Local Implementation of Medical Marijuana:

Lessons for International Policymakers from California [a]

by

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Abstract:

Controversial policies are difficult to implement in every country. In the United States, policy implementation can require coordination between national, state, and local regulations. However, these policy makers often have different perspectives on controversial issues, including medical marijuana. These conflicts have led to inconsistencies between national, state, and local regulations, resulting in deep-rooted uncertainty. In the U.S., California was a pioneer in the decriminalization of medical marijuana. As such, there was no precedent for the laws and regulations implementing this policy, and many aspects of these policies remain unclear or even contradictory across the local, state, and federal levels. While the policies remain unclear, what is clear is the large efficiency cost this uncertainty has imposed on local officials and medical marijuana users alike. The vagueness of California's medical marijuana laws has led to costly legal disputes between local, state, and federal actors, and medical marijuana collectives, growers, and users. This study describes the variance in policies that have emerged within California, so as to illustrate how communities have attempted to "manage" the medical marijuana issue. It provides an illustrative example of the variety of ways in which medical marijuana policies can emerge, even within a locality where the policy is at odds with federal law. To do this, we present findings from two complementary sources of data: (a) a search of local public ordinances pertaining to the supply, access, and use of medicinal marijuana; and (b) a survey of county-level public officials in California. Phone interviews were conducted with representatives from both public health and law enforcement agencies. These interviews were designed to elicit information about the existence of both formal and informal policies on medical marijuana, as well as changes in these policies over time. Results indicate that for some areas of regulation, such as the availability of an elective Medical Marijuana Identification Card, there is little variation in response across agencies and locations. In other areas, such as how much marijuana an individual is allowed to possess or cultivate, responses diverge sharply. We attempt to characterize the variation in policies across counties over time. We then compare the current context in California to other medical marijuana policies within the U.S. and abroad to draw broader lessons for regulating a policy that has widespread support in principle but not necessarily in practice.

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I. Background

In 1996, California pioneered the decriminalization of medical marijuana in the U.S. with the passage of Proposition 215, also known as the Compassionate Use Act of 1996. This law *"ensure(s) that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate…"* and that those *"who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction."*[1] However, the law does not address any channels through which marijuana may be supplied or obtained, instead leaving these responsibilities to the counties and cities of California.

Combined with federal law, which prohibits the manufacturing, distribution and dispensing of marijuana for medicinal purposes by listing it as a Schedule I controlled substance[2] under the federal Controlled Substances Act[3], the ambiguity in state law has left localities to take a trial and error approach to defining medical marijuana regulations. While some counties are primarily concerned with facilitating access for patients, others have attempted to create such tight restrictions that they amount to de facto prohibition. Most, however, are interested in a middle ground; enabling access for those who need it while acknowledging that "the potential of unregulated provision of marijuana … and the potential direct and indirect adverse effects of such uses, present a clear and present threat to the general public, health, safety and welfare."[4]

Local incremental adjustments have proven necessary for jurisdictions to determine how to effectively regulate medical marijuana. These regulations have largely taken the form of ordinance amendments and resolutions. Legal challenges to these regulations and thus further interpretation by the courts has resulted in a patchwork of county-level policy patterns. Contradictory rulings in the California court system regarding local jurisdictional power to permit, regulate, or ban cultivation and, most controversially, medical marijuana dispensaries has

[1] Cal. Prop. 215 (1996), *codified at* Cal. H. & S.C. 11362.5.

[2] "Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. Schedule I drugs are the most dangerous drugs of all the drug schedules with potentially severe psychological or physical dependence." - Office of National Drug Control Policy. Marijuana Resource Center: Federal Laws Pertaining to Marijuana.

[3] Title 21 United States Code (USC) Controlled Substances Act. Section 812. Schedules of Controlled Substances.

[4] Calaveras County Urgency Interim Ordinance No. 2811. Sept. 27, 2004.

meant that counties and cities face deep uncertainty with every attempt to enact regulatory policy.

The resulting legal inefficiency is costly to actors at the federal, state, county, organizational and individual levels. The former three spend significant time and resources struggling to define how authority is distributed and asserted by drafting legal documents, initiating court cases and implementing the resulting policies. Dispensaries and collectives lobby for permissive regulations and face legal costs when the policy landscape shifts against them. Medical marijuana patients are faced with the constant possibility that they will lose access to their medication due to dispensary bans in their jurisdiction or even arrest under federal law. Some community activists expend effort and resources to prevent the proliferation of storefront dispensaries with the allegation that they generate crime, increase marijuana use among youth, or otherwise negatively affect the community. Other activists work to keep these dispensaries in their communities. Each group of actors described here has mobilized significant resources and managed to influence policy via litigation or the initiative process – creating a constantly shifting policy landscape. Thus, it may not be surprising that studies of the impacts of the California policies on perceptions, use or harms generate somewhat mixed results depending on what years the policy is being evaluated.

In this paper we examine the current variation in local county ordinances within the state of California, demonstrating the extent to which ambiguities in the 1996 state law has generated a myriad of alternative local systems that attempt to protect patients' rights or community positions regarding the state policy. The exercise demonstrates how differently a vague law might be interpreted and implemented, and demonstrates through a few select examples how susceptible local regulations are to differential interpretations of Federal law, State law and local interest groups (for or against the policy). Finally, we attempt to put into context the findings of the California experience within the international context of marijuana policy experimentation. To our knowledge, our project is the first to consider how localities formulate and enact regulation broadly within a conflicting federal and state legal framework. While we focus on counties only in this work, future work will also consider the regulatory efforts of cities, another critical actor in defining medical marijuana policy.

II. Analysis of County Medical Marijuana Policies in California

Within California, counties have a distinct, albeit limited, sphere of control in which they can create policy. Under the California state constitution, "[a] county or city may make and enforce within its limits all local, police, and other ordinances and regulations not in conflict with general laws."[5] This provision creates a broad grant of power with two significant qualifications. First, a county can only enforce ordinances and regulations within its sphere of political control. Consequently, county ordinances are only effective within the areas of the county that have not been incorporated as a city. Second, counties cannot pass ordinances that conflict with state laws. However, within these restrictions, counties have far-reaching powers to make ordinances, and they have exercised these powers to craft a wide variety of policies regarding medical marijuana.

In order to construct a picture of the state of local law in every California county over time, we began by searching for every county-level law regarding medical marijuana that had been enacted since the state law was adopted in November 1996. Because county-level laws are generally not included in commercially available legal databases, we conducted internet searches to find ordinances and resolutions, and associated passage information. The availability and completeness of this information varied greatly between counties: some counties had comprehensive, searchable databases containing all county-level laws, while no information regarding passed ordinances or resolutions could be found in others. Where information describing an ordinance and its passage was available (generally in the minutes from Board of Supervisors' meetings) but the ordinance itself was not, the available information regarding the ordinance was used. As a result, our analysis is limited to the 49 out of 58 counties in which some information regarding ordinances or resolutions could be obtained. The remaining 9 counties – Alpine, Imperial, Monterey, Sierra, Plumas, Siskiyou, Tuolumne, Ventura, and Yolo – are geographically and demographically diverse, ranging in population size from 1,175 (in Alpine) to 823,318 (Ventura).[6]

Once we obtained the most complete sample of county-level ordinances possible, we used systematic content analysis to draw out important information regarding medical marijuana

[5] Cal Const. Art. XI, § 7.
[6] 2010 U.S. Census, *available at* http://www.census.gov/popfinder/

cultivation, distribution, and consumption. Specific dimensions of interest we examined for each of these main activities included the following: licensing requirements and restrictions, permitting process and fees, agency responsible for oversight, operational requirements, and penalties for violations. Based on information related to these specific dimensions, we constructed and analyzed 29 different variables allowing us to examine the variation not just in the existence of particular dimensions but the level of detail provided. Table 1 provides an overview of a few key dimensions for the 8 largest counties (in terms of population) within the state, and 3 smaller counties.

While it may seem odd that such laws exist given they conflict with federal laws, local jurisdictions have an incentive to specify rules on the cultivation/production and distribution mechanisms for medical marijuana in an attempt to protect patients and assist local law enforcement. By allowing home cultivation, medical marijuana patients are not subjected to federal laws prohibiting the distribution and sale of marijuana. Furthermore, if localities impose restrictions on maximum cultivation quantities, they reduce the risk of federal prosecution for patients since the likelihood of arrest and associated penalties are lower for small amounts of marijuana. However, the ability to enforce home cultivation regulations is difficult for local, state, and federal law enforcement, especially if permits are not uniformly required for all cultivation (Pacula et al., 2002). Additionally, statutes may not reflect actual enforcement within each jurisdiction (Pacula et al., 2003). This is the case in California, as several jurisdictions require no permit for individual cultivation, while those that do have various permit requirements and issuing agencies. Local law enforcement is left to decide on a case-by-case basis whether a particular instance of cultivation is operating in compliance with local regulations.

Some California counties and cities have passed ordinances to allow individual and collective or cooperative cultivation, sometimes requiring permits issued by various local governing bodies. When individual cultivation is concurrently allowed, organized production becomes more difficult to regulate since it is not easily discernible from which source the marijuana originated, or whether that source was compliant (Caulkins et al., 2011). Further, when laws do not specifically address sources of medical marijuana, it becomes difficult for law enforcement to differentiate between legitimate and illegitimate users. (Pacula et al., 2002).

Table 1:

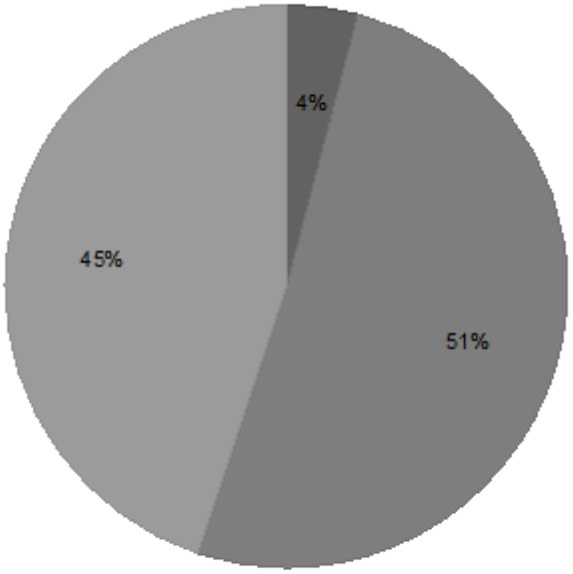
County	*Population*	*Cultivation Allowed*	*# of Plants*	*License/permit required for distribution*	*Licensing Agency*	*Possession Limits*
Los Angeles	10,441,080	Yes	N/S	Yes	Zoning Agency	N/S
San Diego	3,224,432	Yes	N/S	Yes	Law Enforcement Agency	N/S
Orange	3,166,461	Not Specified	N/S	Not Specified	N/A	N/S
Riverside	2,139,535	Not Specified	N/S	Not Specified	N/A	N/S
San Bernardino	2,073,149	Yes	N/S	Not Specified	N/A	N/S
Santa Clara	1,880,876	Not Specified	N/S	Not Specified	N/A	N/S
Alameda	1,574,857	Not Specified	N/S	Yes	Law Enforcement Agency	N/S
Sacramento	1,445,327	Not Specified	N/S	Not Specified	N/A	N/S
Santa Cruz	272,201	Yes	N/S	Yes	Zoning Agency	N/S
Butte	221,786	Yes	Depends on plot size	Not Specified	Not Specified	N/S
Humboldt	134,623	Yes	50 sq. feet or less	Yes	Zoning	3 lbs.

Cultivation Restrictions

We first investigated county-level attempts to regulate the cultivation of medical marijuana. 22 out of 49 observed counties (51%) currently do not address cultivation at the local level at all. The counties that currently do not regulate medical marijuana cultivation are a diverse group, and include counties that have actively sought to regulate other aspects of medical marijuana supply and use (including Riverside) and those that have barely engaged the issue

(including Marin). Additionally, 2 out of 49 counties (4%) explicitly prohibit medical marijuana cultivation, while the remaining 25 (45%) allow some form of cultivation (See Figure 1). However, the decision to explicitly allow or prohibit the cultivation of medical marijuana is only the beginning of the story: counties also enact and implement various policies to regulate medical marijuana cultivation and mitigate potential problems associated with these activities.

Figure 1: County Rules on Medical Marijuana Cultivation



Counties may create licensing or permitting regimes to facilitate regulation of medical marijuana cultivation, and 16% (4 out of 25 that allow some form of cultivation) have done so at some point. For example, San Bernardino County requires that, "[b]efore commencing the cultivation and/or distribution of medical marijuana, operators of those facilities . . . shall register with Land Use Services, and renew said registration on an annual basis."[7] Similarly, San Diego County requires that medical marijuana collective facilities, including any location at which members of a medical marijuana collective collectively or cooperatively cultivate" medical marijuana,[8] obtain a license from the Sheriff's office before undertaking activities. Additionally,

[7] San Bernardino County, California, Ord. No. 4140 § 3 (2011).
[8] San Diego County, California, Ord. No. 10120 § 5 (2011).

some counties have placed limits on the amount of medical marijuana that can be cultivated at one grow site.

Of the 25 localities that allow some form of medical marijuana cultivation, 11 place some sort of restriction on the amount of medical marijuana that can be grown. These restrictions generally take the form of a limitation on either the absolute number of plants that can be grown or the area in which medical marijuana can be cultivated. For example, cultivation sites in Mendocino may only grow up to 25 plants, while patients and caregivers growing medical marijuana in Trinity may only grow medical marijuana within a specific area that depends on the size of the plot.

Local level regulations may also specify whether cultivation should be conducted indoors or outdoors. Counties do not appear to adopt uniform policies on indoor or outdoor cultivation: 24% (6 out of 25) localities that allow cultivation do not address either whether this cultivation should take place indoors or outdoors, 16% (4 out of 25) specify that cultivation can only take place indoors, 8% (2 out of 25) allow outdoor cultivation without addressing indoor cultivation, and 40% (10 out of 25) explicitly specify that cultivation can occur in either location. However, restrictions on indoor cultivation are generally fewer. Of the 25 counties that allow medical marijuana cultivation, 48% (12 out of 25) allow some form of outdoor cultivation; 58% (7 out of 12) of those counties that allow outdoor cultivation of medical marijuana do so only if the cultivation is concealed from the general public. In contrast, 68% (17 out of 25) of counties that allow cultivation explicitly allow for indoor cultivation, while the remaining32% (8 out of 25) are silent on the matter.

In order to minimize the potential risk to the general public, some localities have taken the additional step of requiring medical marijuana grow sites to undertake security precautions. Of the 25 counties that allow medical marijuana cultivation, 36% (9 out of 26) of counties require such security provisions, while the remaining 62% (16 out of 26) counties do not address security requirements. This implies that a significant number of counties believe that medical marijuana cultivation engenders criminal activity or other harms and have sought to ameliorate some of the negative consequences without preventing cultivation entirely. Furthermore, this

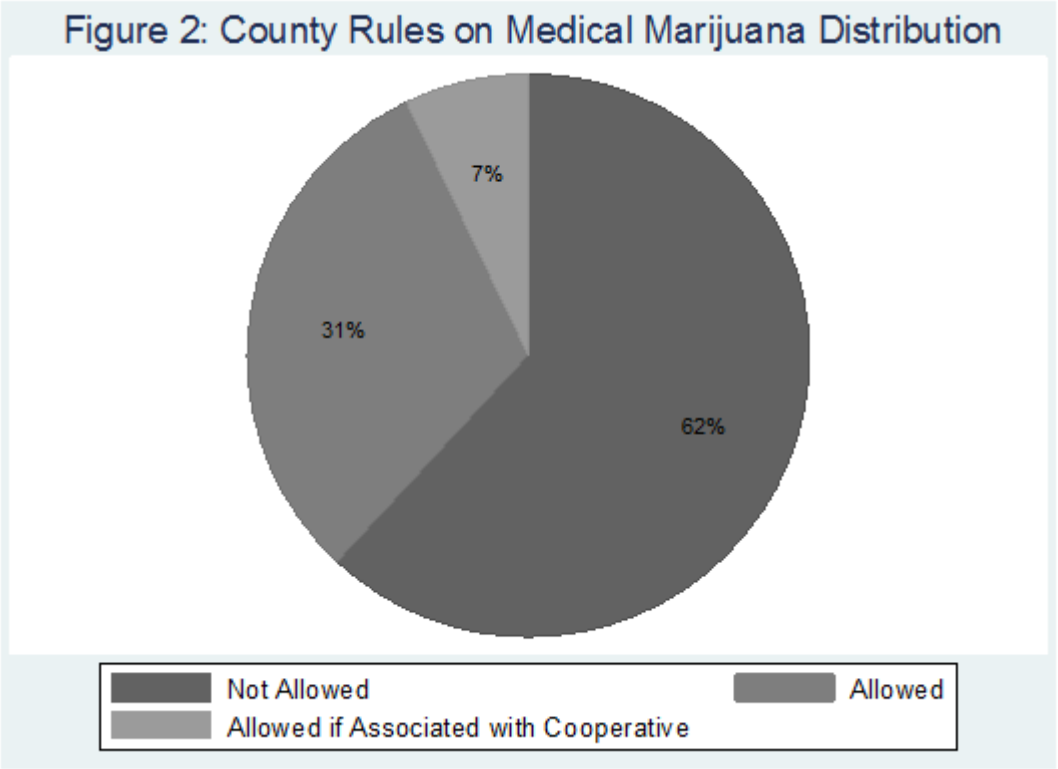
suggests that at least some counties have attempted to weigh the corresponding interests of patients in obtaining medical marijuana and the public interest in safety.

Distribution Restrictions

We also investigated trends in county-level distribution restrictions. In contrast to cultivation, counties far more actively regulate distribution. While 7 out of 49 counties do not address distribution, 26 of the remaining 42 counties (62%) explicitly prohibit dispensaries, 13 or 31% of the 42 allow dispensaries without additional caveats, and 3 or 7% of 42 allow dispensaries only when they are associated with a cooperative or collective. (See Figure 2) Within the 26 counties that explicitly prohibit medical marijuana dispensaries, most (77% or 20 of the 26) do not specify the penalty for violation of the ban. In 4% of these counties (1 out of 26), the highest penalty allowable for non-compliance is a fine; in 8% (2 out of 26), the highest penalty allowable is abatement; in 15% (3 out of 26), some more severe penalty may be allowed, such as using "any and all remedies available" to punish violations of the medical marijuana dispensary ban.[9] All four counties allowing the most severe penalty for violations of the medical marijuana dispensary ban (Amador, Butte, El Dorado, Kings) are smaller counties without major metropolitan centers that might need stricter penalties to enforce their ordinances in a less populated area. However, further research is needed before any definitive conclusions can be drawn about factors that might make counties inclined to pass strict penalties for violations of medical marijuana dispensary bans.

Some counties have placed limitations on the methods by which a medical marijuana dispensary can obtain marijuana. In 13 out of 16 counties that explicitly allow medical marijuana dispensaries, there is no discussion of the sources from which a dispensary may obtain marijuana. The remaining 3 counties require that medical marijuana dispensaries only distribute marijuana grown by their members. For example, Santa Cruz passed an ordinance in 2011 which required that "the marijuana used in the products dispensed by the cooperative shall be grown locally only."[10]

[9] Butte County, California, Ord. No. 4037 (2012).
[10] Santa Cruz County, California, Ord. No. 5090 (2011).



Counties have attempted to regulate medical marijuana dispensaries in several other ways. First, 19% of counties that allow medical marijuana dispensaries (3 out of 16) have placed outright limitations on the number of dispensaries, either by establishing a limit on the number of allowable dispensaries, or limiting allowable dispensaries to those in existence when the ordinance took effect. Second, 81% of counties that allow retail sales of medical marijuana (13 out of 16) require a permit or a license to operate a dispensary. However, even among counties that require a permit to operate a dispensary, there is additional variation in the governmental body that issues the permit and the requirements that must be met to obtain a permit.

The counties that require dispensaries to obtain permits vary greatly, and include some of the counties that have the longest and most involved history with medical marijuana, including Alameda and Humboldt counties. Within the counties that require dispensaries to obtain permits, most (62% or 8 of 13) issue permits through a zoning board or an equivalent entity, with rest issuing permits through a law enforcement agency (15% or 2 out of 13), a public health agency (15% or 2 out of 13), or some other type of agency (8% or 1 out of 13). The choice of permitting body may have a subtle but meaningful impact on the way the permit requirements are enforced:

zoning boards may be more accustomed to negotiating with permit applicants, while law enforcement may take a more adversarial stance. Furthermore, the choice of permitting body suggests the context in which the county views medical marijuana.

Some counties have developed operating requirements for dispensaries: mandatory standards for organizations operating as medical marijuana dispensaries. These requirements can be extremely detailed. For example, Shasta County has set forth operating requirements that include the number of parking spaces that must be provided, minimum standards for litter removal, and the prohibition of persons loitering near the entrance of dispensaries. Of the 16 counties that allow medical marijuana dispensaries, 13 require that the dispensaries comply with operating requirements, while 3 have no such requirement. Often, operating requirements must be complied with as part of a permitting process. It is therefore unsurprising that 85% (11 out of 13) of counties that require medical marijuana dispensaries to obtain a permit also have operating requirements, while only 67% (2 out of 3) of counties that allow medical marijuana dispensaries without permits have operating requirements.

Additionally, counties may require that dispensaries meet certain security requirements, in order to minimize crime associated with dispensaries. For example, a county may mandate that a dispensary install an alarm system, surveillance cameras, or hire a private security guard. Of the 16 counties that allow medical marijuana dispensaries, 10 have security requirements. Just like operating requirements, counties often mandate security requirements during the permitting process. Consequently, 69% (9 out of 12) of counties that require a permit to operate a medical marijuana dispensary also have security requirements, while only 33% (1 out of 3) of counties that explicitly allow medical marijuana dispensaries without a permit have security requirements. Furthermore, counties that require security provisions for dispensaries may be inclined to require security provisions in other parts of the supply chain: 67% (4 out of 6) of counties with security requirements for marijuana grow sites also have security requirements for dispensaries.

Consumption Restrictions

Finally, counties may enact policies that either facilitate or restrict medical marijuana consumption and possession by patients, and possession by primary caregivers. Primary caregivers, defined as "the individual designated by the [patient] . . . who has consistently

assumed responsibility for the housing, health , or safety of that person," also enjoy protection from prosecution under California state law.[11] These restrictions are far less common than those relating to cultivation or distribution; 13 out of 49 counties do not address consumption of medical marijuana by patients, instead relying exclusively on state laws to facilitate and regulate consumption. The remaining 36 counties all explicitly allow the consumption of medical marijuana.

Similarly, 43 counties either do not address possession of medical marijuana by patients and caregivers, or discuss it but do not place limits on the quantity of medical marijuana that can be possessed. Of the 6 remaining counties, 67% (4 out of 6) have explicit limitations on the quantities of medical marijuana that can be possessed ranging from 8 ounces (Tulare) to 3 pounds (Humboldt). The remaining 33% (2 out of 6) of counties that restrict the possession of medical marijuana by patients and caregivers either frame these limitations in terms of a "reasonable" amount of medical marijuana or provide some other form of restriction on possession that does not depend on quantity.

Finally, state law mandates that "[e]very county health department, or the county's designee, shall" administer a state medical marijuana ID card program by, among other things, "[p]rovid[ing] applications upon request to individuals seeking to join the identification card program" and "[i]ssu[ing] identification cards . . . to approved applicants and designated primary caregivers."[12] These ID cards are voluntary,[13] and intended to provide medical marijuana patients and caregivers a convenient method of verifying their status to law enforcement officers. Virtually all counties have implemented these ID card programs. The exceptions are Colusa and Sutter counties.

The contrast between the regulation of consumption and either cultivation or distribution of medical marijuana by counties in California highlights a central tension in medical marijuana policy throughout the nation: while the public is broadly supportive of medical marijuana use among qualified patients, they remain deeply uncomfortable loosening the channels through which medicinal marijuana can be supplied to patients.

[11] Cal. Prop. 215 (1996), *codified at* Cal. H. & S.C. 11362.5.
[12] Cal. S.B. 420 Sec.2, *codified at* Cal. H & S.C. 11362.71(b)
[13] *Id.*

III. Responses to County Regulations

As counties seek to formulate a legally and socially acceptable set of regulations for medical marijuana within a vague and often conflicting legal framework, they have been met with complications on nearly all sides. Federal agencies have exercised their authority to enforce marijuana as an illegal drug; medical marijuana advocates have launched lawsuits against counties to overturn bans on dispensaries; and community activist groups have formed to challenge the legalization of medical marijuana and the location of dispensaries.[14] All the while, the California Supreme Court has yet to take a stance on the rights of counties and cities to regulate medical marijuana facilities, and state intermediate appellate courts has issued inconsistent rulings on the matter.

At the federal level, the Drug Enforcement Administration (DEA) is the sole federal agency dedicated exclusively to drug law enforcement.[15] Under this authority, the DEA specifically targets cultivation and trafficking of marijuana, "even in states that have approved the use of 'medical' marijuana."[16] Federal law authorizes the DEA to investigate and prosecute medical marijuana cultivation and distribution operations[17], regardless of state or local statutes.

One such example of federal enforcement in a locality that permitted cultivation is the case of Mendocino County, which drafted and enacted Ordinance No. 4291 in April 2010. This ordinance allowed cultivation of up to 25 plants by registered individuals or collectives, with the possibility of an exemption permit issued by the Sheriff to grow more than 25 plants.[18] Eighteen growers signed up in the first year, and the DEA responded swiftly, raiding the farm of the first registered grower.[19] Despite this federal action, a reported 91 collectives applied for and were granted permits to grow up to 99 plants in the following year. In March 2012, the U.S. Attorney for the Northern District of California threatened legal action against the program and county officials, leading to an amendment to the ordinance to no longer allow exemption permits. In

[14] Coalition for a Drug Free California – Programs.
[15] U.S. Department of Justice. (2013) DEA Fact Sheet.
[16] U.S. Department of Justice. (2011) The DEA Position on Marijuana.
[17] U.S. Department of Justice. DEA Marijuana News Releases.
[18] Mendocino County, California, Ord. No. 4291 (2012).
[19] Mozingo, Joe. "Mendocino County spars with feds over conflicting marijuana laws." *Los Angeles Times*. Jan. 20, 2013.

October 2012, the U.S. Attorney's Office issued subpoenas to the county, requesting information on all permit holders and inspectors, inspections, communications with permit applicants, and account numbers for funds received through the program. In response, Mendocino County hired an attorney to represent the county in the handling of the subpoena.[20] As of March 2013, four U.S. District Court hearings had been delayed as the U.S. Attorney and county grappled to find a mutually agreeable resolution.[21]

Federal involvement has also occurred in jurisdictions that have attempted to explicitly prohibit medical marijuana operations. In September 2006, Riverside County passed Zoning Ordinance Number 348.4423, prohibiting the establishment or operation of medical marijuana dispensaries by declaring them a non-permitted use in any zone classification.[22] Despite this ban, the Riverside Sheriff's Office found many storefronts throughout the county operating illegally without a license or permit.[23] County efforts to close the offending businesses via civil lawsuits proved only partially successful. In October 2012, the U.S. Attorney for the Central District of California began issuing warning letters to dispensaries threatening civil foreclosure, citing the illegality of marijuana under federal law.[24] At the time of this writing, the county and dispensaries were awaiting the first ruling of the California Supreme Court on whether local governments can ban dispensaries.[25]

The City of Los Angeles also provides a vivid illustration of how medical marijuana interest groups can affect policymaking. Beginning in 2005, the number of medical marijuana dispensaries in Los Angeles grew from only a handful to over 600 in just five years (Chang and Jacobson, 2013). During this period, hundreds of dispensaries opened without city council oversight, in spite of a moratorium to prohibit new dispensaries that were not registered prior to November 2007.[26,27] In January 2010, the city council approved Ordinance No. 181069 amid

[20] Revelle, Tiffany. "Mendocino Co. hires SF lawyer due to fed subpoena over marijuana." *The Ukiah Daily Journal.* Dec. 12, 2013.
[21] Downs, David. "Feds' Medical Pot Fishing Expedition Hits Mendocino Chop." *East Bay Express.* March 27, 2013.
[22] Riverside County, California, Ord. No. 378.4423 (2006).
[23] Interview with Riverside Law Enforcement. January, 2013.
[24] Moore, Corey and J. Small. "Crackdown on California pot dispensaries begins." *Southern California Public Radio.* Oct. 7, 2011.
[25] Mach, Andrew. "California Supreme Court to weigh cities' bans on medical marijuana." *NBC News.* Feb. 5, 2013.
[26] Lopez, R.J. "Map shows L.A. pot dispensaries slated to shut down." *Los Angeles Times.* May 5, 2010.

complaints from neighborhood activists.[28] This statute capped the number of collectives in the city at seventy, and would have the effect of closing over 400 dispensaries that had opened in violation of the moratorium. Compliant dispensaries that were registered with the city before the moratorium were allowed to continue operations.[29] However, the ordinance never came into effect as over 100 dispensaries filed more than 40 lawsuits against the city to challenge its constitutionality. In December 2010, the Los Angeles County Superior Court ruled against the city, leaving them with little regulatory control over dispensaries.[30]

The battle continued in 2011 as the City of Los Angeles opened lawsuits against dispensaries that violated regulations requiring minimum distances from schools.[31] In early 2012, the city council unanimously voted to pass an ordinance that would ban all dispensaries, citing the rapid growth of storefronts across the city and violations of distance requirements. Mayor Antonio Villaraigosa and the Los Angeles Police also gave vocal support to the ban.[32] Once again, proponents of medical marijuana launched a campaign to prevent the ordinance from enactment, acquiring 50,000 signatures on a petition forcing a referendum on the ban. This time, however, the city council overturned its own initiative in October 2012 with an 11-2 vote.[33] Currently, a 'gentle-ban' ordinance is scheduled to appear on the ballot in May 2013 in Los Angeles containing similar language to the one defeated in 2010, and an increase in taxes on medical marijuana sales. Representatives of pre-moratorium dispensaries have thrown their support behind the city's new proposal, with the hope that they would have better chances of protection under the city's plan.[34] However, medical marijuana activists appear prepared to pursue another referendum against the ordinance, should it be passed.[35]

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[27] Americans for Safe Access. Los Angeles Interim Control Ordinance (Moratorium).
[28] Hoeffel, J. "Judge issues injunction against L.A.'s medical marijuana law." *Los Angeles Times*. Dec. 11, 2010.
[29] Los Angeles, California, Ord. No. 181069
[30] Hoeffel, J. "Judge issues injunction against L.A.'s medical marijuana law." *Los Angeles Times*. Dec. 11, 2010.
[31] Hoeffel, J. "L.A. sues to force pot dispensaries to close." *Los Angeles Times.* Dec. 2, 2010.
[32] Miles, K. "LA Marijuana Dispensary Ban Approved by Council, Expected to go into Effect in 30 Days." *Huffington Post.* July 24, 2012.
[33] Miles, K. "LA Medical Marijuana Dispensary Ban Repealed by City Council Vote." *Huffington Post.* Oct. 2, 2012.
[34] Linthicum, Kate. "Proponents of L.A. medical marijuana ballot measure shift support." *Los Angeles Times.* Jan. 28, 2013.
[35] Linthicum, Kate. "'Gentle ban' on pot shops sought by L.A. City Atty. Trutanich." *Los Angeles Times.* Jan. 13, 2012.

Rulings in trial level and intermediate appellate level courts have been more confusing than helpful as localities navigate the throng of lawsuits. A 2008 lawsuit by San Diego and San Bernardino counties set the stage for the ensuing slew of court battles when an appellate court ruled that counties could not invoke federal preemption under the Controlled Substances Act to reject their obligations under state law.[36] The counties had argued that the federal Controlled Substances Act had the effect of prohibiting them from regulating dispensaries under state law. Some subsequent cases have supported the localities' authority to allow, regulate, or ban medical marijuana establishments[37], while others have concluded that the operation of dispensaries was authorized under state law and could not be locally prohibited.[38,39,40] The contradictory findings of the courts throughout the state led the California Supreme Court to begin a review of these cases on February 5th, 2013[41]. The decision was pending at the time of this writing, but expected within 90 days of the hearing. A ruling by the Supreme Court will supersede the preceding findings of the lower courts and probably clarify the discretion that counties and cities have in regulating medical marijuana operations, after 17 years of near-constant lawmaking, litigation, and headache.

IV. California's Experience within the International Context

The fact that U.S. states are passing laws that not only decriminalize but also facilitate access to medical marijuana, thus contradicting a federal prohibition, is not entirely unique in the international realm. A few countries have demonstrated similar inconsistencies (or perhaps a better term is "flexibility") in the implementation of their own marijuana policies. The most well-known example is that of the Netherlands, where cannabis coffee shops have been permitted despite a federal prohibition on the cultivation and distribution of marijuana. A formal

[36] *County of San Diego et al., v. San Diego NORML et al., Wendy Christakes et al.* Super. Ct. Nos GIC860665, GIC861051 (Calif. 4th App. Dist. 2008)

[37] (1) *City of Corona v. Naulls* (2008) 166 Ca.App.4th 418; (2) *City of Claremont v. Kruse* (2009) 177 Cal.App.4th 1153; (3) *County of Los Angeles v. Hill* (2011) 192 Cal.App.4th 861. [*see* McEwen (2012)]

[38] McEwen, S.A., Esq. (2012) Public Law Update, March 2012: Medical Marijuana Update. Burke, Williams & Sorensen, LLP.

[39] *City of Lake Forest v. Evergreen Holistic Collective*, Super. Ct. No. 30-2009-00298887 (Calif. 4th App. Dist. 2012)

[40] Santschi, Darrell R., R.D. DeAtley, J. Horseman. "Riverside: Court rules county can't target pot dispensaries." *The Press-Enterprise.* Aug. 3, 2012.

[41] Mach, Andrew. "California Supreme Court to weigh cities' bans on medical marijuana." *NBC News.* Feb. 5, 2013.

policy of non-enforcement for the possession or sale of up to 30g was adopted in 1976 and subsequently reduced to 5g in 1995 amid domestic and international pressures. From 1976 to 1986, a set of regulations emerged that allowed coffee shops to avoid prosecution for selling small amounts of cannabis as long as they follow five rules, including (1) no advertising, (2) no hard drug sales, (3) no sales to minors, (4) no sales exceeding the quantity threshold, and (5) no public disturbances. In 1980 the Ministry of Justice decentralized implementation to local discretion, allowing differential levels of enforcement across cities and towns (*see* MacCoun & Reuter, 1997).

Spain presents another example, where the presence of cannabis social clubs has been tolerated since 2003 when the Spanish Supreme Court ruled that possession of even large amounts of cannabis is not a crime if there is no intent to traffic (and the clubs greatly expanded after a 2005 European Commission statement excluded cultivation of cannabis as a punishable offense if it is for personal consumption). With no clear channel of regulation or enforcement, the Spanish cannabis social clubs were left to develop their own legal and operational standards. However, the functions of these clubs have over time become fairly standardized, and some have even campaigned for oversight and regulation of the associations by public institutions, which would eliminate legal uncertainty (Barriuso, 2011).

Moreover, there are additional international examples of countries that specify in their national law that implementation can be determined at a more local level. In Australia, for example, states and territories retain authority for legislating and implementing their own marijuana policies under a Federal system, while federal involvement is limited to funding decisions based on compliance with the broad national goal of "minimize(ing) the harmful effects of drugs on Australian Society" [42] (Bammer et al., 2002). Of eight independent jurisdictions, four have removed criminal penalties for small-scale cultivation of up to 2 plants (Reuter, 2010). The higher courts of Australia have not ruled on a defense of necessity in relation to the cultivation of marijuana for medical use, and the issue is left to lower courts, where there remains potential for contradictory findings (Bogdanoski, 2010; *discussing* Heilpern and Rayner, n 128) A perhaps more surprising example is that of Germany, where despite a federal prohibition on marijuana, it is the *Länder* (states) that have the authority to set guidelines for the

[42] Australian Government National Drug Strategic Framework.

prosecution of cases involving possession or purchase of small amounts of marijuana for personal use. Interestingly, despite a 1994 Federal Constitutional Court ruling that differences in prosecution policies across *Länder* were an unacceptable violation of equal and non-discriminatory treatment, considerable variation still exists across the *Länder* because of differences in the interpretation and implementation of three federal criminal codes (Schäfer and Paoli, 2004; see also Körner, 1996; Pacula et al., 2004).

Interestingly, in the policy area of medical marijuana, the international examples have generally adopted a far more centralized national approach rather than regional or jurisdictional approaches used for decriminalization policy. Canada's 2001 policy is not all that different from elements of the laws adopted within the U.S. states, albeit with a lot more federal coordination. The possession and cultivation of medical marijuana is allowed if the patient/grower submits an application and it is approved by Health Canada. All patients must receive a patient identification card. Rules are specified for acceptable medical conditions in which marijuana can be used and the amount a person can be in possession of (30-day supply). The patient can either grow the cannabis at home or purchase it from a government sanctioned producer. However, Canada's Minister of Health released a statement in December 2012 describing a sweeping overhaul of the country's medical marijuana policy.[43] Citing public health, safety, and security concerns, the new regulations will prohibit all cultivation by the public and regulate marijuana like other medical narcotics. Beginning in March 2014, all distribution of marijuana will only be through authorized vendors that meet strict security requirements.

Canada's proposed prohibition of home cultivation and movement to selective producers that meet very strict rules and restrictions is consistent with medical marijuana models adopted more recently by both Israel and the Netherlands. Both countries allowed medical marijuana to exist only through a tightly controlled regulatory system operated through the federal ministries of health. Israel's Health Ministry approved domestic production in 2011[44], and all domestically produced medical cannabis is grown by eight growing operations[45] under the Health Ministry's supervision (Gieringer, 2012). The Netherlands, which has had a medical marijuana policy since

[43] Health Canada. "Harper Government Announces Proposed New Marihuana for Medical Purposes Regulations – Changes improve public safety, maintain patient access." Dec. 16, 2012.
[44] Siegel-Itzkovich, J. "Israel to grow medical cannabis to keep down prices." *Jerusalem Post.* July 29, 2011.
[45] Bohn, L.E. "Israel pushing ahead in medical marijuana industry." *Associated Press*. Nov. 3, 2012.

2001[46], has an even more restrictive production system with only one company, Bedrocan BV, contracted to supply all medicinal cannabis by the Ministry of Health, Welfare and Sport.[47]

With discussion of medical marijuana policy becoming more common in the international arena (Kilmer and Burgdorf, 2013), California can serve as an interesting natural laboratory of the variety of ways in which a system might develop in light of the enormous variation that has emerged across its 58 counties. However, it is also a reminder of the unintended consequence of vagueness in a policy, as the heterogeneity and ambiguity in policies has led to costly legal inefficiencies that could have been minimized with a few simple considerations.

V. Conclusion

In this paper we describe the ways that national and state policy has defined (or failed to define) the options available to California counties and cities for regulating local medical marijuana. The authority of these jurisdictions was unclear since the inception of California's Proposition 215, and subsequent court rulings further convoluted their options to regulate a medical marijuana industry that aggressively propagated in their communities.

An analysis of the local ordinances passed by counties illustrates the variety of approaches they have attempted to take in order to assert regulation, and the current state of county regulations. We also provide accounts of localities that have experienced particularly intense pressures from federal, state, and public actors to enact, repeal, or modify policy.

We also explain the costly confusion and inefficiencies that have developed as a result of ambiguity about the powers of local governments to enact medical marijuana laws and policy. This ambiguity about the legal status of medical marijuana under state law has likely increased costs and perhaps deterred legitimate businesspersons from entering into this market. The California Supreme Court is scheduled to soon make a ruling that may have the effect of clarifying these issues.

[46] Ministry of Health, Welfare and Sport Office for Medicinal Cannabis hompage.
[47] Bedrocan BV Homepage (translated).

Finally, we relate the complications of local medical marijuana policy in California to international contexts. Several relevant similarities emerge, and we suggest that countries that are fine-tuning or considering medical marijuana policies of their own could use California's experience as a reference for drafting policy that reduces the likelihood of legal inefficiencies or the formation of heterogeneous regulations from occurring in the local implementation of medical marijuana programs.

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