive Product from Collective or Patients	On-Site Consumption	Edibles Sold	Edibles Consumed On-Site
Alameda	NA	NP	NA	NP
Calaveras	NP	NP	NA	NP
Modoc	NA	NP	NA	NP
San Diego	NA	NA	NA	NA
San Luis Obispo	NA	NA	NA	NA
San Mateo	•	NP	NP	NP
Santa Clara	NA	NP	NA	NP
Santa Cruz*	NA	NP	NA	NP
Sonoma	NA	NP	NA	NP
Stanislaus	NA	NP	NA	NP

Key:

• = permitted

NP= not permitted

NA= not addressed in ordinance

* known as cooperatives in ordinances not dispensaries

TABLE 9 DISPENSARY REGULATIONS FOR MINORS BY COUNTY

County	Persons Under 18 Permitted to be Employed	Patient Under 18 Permitted to Enter	Patient Under 18 Permitted only with Guardian
Alameda	NP	NP	NP
Calaveras	NP	•	•
Modoc	NP	NP	NP
San Diego	NA	NA	NA
San Luis Obispo	(persons under 21 not permitted)	NP	•
San Mateo	NP	NP	•
Santa Clara	NA	NA	NA
Santa Cruz*	NP	NA	NA
Sonoma	NP	NP	NP
Stanislaus	NP	NP	NP

Key:

• = permitted

NP= not permitted

NA= not addressed in ordinance

* known as cooperatives in ordinances not dispensaries

TABLE 10 INTERNAL DISPENSARY REGULATIONS BY COUNTY

County	Delivery Permitted	Not Permitted to Employ Felons	Paraphernalia Sold On-Site	Only Permitted in Certain County Zones
Alameda	NP	•	NP	Commercial or Industrial Zoning Districts
Calaveras	NP	NA	NA	CP Professional Office Zoning District
Modoc	NA	NA	NP	Commercial Zoning District
San Diego	NA	NA	NA	M50, M52, M54, or M58 Zoning Districts
San Luis Obispo	NA	NA	NP	Outside of CBD Zoning District
San Mateo	NP	•	NP	NA
Santa Clara	NP	NA	NA	CN, CG, MH, and ML Zoning Districts
Santa Cruz*	NA	NA	NA	PA, C-1, C-2, and C-4 Zoning Districts
Sonoma	NA	NA	NA	C1, C2, and LC Zoning Districts
Stanislaus	NP	NA	NP	C-2 and M Zoning Districts

Key:

• = permitted

NP= not permitted

NA= not addressed in ordinance

* known as cooperatives in ordinances not dispensaries

TABLE 11 EXTERNAL DISPENSARY REGULATIONS BY COUNTY

County	Alcohol Not Permitted On-Site	Security Regulations	Limit Number of Dispensaries	Require Dispensary Permits	Require Fees from Dispensary
Alameda	•	•	•	•	•
Calaveras	•	•	NP	•	•
Modoc	•	•	NP	•	•
San Diego	NA	•	NP	•	•
San Luis Obispo	NA	•	NP	•	•
San Mateo	NA	•	NP	•	•
Santa Clara	NA	NA	NP	•	•
Santa Cruz*	NA	•	NP	•	•
Sonoma	•	•	NP	•	•
Stanislaus	•	•	•	•	•

Key:

• = permitted

NP= not permitted

NA= not addressed in ordinance

* known as cooperatives in ordinances not dispensaries

TABLE 12 DISPENSARY REGULATIONS FOR PATIENTS BY COUNTY

County	Require Patients to have ID Card or Written Dr.'s Recommendation with a Photo ID OR Must Be a Caregiver	Quantity of Product Limited by Number of Patients	Limited to Non-Residential; must be 1000-300 feet from schools, parks, and other facilities where the primary participant is Under 18	External Signage Not Permitted OR Limited	No Outside Advertisements
Alameda	•	•	•	NA	NA
Calaveras	NA	•	•	•	NA
Modoc	•	•	•	•	NA
San Diego	NA	NA	•	•	NA
San Luis Obispo	NA	NA	•	NA	NA
San Mateo	•	•	•	•	•
Santa Clara	•	NA	•	•	NA
Santa Cruz*	•	NA	•	•	•
Sonoma	•	•	•	•	•
Stanislaus	•	•	•	•	NA

Key:

• = permitted

NP= not permitted

NA= not addressed in ordinance

* known as cooperatives in ordinances not dispensaries

TABLE 13 DISPENSARY OPERATING REGULATIONS BY COUNTY

County	Adequate Parking Demanded	Permitted to Provide Extra Social Services	Regulated or Limited Business Hours	Can't See Anything From Outside Dispensary
Alameda	NA	NA	•	•
Calaveras	•	NA	•	•
Modoc	NA	NA	•	NA
San Diego	•	NA	NA	•
San Luis Obispo	NA	NA	•	•
San Mateo	NA	NA	NA	•
Santa Clara	NA	NA	•	NA
Santa Cruz*	•	NA	•	•
Sonoma	NA	NA	NA	NA
Stanislaus	NA	NA	•	NA

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TABLE 14 DISPENSARY REGULATIONS PUNISHABLE BY FINE BY COUNTY

County	Punishment is a Misdemeanor for these Offenses	Litter Removal Required	Maintain Records and/or Registry	Require Labeling of Dispensary Products
Alameda	NA	•	•	•
Calaveras	•	NA	•	NA
Modoc	NA	NA	•	NA
San Diego	NA	NA	NA	NA
San Luis Obispo	NA	NA	NA	NA
San Mateo	•	NA	NA	NA
Santa Clara	NA	NA	NA	NA
Santa Cruz*	NA	•	•	NA
Sonoma	NA	NA	•	NA
Stanislaus	NA	NA	•	•

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TABLE 15 DISPENSARY LIMITS AND INSPECTIONS BY COUNTY

County	Limit Number of Patients a Dispensary Can Serve	Inspections Performed By:
Alameda	NP	County Board of Supervisors and Sheriff
Calaveras	NP	Planning Director and Planning Department
Modoc	•	County Board of Supervisors and Sheriff
San Diego	NP	County Board of Supervisors and Sheriff
San Luis Obispo	NP	County Board of Supervisors and Sheriff
San Mateo	NP	County Board of Supervisors and Sheriff
Santa Clara	NP	Planning Office, Public Health Department, and Sheriff
Santa Cruz*	NP	Planning Director and Sheriff
Sonoma	NP	County Board of Supervisors and Sheriff
Stanislaus	NP	Sheriff, Department of Planning and Community Development, and Health Services

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