I MINA' TRENTA NA LIHESLATURAN GUÅHAN
2010 (Second) Regular Session

2010 JUN 17 PM 4:16

Bill No. 423-30 (cor)

Introduced by: **R.J. RESPICIO**

AN ACT TO AUTHORIZE AND REGULATE THE RECOMMENDING AND CERTIFYING OF THE USE OF MEDICINAL *CANNABIS* BY LICENSED PHYSICIANS TO PATIENTS WITH DEBILITATING MEDICAL CONDITIONS, AND TO CREATE CANNABIS DISPENSARIES, TO BE KNOWN AS "COMPASSIONATE CARE CENTERS," TO MAKE MEDICINAL *CANNABIS* AVAILABLE FOR SUCH PATIENTS. THIS ACT SHALL BE KNOWN AS "THE COMPASSIONATE HEALTH CARE ACT OF 2010."

BE IT ENACTED BY THE PEOPLE OF GUAM:

PART I – FINDINGS AND INTENT

Section 1. Legislative Findings of Fact. *I Liheslaturan Guåhan* lists the ten (10) following findings of fact:

1. **THE U.S. JUSTICE DEPARTMENT HAS ORDERED AGENTS TO STOP ARRESTING PATIENTS AND SUPPLIERS WHO FOLLOW STATE MEDICAL CANNABIS LAWS.** The United States Justice Department has issued guidelines ordering federal drug agents to cease arresting or charging patients, caregivers or suppliers who conform to state laws on medical cannabis. Attorney General Eric Holder has stated that under the Obama administration,

users and suppliers who are involved in only medicinal cannabis supply and use should be safe from Federal prosecution.

On October 19, 2009, Deputy Attorney General David W. Ogden released a *"Memorandum for Selected United States Attorneys" concerning "Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana."*

The Justice Department Memorandum states in part:

"As a general matter, pursuit of (significant traffickers of illegal drugs, including marijuana, and the disruption of illegal drug manufacturing and trafficking networks) should not focus federal resources in your States on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana. For example, **prosecution of individuals with cancer or other serious illnesses who use marijuana as part of a recommended treatment regimen consistent with applicable state law, or those caregivers in clear and unambiguous compliance with existing state law who provide such individuals with marijuana, is unlikely to be an efficient use of limited federal resources.**" (emphasis added).

On October 20, 2009, the Los Angeles Times reported on the new guidelines: "The Justice Department's guidelines ended months of uncertainty over how far the Obama White House planned to go in reversing the Bush administration's position, which was that federal drug laws should be enforced even in states like California, with medical marijuana laws on the books.

"The new guidelines tell prosecutors and federal drug agents they have more important things to do than to arrest people who are obeying state laws that allow some use or sale of medical marijuana."

Attorney General Holder said in a statement: "It will not be a priority to use federal resources to prosecute patients with serious illnesses or their caregivers who are complying with state laws on medical marijuana, but we will not tolerate drug traffickers who hide behind claims of compliance with state law to mask activities that are clearly illegal."

[Department of Justice Memorandum of Oct. 19, 2009, Subject: Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana" attached as exhibit 1]

[http://blogs.usdoj.gov/blog/archives/192]

[Los Angeles Times story attached as exhibit 2]

[http://articles.latimes.com/2009/oct/20/nation/na-medical-marijuana20]

2. TWENTY-SEVEN (27) JURISDICTIONS WITHIN THE UNITED STATES HAVE REFORMED THEIR CANNABIS LAWS. Since 1973, the District of Columbia and 26 states – Alaska, Arizona, California, Colorado, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Rhode Island, Vermont, Washington and Wisconsin -- in which about half of the U.S. population reside -- have passed a variety of laws to decriminalize *Cannabis Sativa* or *Indica* (marijuana or marihuana) and to permit the use of the plant for medicinal purposes. In most cases in these jurisdictions, doctors, suppliers and users of cannabis face neither jail time nor arrest or criminal records, for the recommending, certifying, possession, dispensing or use of a small amount of cannabis, often limited to one ounce for medicinal purposes.

3. COURTS HAVE RULED THAT DOCTORS WHO RECOMMEND OR CERTIFY THE USE OF CANNABIS ARE SAFE FROM PROSECUTION. On October 29, 2002, the Ninth Circuit

Court of Appeals unanimously upheld the right of doctors to recommend cannabis to their patients.

Chief Judge Mary M. Schroeder and Circuit Judges Betty B. Fletcher and Alex Kozinski affirmed that it is not the role of the federal government to regulate the practice of medicine. "The order enjoins the federal government from either revoking a physician's license to prescribe controlled substances or conducting an investigation of a physician that might lead to such revocation, where the basis for the government's action is solely the physician's professional 'recommendation' of the use of medical marijuana. The government has not provided any empirical evidence to demonstrate that this injunction interferes with or threatens to interfere with any legitimate law enforcement activities. The district court, on the other hand, explained convincingly ... how the government's professed enforcement policy threatens to interfere with expression protected by the First Amendment. We therefore affirm."

In October 2003, the U.S. Supreme Court, in Conant v. Walters, let the Ninth Circuit's ruling stand, the heart of the matter being the

First Amendment's protection of a physician's right to speak openly and candidly about cannabis' potential risks and therapeutic benefits.

According to the State of Hawaii's *Guide for Patients, Physicians and Caregivers:* "Physicians may therefore recommend medical marijuana to patients free from federal threats or interference as long as they do not do more than is required of them by the (State's medical marijuana) Act."

[Conant v. Walters Opinion attached as Exhibit 3.]

[Hawaii Guide attached as Exhibit 4.]

4. MANY PROFESSIONALS SUPPORT THE USE OF CANNABIS FOR CERTAIN MEDICINAL PURPOSES.

- "The evidence is overwhelming that [cannabis] can relieve certain types of pain, nausea, vomiting and other symptoms caused by such illnesses as multiple sclerosis, cancer and AIDS -- or by the harsh drugs sometimes used to treat them. And it can do so with remarkable safety. Indeed, [cannabis] is less toxic than many of the drugs that physicians prescribe every day." **FORMER U.S. SURGEON GENERAL JOYCELYN ELDERS, MD.**

- "The evidence in this record clearly shows that (cannabis) has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be unreasonable, arbitrary and capricious for DEA (U.S. Drug Enforcement Agency) to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record." **JUDGE FRANCIS L. YOUNG, DEA ADMINISTRATIVE LAW JUDGE.**
- "...there is very little evidence that smoking [cannabis] as a means of taking it represents a significant health risk. Although cannabis has been smoked widely in Western countries for more than four decades, there have been no reported cases of lung cancer or emphysema attributed to [cannabis]. I suspect that a day's breathing in any city with poor air quality poses more of a threat than inhaling a day's dose -- which for many ailments is just a portion of a joint -- of [cannabis]." **LESTER GRINSPOON, MD, EMERITUS PROFESSOR OF PSYCHIATRY, HARVARD MEDICAL SCHOOL.**
- "Patients receiving cannabinoids (smoked marijuana and marijuana pills) had improved immune function compared with

those receiving placebo. They also gained about 4 pounds more on average than those patients receiving placebo." DONALD ABRAMS, MD, ET AL. "SHORT-TERM EFFECTS OF CANNABINOIDS IN PATIENTS WITH HIV-1 INFECTION," ANNALS OF INTERNAL MEDICINE.

- "For some users, perhaps as many as 10 per cent, cannabis leads to psychological dependence, but there is scant evidence that it carries a risk of true addiction. Unlike cigarette smokers, most users do not take the drug on a daily basis, and usually abandon it in their twenties or thirties. Unlike for nicotine, alcohol and hard drugs, there is no clearly defined withdrawal syndrome, the hallmark of true addiction, when use is stopped." COLIN BLAKEMORE, PHD, CHAIR, DEPT. OF PHYSIOLOGY, UNIVERSITY OF OXFORD (U.K.), AND LESLIE IVERSEN, PHD, PROFESSOR OF PHARMACOLOGY, OXFORD UNIVERSITY.

5. CANNABIS IS SAFER THAN ALCOHOL AND CIGARETTES. Studies have shown cannabis to be safer than either alcohol or cigarettes, both of which are legal and available for adult consumption:

• **"Marijuana is far less addictive than alcohol and nicotine.** Cannabis is not physically addictive, it does not have long-term toxic effects on the body, and it does not cause its consumers to become violent." **JACK E. HENNINGFIELD, PHD FOR THE NATIONAL INSTITUTE ON DRUG ABUSE (NIDA).**

• **"Research concludes that alcohol and tobacco are more dangerous than some illegal drugs like marijuana."** Professor David Nutt, Bristol University, Great Britain, proposing a new framework for the classification of harmful substances, based on the actual risks posed to society. Using three factors (physical harm to the user, potential for addiction, and impact on society of the drug's use), Dr. Nutt asked psychiatrists specializing in addiction and legal/police officials with scientific or medical expertise – to assign scores to 20 different drugs, including cannabis, heroin, barbiturates, alcohol, cocaine, street methadone, ecstasy, tobacco, amphetamines, and LSD. Heroin and cocaine were ranked most dangerous, followed by barbiturates and street methadone.

Alcohol was the fifth-most harmful drug, and tobacco was the ninth. Cannabis came in 11th.

[http://www.cbc.ca/health/story/2007/03/23/alcohol-tobacco.html]

• **Cannabis is safer than alcohol or tobacco for pregnant women.** A study of the use of tobacco, alcohol, caffeine and cannabis during pregnancy reveals that tobacco and alcohol have negative effects on birth weight, size, and length and head circumference. In contrast, "neither cannabis nor caffeine use had a significant negative effect on any growth parameter." **P.A. FRIED AND C.M. O'CONNELL, DEPARTMENT OF PSYCHOLOGY, CARLETON UNIVERSITY, OTTAWA, ONTARIO, CANADA.**

[http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T9X-474X5WJ-3J&_user=10&_coverDate=04%2F30%2F1987&_rdoc=1&_fmt=high&_orig=search&_sort=d&_docanchor=&view=c&_searchStrId=1336529784&_rerunOrigin=google&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=46f19ecae6fe3b8998a86cd910191a60]

6. ENFORCEMENT COSTS FEDERAL, STATE AND LOCAL GOVERNMENTS ABOUT $10.1 BILLION ANNUALLY. According to research studies, including the Miron Report (see No. 10 below), legalizing cannabis would save $7.7 billion per year in

government expenditures on enforcement of prohibition, and would yield tax revenue of $2.4 billion annually if cannabis were taxed like all other goods. The total cost and revenue lost is estimated to be at least $10.1 billion annually. In a recent year, more people (about 829,000) were arrested for cannabis-based crimes, than the combined total arrested for all violent crimes, including murder, rape, robbery and aggravated assault.

7. **STRICT LAWS DON'T WORK AND DON'T REDUCE AVAILABILITY.** Cannabis continues to be illegal in many jurisdictions, which promotes illegal and on rare occasions, violent activities, that could be virtually eliminated through decriminalization. Despite strict cannabis laws in a number of states, the United States has the largest number of cannabis consumers of any country. Surveys taken across the United States have found that nearly a third (1/3) of the population, (about 100 million people) have acknowledged that they have used cannabis, and some 15 million consume cannabis each month. The percentage of Americans consuming cannabis is double the percentage of those that consume cannabis in the Netherlands, where the selling and possession of

cannabis is legal. Despite many decades and the arrest of many millions of non-violent cannabis consumers, laws have failed to deter cannabis users from consumption, or control cannabis, or reduce its availability.

One need only to look at America's history in the first half of the 20th Century for guidance on the results of forced prohibition: On January 16, 1920, the Eighteenth Amendment to the U.S. Constitution banned the sale, manufacture, and transportation of alcohol for consumption in America, which led to a rise in alcohol smuggling, caused an exponential growth in bootlegging, increased the power of organized crime gangs and syndicates, and cost our nation many lives while wasting many billions of dollars in futile attempts to prevent the consumption of alcohol.

On December 5, 1933, the ratification of the Twenty-First Amendment repealed prohibition, making the consumption of alcohol by adults legal once again, giving rise to the lawful, legally controlled, financially profitable and taxable adult beverage market that exists today.

8. RELAXED LAWS DON'T INCREASE USE. National Research Council studies of states where cannabis is decriminalized show little apparent relationship between severity of sanctions and the rate of consumption. Liberalized laws have neither contributed to an increase in cannabis consumption, nor negatively impacted adolescent attitudes toward drug use.

9. SURVEY SHOWS MOST AMERICANS SUPPORT LEGALIZING MEDICINAL CANNABIS. A national survey within the 48 states by the Pew Research Center for the People & the Press, conducted March 10-14, 2010 among 1,500 adults on landlines and cell phones, revealed that 73% favor allowing the sale and use of cannabis for medicinal purposes. 23% of respondents were opposed and 4% didn't know. The survey area did not include Alaska, Washington, D.C. and Hawaii, three jurisdictions in which medicinal cannabis programs have already been implemented.

[http://pewresearch.org/pubs/1548/broad-public-support-for-legalizing-medical-marijuana]

10. 2005 REPORT ESTIMATES MULTI-BILLION-DOLLAR ECONOMIC WINDFALL IF CANNABIS IS LEGALIZED AND TAXED. A research report published in 2005 by Harvard University

Economics Professor Jeffrey A. Miron examined the budgetary implications of taxing and regulating cannabis like other goods across the country and at the federal level, and estimated that legalizing cannabis would save $7.7 billion per year in government expenditures on enforcement of prohibition, and that $5.3 billion of this savings would accrue to state and local governments (including the Government of Guam), while $2.4 billion would accrue to the federal government.

Miron's report also estimated that legalization would yield tax revenue of $2.4 billion annually if cannabis were taxed like all other goods, and $6.2 billion annually if it were taxed at rates comparable to taxes on alcohol and tobacco. Miron concluded: "Whether cannabis legalization is a desirable policy depends on many factors other than the budgetary impacts ... but these (budgetary) impacts should be included in a rational debate about cannabis policy."

Nobel Laureate Economist Milton Friedman and 553 other distinguished economists and educators support the Miron report and have appealed for officials to take action. In an open letter in 2005 to then-President of the United States George W. Bush, the U.S.

Congress, State Governors, and State Legislatures they wrote: "We therefore urge the country to commence an open and honest debate about marijuana prohibition. We believe such a debate will favor a regime in which marijuana is legal but taxed and regulated like other goods."

[Miron Report attached as Exhibit 5.]

Section 2. Legislative Findings. As evidenced by the statements of fact in Section 1 of this act, *I Liheslatura* finds that:

(a) Laws criminalizing cannabis (marijuana or marihuana) have failed to control, reduce or eliminate usage;

(b) Many citizens in need of the therapeutic medicinal effects of cannabis have been denied this treatment because of outmoded laws;

(c) The federal government's former "prohibition" policies, and efforts to enforce criminal sanctions and penalties on users of cannabis, have proven to be a tremendous waste of criminal justice resources that could be better expended on more serious crimes;

(d) The Obama administration's progressive cannabis policy implemented in October, 2009, which calls for Federal officials to stop arresting or charging patients, caregivers or suppliers who conform with

state laws on medical cannabis, sends a clear signal to those jurisdictions without medicinal cannabis laws that they should begin to consider assisting their citizens who can be comforted through the use of this drug;

(d) For a number of years, efforts have been, and are being made in jurisdictions across the United States to implement a more sensible policy relative to cannabis usage;

(e) Medical and legal professionals have spoken out in favor of the medicinal use of cannabis;

(f) The compassionate national trend of relaxing laws relative to medicinal cannabis offers needed assistance and relief to many people across our country; and

(g) *I Liheslaturan Guahan,* as the lawmaking body for the people of Guam, has the duty to regulate laws relating to health, medical practices and well-being in a manner that respects the personal decisions made jointly by patients and their physicians concerning the relief of suffering, including the medicinal use of cannabis.

Section 3. Legislative Intent. Based on the findings listed in Section 2 of this Act, it is the intent of *I Liheslatura* to:

(a) Enact laws to permit licensed physicians to recommend and certify patient use of cannabis for medicinal purposes;

(b) Permit the licensing of cannabis dispensaries, in order to produce medicinal cannabis to fill recommendations and certifications for licensed medicinal cannabis patients;

(c) Permit certain individuals, including providers, caregivers and qualifying patients, to engage in the cultivation, harvesting and preparation of cannabis for authorized sale and medicinal use;

(d) Eliminate penalties for the simple possession and/or use of cannabis by individuals 18 or more years of age, in the amounts and under the conditions delineated in this act;

(e) Provide restrictions on the public use of cannabis; and

(f) Change the inclusion of "cannabis (marijuana or marihuana)" from Guam's Schedule I list of Controlled Substances to Guam's Schedule V list of Controlled Substances.

It IS NOT the intent of *I Liheslatura* to:

(a) Affect the application or enforcement of the laws of Guam relating to public health and safety or protection of children and others relative to the following:

i. possession on school grounds;

ii. relative to minors;

iii. relative to chemical production;

iv. relative to loitering to commit a crime or acts not authorized by law;

v. relative to driving while under the influence;

vi. relative to contributing to the delinquency of a minor; or

(b) Affect the application or enforcement of the laws of Guam prohibiting use of controlled substances in the workplace or by specific persons whose jobs involve public safety.

PART II – COMPASSIONATE HEALTH CARE POLICY

Section 1. "THE COMPASSIONATE HEALTH CARE ACT OF 2010." ***A New*** **Article 23 is** ***added*** **to Title 10 Guam Code Annotated Chapter *12* to read:**

"ARTICLE 23.

THE COMPASSIONATE HEALTH CARE ACT OF 2010.

§122301. Title of Act.

This Act shall be known as "The Compassionate Health Care Act of 2010."

§ 122302. Definitions.

For purposes of this Article, the following words and phrases have been defined to mean:

(a) ***"Adequate supply"*** shall mean an amount of cannabis jointly possessed between the qualifying patient and the caregiver that is not more than is reasonably necessary to assure the uninterrupted availability of cannabis for the purpose of alleviating the symptoms or effects of a qualifying patient's debilitating medical condition; provided that an "adequate supply" shall not exceed three (3) mature cannabis plants, three (3) ounces of usable cannabis, and four (4) immature cannabis plants.

(b) ***"Cannabis"*** shall mean any plant of the genus *Cannabis* family *Moraceae;* a coarse bushy annual with palmate leaves and clusters of small green flowers. Cannabis shall have the same meaning as "marijuana" or "marihuana."

(c) ***"Caregiver"*** means a person, other than a qualifying patient and the qualifying patient's physician, who is eighteen years of age or older who has agreed to undertake responsibility for managing the well-being of a qualifying patient or patients with respect to the

medicinal use of cannabis. In the case of a minor or an adult lacking legal capacity, the caregiver shall be a parent, guardian, or person having legal custody.

(d) ***"Certification"*** means the written certification from a doctor for a patient that indicates to a dispensary that cannabis has been recommended to the qualifying patient for treatment of a diagnosed debilitating medical condition.

(e) "Compassionate Care Center" means a lawfully licensed facility in which takes place the cultivation, processing, and possession for retail sale of cannabis to provide to lawfully authorized persons in possession of a valid certification from a licensed physician, or his/her designated caregiver. A "Compassionate Care Center" is also called a dispensary.

(f) "Debilitating medical condition" shall mean any of the following:

(1) Cancer;

(2) Glaucoma;

(3) Positive status for Human Immunodeficiency Virus (HIV), or the treatment of this condition;

(4) Positive status for Acquired Immune Deficiency Syndrome (AIDS), or the treatment of this condition;

(5) A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:

(i) Cachexia or wasting syndrome;

(ii) Severe pain;

(iii) Severe nausea;

(iv) Seizures, including those characteristic of epilepsy; or

(v) Severe and persistent muscle spasms, including those characteristic of multiple sclerosis or Crohn's disease; or

(6) Any other medical condition approved by the Department of Public Health and Social Services pursuant to administrative rules in response to a request from a physician or potentially qualifying patient.

(g) ***"Department"*** means the Department of Public Health and Social Services.

(h) ***"Dispensary"*** shall have the same meaning as a "Compassionate Care Center."

(i) ***"Distribution"*** as used in the definition of "medicinal use" means the transfer of cannabis and paraphernalia from the provider to the caregiver to the qualifying patient, and/or from the provider to the qualifying patient.

(j) ***"Marijuana"*** **and** ***"Marihuana"*** shall have the same meaning as *"Cannabis."*

(k) ***"Mature Cannabis plant"*** means a cannabis plant that has flowers or buds that are readily observable by an unaided visual examination.

(l) ***"Medicinal use"*** means the acquisition, possession, cultivation, use, distribution, or transportation of cannabis or paraphernalia relating to the administration of cannabis to alleviate the symptoms or effects of a qualifying patient's debilitating medical condition.

(m) ***"Physician"*** means a physician licensed by the Board of Medical Examiners to practice medicine on Guam. "Physician" does not include a physician's assistant.

(n) ***"Provider"*** means a licensed Compassionate Care Center or a board member, principal officer, agent, employee, or volunteer of a licensed Compassionate Care Center.

(o) ***"Qualifying patient"*** means a person who has been diagnosed by a physician as having a debilitating medical condition.

(p) ***"Usable cannabis"*** means the dried leaves and flowers of the plant *Cannabis* family *Moraceae*, and any mixture or preparation thereof, that is appropriate for the medicinal use of cannabis. "Usable cannabis" does not include the seeds, stalks, and roots of the plant, or a seedling with no observable flowers or buds.

(q) ***"Written certification"*** means the qualifying patient's medical records or a statement signed by a qualifying patient's physician, stating that in the physician's professional opinion, the qualifying patient has a debilitating medical condition and the potential benefits of the medicinal use of cannabis would likely outweigh the health risks for the qualifying patient.

The Department of Public Health and Social Services may require, through its rulemaking authority, that all written certifications comply with a designated form. "Written certifications"

shall be valid for any term up to two (2) years as designated by the qualifying patient's physician.

§ 122303. Medicinal use of cannabis; conditions of use.

(a) The medicinal use of cannabis by a qualifying patient shall be permitted only if:

(1) The qualifying patient has been diagnosed by a physician as having a debilitating medical condition;

(2) The qualifying patient's physician has certified in writing that, in the physician's professional opinion the potential benefits of the medicinal use of cannabis would likely outweigh the health risks for the particular qualifying patient;

(3) The physician has written a certification for the qualifying patient that provides instructions for the amount of cannabis to be provided, and the recommended dosage; and

(4) The amount of cannabis in possession of a qualifying patient does not exceed an adequate supply.

(b) For a qualifying patient under the age of eighteen (18) years, the medicinal use of cannabis shall be permitted only if:

(1) The qualifying patient's physician has explained the potential risks and benefits of the medicinal use of cannabis to the qualifying patient and to a parent, guardian, or person having legal custody of the qualifying patient; and

(2) A parent, guardian, or person having legal custody consents in writing to:

(i) Permit the qualifying patient to use cannabis for medicinal purposes;

(ii) Serve as the qualifying patient's caregiver; and

(iii) Control the acquisition of the cannabis, the dosage, and the frequency of the medicinal use of cannabis by the qualifying patient.

(c) The authorization for the medicinal use of cannabis in this section shall not apply to the medicinal use of cannabis:

(1) On any school grounds;

(2) At any public place or location open to the public;

(3) While operating any vehicle, public or private;

(4) In any workplace unless the patient is working at his or her place of residence; or

(5) In the presence of a person or persons under the age of eighteen (18).

§ 122304. Registration requirements.

(a) **Physicians.** Physicians who issue written certification shall transmit the names, addresses, patient identification numbers, and other identifying information of the patients to whom they have issued written certifications, to the Department of Public Health and Social Services.

(b) **Qualifying Patients.** Qualifying patients shall register with the Department of Public Health and Social Services. Such registration shall be effective until the expiration of the certificate issued by the physician. Every qualifying patient shall provide sufficient identifying information to establish his/her personal identity. Qualifying patients shall report changes in information within five (5) working days.

The Department of Public Health and Social Services shall issue to the qualifying patient a registration certificate, which shall include the patient's name and address, and, if applicable, the name and address of the caregiver. The Department may charge a fee not to exceed Twenty-Five Dollars ($25) for the original certificate; and a fee not to exceed Ten Dollars ($10) for replacement of a lost certificate.

(c) **Caregivers.** Caregivers shall register with The Department of Public Health and Social Services. Caregivers may be responsible for the care of more than one (1) qualifying patient, but no more than five (5), at any given time.

Every caregiver shall provide sufficient identifying information to establish his/her personal identity to the Department. Caregivers shall report changes in information within five (5) working days.

The Department of Public Health and Social Services shall issue to each caregiver a registration certificate, which shall include the caregiver's name and address. The Department may charge a fee not to exceed Twenty-Five Dollars ($25) for the original certificate; and a fee not to exceed Ten Dollars ($10) for replacement of a lost certificate.

(e) Upon an inquiry by a law enforcement agency, the Department shall verify whether the particular qualifying patient or caregiver has registered with the Department and may provide reasonable access to the registry information for official law enforcement purposes.

§ 122305. Personal cannabis supply.

A qualifying patient may cultivate up to three (3) cannabis plants and possess up to three (3) ounces of usable cannabis for his or her medicinal use. A caregiver, may cultivate up to three (3) cannabis plants and possess up to two (2) ounces of usable cannabis for each patient for which he or she is a caregiver, except that no caregiver shall possess an amount of cannabis in excess of three (3) plants and three (3) ounces of usable marijuana for each qualifying patient to whom he or she is connected as a caregiver through the Department's registration process. A qualifying patient and his/her caregiver shall be exempt from the provisions of Title 9 GC Chapter 67, §67.401.2(b)(2).

§ 122306. Affirmative defense.

A qualifying patient or caregiver may assert the medicinal use of cannabis as an affirmative defense to any prosecution involving cannabis under this chapter provided that the qualifying patient or the caregiver has strictly complied with the requirements herein.

Any qualifying patient or caregiver not complying with the permitted scope of the medicinal use of cannabis shall not be afforded the protections against searches and seizures pertaining to the misapplication of the medicinal use of cannabis.

No person shall be subject to arrest or prosecution for simply being in the presence or vicinity of the medicinal use of cannabis as permitted under this chapter.

§ 122307. Protections afforded to physician.

Pursuant to Title 10 GCA Chapter 12 §12218 and §12219 no physician shall be subject to arrest or prosecution, penalized in any manner or denied any right or privilege for recommending or providing written certification for the medicinal use of cannabis for a qualifying patient; provided that:

(a) The physician has diagnosed the patient as having a debilitating medical condition, as defined in this chapter;

(b) The physician has explained the potential risks and benefits of the medicinal use of cannabis, as required under this chapter;

(c) The written certification is based upon the physician's professional opinion after having completed a full assessment of the patient's medical history and current medical condition made in the course of a bona fide physician-patient relationship; and

(d) The physician has complied with the registration requirements of this chapter.

§ 122308. Protection of cannabis and other seized property.

Cannabis, paraphernalia, or other property seized from a qualifying patient or caregiver in connection with a claimed medicinal use of cannabis under this chapter shall be returned immediately upon the determination by a court that the qualifying patient or caregiver is entitled to the protections of this chapter, as evidenced by a decision not to prosecute, a dismissal of charges, or an acquittal; provided that law enforcement agencies seizing live

plants as evidence shall not be responsible for the care and maintenance of such plants.

§ 122309. Fraudulent misrepresentation; penalty.

(a) Fraudulent misrepresentation to a law enforcement official of any fact or circumstance relating to the medicinal use of cannabis to avoid arrest or prosecution under this chapter shall be a petty misdemeanor.

(b) Fraudulent misrepresentation to a law enforcement official of any fact or circumstance relating to the issuance of a written certificate by a physician not covered under this chapter for the medicinal use of cannabis shall be a misdemeanor. This penalty shall be in addition to any other penalties that may apply for the non-medicinal use of cannabis. Nothing in this section is intended to preclude the conviction of any person for any other offense.

§ 122310. Administrative rules, forms and procedures.

The Department of Public Health and Social Services shall develop and regularly update administrative rules, forms and procedures as needed and consistent with the requirements of this Article 23 and Article 24, subject to the provisions of the

Administrative Adjudication Act, Title 5 Guam Code Annotated, Chapter 9."

Section 2. "COMPASSIONATE CARE CENTERS." ***A New*** **Article 24 is** ***added*** **to Title 10 Guam Code Annotated Chapter** ***12*** **to read:**

"ARTICLE 24.

COMPASSIONATE CARE CENTERS.

§ 122401. Compassionate Care Centers, Function.

§ 122402. Registration and Application Requirements.

§ 122403. Establishment.

§ 122404. Consideration of Applications.

§ 122405. Tracking patients.

§ 122406. Compassionate Care Registry Identification Cards.

§ 122407. Expiration, Renewal or Termination of Registration Certificate.

§ 122408. Compassionate Care Center, Name.

§ 122401. Compassionate Care Centers, Function.

A Compassionate Care Center registered under this section may acquire, possess, cultivate, manufacture, deliver, transfer, transport, supply, or dispense cannabis, and related supplies and

educational materials, to registered qualifying patients and their registered caregivers.

§122402. Registration and Application Requirements for Centers.

Not later than ninety (90) days after the effective date of this act, the Department shall promulgate the administrative rules, forms, procedures and regulations governing the manner in which it shall consider and process applications for registration certificates for Compassionate Care Centers, including regulations governing:

(a) The form and content of registration and renewal applications;

(b) Minimum oversight requirements for Compassionate Care Centers;

(c) Minimum record-keeping requirements for Compassionate Care Centers;

(d) Minimum security requirements for Compassionate Care Centers;

(e) Minimum operational guidelines for Compassionate Care Centers; and

(f) Procedures for suspending or terminating the registration of Compassionate Care Centers that violate the provisions of this section or the regulations promulgated pursuant to this subsection.

(g) Each application for establishing a Compassionate Care Center shall include:

(i) A non-refundable application fee paid to the Department in the amount of two hundred fifty dollars ($250);

(ii) The proposed legal name and proposed articles of incorporation of the Compassionate Care Center;

(iii) The proposed physical address of the Compassionate Care Center, if a precise address has been determined, or, if not, the general location where it would be located. This may include a second location for the cultivation of medicinal cannabis;

(iv) A description of the enclosed, locked facility that would be used in the cultivation of cannabis;

(v) The name, address, and date of birth of each

principal officer and board member of the Compassionate Care Center, to be updated annually by the Compassionate Care Center;

(vi) Proposed security and safety measures which shall include at least one security alarm system for each location, planned measures to deter and prevent the unauthorized entrance into areas containing cannabis and the theft of cannabis, as well as a draft employee instruction manual including security policies, safety and security procedures, personal safety and crime prevention techniques; and

(vii) Proposed procedures to ensure accurate record keeping.

§ 122403. Establishment of Centers.

(a) Within thirty (30) days of the approval of their administrative rules and regulations, the Department shall make available to the public the requirements to operate a Compassionate Care Center and begin accepting applications for a thirty (30)-day period for the operation of three

Compassionate Care Centers in Guam.

(b) Within thirty (30) days of the conclusion of the application period, the Department shall conduct a public hearing on the granting of an application to at least a single Compassionate Care Center.

(c) Within thirty (30) days of the adjournment of the public hearing on the granting of an application to at least a single Compassionate Care Center, the Department shall grant at least a single registration certificate to a single Compassionate Care Center, providing at least one applicant has applied who meets the requirements of this act. The Department may grant up to three (3) registration certificates if three (3) qualified applicants exist.

(d) On the one (1) year anniversary of the effective date of this act, and on each subsequent anniversary date, if there are fewer than three (3) operational Compassionate Care Centers in Guam, the Department shall accept applications, provide for input from the public, and issue a registration certificate if at least one qualified applicant exists.

(e) Any time a Compassionate Care Center registration certificate is revoked, relinquished, or expires, the Department shall accept applications for a new Compassionate Care Center.

(f) If at any time after three (3) years after the effective date of this act, fewer than three (3) Compassionate Care Centers are holding valid registration certificates in Guam, the Department shall accept applications for a new Compassionate Care Center. No more than three (3) Compassionate Care Centers may hold valid registration certificates at one time.

§ 122404. Consideration of Compassionate Care Center Applications.

(a) Any time one or more Compassionate Care Center registration applications are being considered, the Department shall allow for comment by the public and shall solicit input from registered qualifying patients, and caregivers.

(b) Each time a Compassionate Care Center certificate is granted, the decision shall be based upon the overall health needs of qualified patients and the safety of the public, including, but not limited to, the following factors:

(i) Convenience to patients to access the Compassionate Care Center if the applicant were approved;

(ii) The applicant's ability to provide a steady supply to the registered qualifying patients in Guam;

(iii) The applicant's experience running a non-profit or business;

(iv) The wishes of qualifying patients regarding which applicant is to be granted a registration certificate;

(v) The wishes of the residents where the Compassionate Care Center would be located, as indicated by written petition certified by the Municipal Planning Council for affected municipality;

(vi) The sufficiency of the applicant's plans for record keeping and security, which records shall be considered confidential health care information under Guam law and are intended to be deemed protected health care information for purposes of the Federal Health Insurance Portability and Accountability Act of

1996, as amended; and

(vii) The sufficiency of the applicant's plans for safety and security, including proposed location, security devices employed, and staffing;

(c) After a Compassionate Care Center is approved, but before it begins operations, it shall submit the following to the Department:

(i) A fee paid to the Department in the amount of one thousand dollars ($1,000);

(ii) The legal name, articles of incorporation and current business license of the Compassionate Care Center;

(iii) The physical address of the Compassionate Care Center; this may include a second address for the secure cultivation of cannabis;

(iv) The name, address, and date of birth of each principal officer and board member of the Compassionate Care Center;

(v) The name, address, and date of birth of any

person who will be an agent of, or employed by the Compassionate Care Center at its inception.

§ 122405. Tracking patients.

The Department shall track the number of registered qualifying patients who designate each Compassionate Care Center, and issue a written statement to the Compassionate Care Center regarding the number of qualifying patients who have designated the Compassionate Care Center for them. This statement shall be updated each time a new registered qualifying patient designates the Compassionate Care Center or ceases to designate the Compassionate Care Center and may be transmitted electronically if the Department's regulations so provide.

§ 122406. Compassionate Care Registry Identification Cards.

(a) The Department shall issue each principal officer, board member, agent, volunteer and employee of a Compassionate Care Center a Compassionate Care Registry Identification Card or renewal card within ten (10) days of receipt of the person's name, address, date of birth, and a fee in

an amount established by the Department. Each card shall specify that the cardholder is a principal officer, board member, agent, volunteer, or employee of a Compassionate Care Center and shall contain the following:

(i) The name, address, and date of birth of the principal officer, board member, agent, volunteer or employee;

(ii) The legal name of the Compassionate Care Center to which the principal officer, board member, agent, volunteer or employee is affiliated;

(iii) A random identification number that is unique to the cardholder;

(iv) The date of issuance and expiration date of the registry identification card; and

(v) A photograph, if the department decides to require one;

(b) The Department shall ***not*** issue a registry identification card to any principal officer, board member, agent, volunteer, or employee of a Compassionate Care Center

who has been convicted of a felony drug offense. The Department may conduct a background check of each principal officer, board member, agent, volunteer, or employee in order to carry out this provision. The Department shall notify the Compassionate Care Center in writing of the purpose for denying the registry identification card. The department may grant such person a registry identification card if the department determines that the offense was for conduct that occurred prior to the enactment of the Compassionate Health Care Act or that was prosecuted by an authority other than Guam and for which the Compassionate Health Care Act would otherwise have prevented a conviction;

(c) A registry identification card of a principal officer, board member, agent, volunteer, or employee shall expire three (3) years after its issuance, or upon the expiration of the registered organization's registration certificate, whichever occurs first.

§ 122407. Expiration, Renewal or Termination of Registration Certificate.

(a) A Compassionate Care Center's registration shall expire three (3) years after its registration certificate is issued. The Center may submit a renewal application beginning sixty (60) days prior to the expiration of its registration certificate.

(b) The Department shall grant a Compassionate Care Center's renewal application within thirty (30) days of its submission if the following conditions are all satisfied:

(i) The Compassionate Care Center submits the materials required under subdivision (c)(4), including a Five Thousand Dollar ($5,000) fee;

(ii) The Department has not ever suspended the Compassionate Care Center's registration for violations of this act or regulations issued pursuant to this act;

(iii) The Medicinal Cannabis Policy Commission's report, issued pursuant to subsection (j), indicates that the Compassionate Care Center is adequately providing patients' with access to medicinal cannabis at reasonable rates; and

(iv) The Medicinal Cannabis Policy Commission's

report, issued pursuant to subsection (j), does not raise serious concerns about the continued operation of the Compassionate Care Center applying for renewal.

(c) If the Department determines that any of the conditions listed in paragraphs (d)(2)(i) through (d)(2)(iv) exist, the department shall begin an open application process for the operation of a Compassionate Care Center. In granting a new registration certificate, the Department shall consider factors listed in subdivision (c)(3);

(d) The Department shall issue a Compassionate Care Center one or more thirty (30)-day temporary registration certificates after that Compassionate Care Center's registration would otherwise expire if the following conditions are all satisfied:

(i) The Compassionate Care Center previously applied for a renewal, but the department had not yet come to a decision;

(ii) The Compassionate Care Center requested a temporary registration certificate; and

(iii) The Compassionate Care Center has not had its registration certificate revoked due to violations of this act or regulations issued pursuant to this act.

(e) **Inspection.** Compassionate Care Centers are subject to reasonable inspection by the Department. The Department shall give reasonable notice of an inspection under this subsection. During an inspection, the Department may review the Compassionate Care Center's confidential records, including its dispensing records, which may track transactions according to qualifying patients' registry identification numbers to protect their confidentiality.

(f) Requirements for the operations of Compassionate Care Centers:

(1) A Compassionate Care Center shall be operated on a not-for-profit basis for the mutual benefit of its patients.

(2) A Compassionate Care Center need not be recognized as a tax-exempt organization by the Internal Revenue Services;

(3) A Compassionate Care Center may not be located within five hundred feet (500') of the property line of a preexisting public or private school;

(4) A Compassionate Care Center shall notify the Department within ten (10) days of when a principal officer, board member, agent, volunteer or employee ceases to work at the Compassionate Care Center. His or her card shall be deemed null and void and returned to the Department. The cardholder shall be liable for any penalties that may apply to his/her non-medicinal use of cannabis;

(5) A Compassionate Care Center shall notify the Department in writing of the name, address, and date of birth of any new principal officer, board member, agent, volunteer or employee and shall submit a fee in an amount established by the Department for a new registry identification card before a new agent or employee begins working at the Center;

(6) A Compassionate Care Center shall implement appropriate security measures to deter and prevent the unauthorized entrance into areas containing cannabis and the theft of cannabis and shall insure that each location has an operational security alarm system.

(7) The operating documents of a Compassionate Care

Center shall include procedures for the oversight of the Compassionate Care Center and procedures to ensure accurate record keeping;

(8) A Compassionate Care Center is prohibited from acquiring, possessing, cultivating, manufacturing, delivering, transferring, transporting, supplying, or dispensing cannabis for any purpose except to assist registered qualifying patients with the medicinal use of cannabis directly or through the qualifying patients other caregiver;

(9) All principal officers and board members of a Compassionate Care Center must be residents of Guam for at least one (1) year;

(10) Each time a new registered qualifying patient visits a Compassionate Care Center, it shall provide the patient with frequently asked questions designed by the department, which explains the limitations on the right to use medicinal cannabis under state law;

(11) Each Compassionate Care Center shall develop, implement, and maintain on the premises employee and agent

policies and procedures to address the following requirements:

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

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

(12) Each Compassionate Care Center shall maintain a personnel record for each employee and each volunteer that includes an application for employment or to volunteer and a record of any disciplinary action taken;

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

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

(ii) Informational developments in the field of

medicinal use of cannabis.

(14) Each Compassionate Care Center entity shall provide each employee and each volunteer, at the time of his or her initial appointment, training in the following:

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

(ii) Specific procedural instructions on how to respond to an emergency, including robbery or violent accident;

(15) All Compassionate Care Centers shall prepare training documentation for each employee and have employees sign a statement indicating the date, time, and place the employee received said training and topics discussed, to include name and title of presenters. The Compassionate Care Center shall maintain documentation of an employee's and a volunteer's training for a period of at least one (1) year after termination of employment or volunteer services.

(g) Maximum amount of usable cannabis to be dispensed:

(1) A Compassionate Care Center or principal officer,

board member, agent, volunteer or employee of a Compassionate Care Center may not dispense more than two and one half ounces (2.5 oz) of usable cannabis to a qualifying patient or caregiver during a fifteen (15) day period;

(2) A Compassionate Care Center or principal officer, board member, agent, volunteer or employee of a Compassionate Care Center may not dispense an amount of usable cannabis or cannabis plants to a qualifying patient or a caregiver that the Compassionate Care Center, principal officer, board member, agent, volunteer, or employee knows would cause the recipient to possess more cannabis than is permitted under this Act.

(h) **Immunity:**

(1) No registered Compassionate Care Center shall be subject to prosecution; search, except by the Department pursuant to subsection (e); seizure; or penalty in any manner or denied any right or privilege, including, but not limited to, civil penalty or disciplinary action by a business, occupational, or professional licensing board or entity, solely for acting in

accordance with this section to assist registered qualifying patients to whom it is connected through the department's registration process with the medicinal use of cannabis;

(2) No principal officers, board members, agents, volunteers, or employees of a registered Compassionate Care Center shall be subject to arrest, prosecution, search, seizure, or penalty in any manner or denied any right or privilege, including, but not limited to, civil penalty or disciplinary action by a business, occupational, or professional licensing board or entity, solely for working for or with a Compassionate Care Center to engage in acts permitted by this section.

(i) **Prohibitions:**

(1) A Compassionate Care Center may not possess an amount of cannabis that exceeds the total of the allowable amount of cannabis for the total number of patients for whom the Compassionate Care Center serves;

(2) A Compassionate Care Center may not dispense, deliver, or otherwise transfer cannabis to a person other than a qualifying patient or to such patient's caregiver;

(3) A person found to have violated paragraph (2) of this subsection shall be prohibited from serving as an employee, agent, principal officer, or board member of any Compassionate Care Center, and such person's registry identification card shall be immediately revoked;

(4) A person who has been convicted of a felony drug offense shall be prohibited from serving as the principal officer, board member, agent, volunteer, or employee of a Compassionate Care Center unless the Department has determined that the person's conviction was for the medicinal use of cannabis or assisting with the medicinal use of cannabis and issued the person a registry identification card as provided under subdivision (c)(7). A person who is employed by or is an agent, principal officer, or board member of a Compassionate Care Center in violation of this section is guilty of a civil violation punishable by a fine of up to one thousand dollars ($1,000). A subsequent violation of this section is a gross misdemeanor.

(j) **Medicinal Cannabis Policy Commission.**

(1) *I Liheslaturan Guåhan's* Oversight Committee on Health Services shall appoint a nine (9) member commission comprised of: the Legislative Oversight Chairperson, who shall also serve as the Chair of the Commission; two (2) physicians to be selected from a list provided by each of the local medical associations; one (1) nurse to be selection from a list provided by each of the local nursing associations; two (2) registered qualifying patients to be selected from a list provided by the Department; one (1) registered primary caregiver to be selected from a list provided by the Department; the Director of the Department of Public Health and Social Services; and one member of the law enforcement community.

(2) The Commission shall meet at least six (6) times per year for the purpose of evaluating and making recommendations to *I Liheslaturan Guåhan* regarding:

(i) Patient's access to medical marijuana;

(ii) Efficacy of compassion center;

(iii) Physician participation in the Medical Marijuana Program;

(iv) The definition of qualifying medical condition;

(v) Research studies regarding health effects of medical marijuana for patients.

(3) On or before January 1 of every even numbered year, the Commission shall report its findings to *I Liheslaturan Guåhan*.

§ 122408. Compassionate Care Center, Name.

The phrase "Compassionate Care Center" shall be included in the name of each facility registered under this Article 24. A business or businesses not authorized under the provisions of this Title 10 Guam Code Annotated Article 24, shall not use the words "Compassionate Care Center" in that order in any business or corporate name. "

PART III – ADJUSTMENTS TO GUAM CODE ANNOTATED

Section 1. Title 9 Guam Code Annotated Chapter 67 § 67.401.2. Illegal Possession; Defined and Punishment, Subitem (b), shall be *amended* to read:

"(b) Any person who violates Subsection (a) with respect to:

(1) Any controlled substance except marijuana shall be guilty of a felony of the third degree.

(2) More than one (1) ounce of marijuana shall be guilty of a petty misdemeanor except that registered qualifying patients may use and possess medicinal cannabis, and registered caregivers may possess usable cannabis, in amounts as provided in Title 10 GCA Chapter 12 Article 23 §122305.

For the purposes of this Section, "usable cannabis" means the dried leaves and flowers of the plant *Cannabis* family *Moraceae*, and any mixture or preparation thereof. "Usable cannabis" does not include the seeds, stalks, and roots of the plant, or a seedling with no observable flowers or buds.

(3) One (1) ounce or less of marijuana shall be guilty of a violation and punished by a fine of One Hundred Dollars ($100.00).

(4) Any person involved in the ***use*** of marijuana:

(i) On any school grounds;

(ii) At any public place or location open to the public;

(iii) While operating any vehicle, public or private;

(iv) In any workplace unless the patient is working at his or her place of residence; or

(v) In the presence of a person or persons under the age of 18;

shall be guilty of a violation and punished by a fine of One Hundred Dollars ($100.00) for each ounce of marijuana and any additional fraction thereof."

Section 2. ***New*** **Title 10 Guam Code Annotated Chapter 12 §§ 12218 and 12219 are** ***added*** **to read:**

"**§ 12218. Medicinal Cannabis.** Pursuant to the United States Supreme Court ruling in Conant v. Walters (309F.3d 629, 2002), a doctor's right to recommend cannabis to their patients has been upheld. No physician shall be subject to arrest or prosecution, or penalized in any manner, or denied any right or privilege for providing written certification for the medicinal use of cannabis for a qualifying patient, or for recommending medicinal cannabis to a qualified patient; provided that:

(1) The physician has diagnosed the patient as having a debilitating medical condition, as defined in Article 23 Title 10 Guam Code Annotated Chapter 12;

(2) The physician has explained the potential risks and benefits of the medicinal use of cannabis, as required in Article 23 Title 10 Guam Code Annotated Chapter 12;

(3) The written certification given is based upon the physician's professional opinion after having completed a full assessment of the patient's medical history and current medical condition made in the course of a bona fide physician-patient relationship; and

(4) The physician has complied with the registration as required in Article 23 Title 10 Guam Code Annotated Chapter 12."

"**§ 12219. Medicinal Cannabis Exclusion in Drug Testing.** Any individual who is properly registered with the Department of Public Health and Social Services as a medicinal cannabis patient shall not be fined or penalized for any positive drug test findings for cannabis. Individuals whose jobs involve public safety and who are medicinal

cannabis patients shall advise their supervisor of their medical situation and present their registration information. The medicinal cannabis patient shall be assigned to alternate duty if necessary."

Section 3. A *new* §75107 is *added* to Title 10 Guam Code Annotated Chapter 75 to read:

"**§ 71507. Medicinal Cannabis Exclusion in Drug Testing.** Any individual who is properly registered with the Department of Public Health and Social Services as a medicinal cannabis patient shall not be fined or penalized for any positive drug test findings for cannabis (marijuana or marihuana)."

Section 4. Title 9 Guam Code Annotated Chapter 67 § 67.100 definition 20 is *amended* to read:

"(20) *Marijuana,* means all parts of the plant Cannabis, whether growing or not; [~~its seeds;~~] the resin extracted from any part of such plant; and every compound, salt, derivative, mixture or preparation of the plant, or its [~~seeds or~~] resin. The term does not include the mature stalks of the plant; fiber produced from the stalks; oil or cake made from the seeds of the plant; any other compound, salt, derivative, mixture or preparation of the mature stalks, except resin

extracted therefrom; fiber, oil or cake; its seeds; or the sterilized seed of the plant which is incapable of germination."

Section 5. Deletion of Items from Title 9 Guam Code Annotated Chapter 67, Appendix A, representing Schedule I controlled substances.

The following items shall be *deleted* from the list in Title 9 Guam Code Annotated Chapter 67 Appendix A, representing Schedule I controlled substances:

"(19) Marihuana." and

"(27) Tetrahydrocannabinols."

The remaining items on the list in Appendix A shall be renumbered appropriately.

Section 6. Addition of a *new* item (D) to Title 9 Guam Code Annotated Chapter 67, Appendix E representing Schedule V controlled substances.

The following *new* item (D) is *added* to Title 9 Guam Code Annotated Chapter 67, Appendix E representing Schedule V controlled substances, to read:

"(D) "Marijuana," which shall have the same meaning as *"Cannabis"* or *"marihuana;"* any plant of the genus *Cannabis* family *Moraceae."*

PART IV - MISCELLANEOUS PROVISIONS

Section 1. Administrative Rules and Regulations. Within ninety (90) days after the enactment of this Act into law, the Department of Public Health and Social Services shall promulgate the administrative rules, forms and procedures needed to carry out the requirements of Title 10 GCA Article 12 Chapters 23 and 24.

Section 2. Effective Date. This act shall take effect upon enactment into law.

o

EXHIBIT 1

U.S. Department of Justice

Office of the Deputy Attorney General

The Deputy Attorney General

Washington, D.C. 20530

October 19, 2009

MEMORANDUM FOR SELECTED UNITED STATES ATTORNEYS

FROM: David W. Ogden
Deputy Attorney General

SUBJECT: Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana

This memorandum provides clarification and guidance to federal prosecutors in States that have enacted laws authorizing the medical use of marijuana. These laws vary in their substantive provisions and in the extent of state regulatory oversight, both among the enacting States and among local jurisdictions within those States. Rather than developing different guidelines for every possible variant of state and local law, this memorandum provides uniform guidance to focus federal investigations and prosecutions in these States on core federal enforcement priorities.

The Department of Justice is committed to the enforcement of the Controlled Substances Act in all States. Congress has determined that marijuana is a dangerous drug, and 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. One timely example underscores the importance of our efforts to prosecute significant marijuana traffickers: marijuana distribution in the United States remains the single largest source of revenue for the Mexican cartels.

The Department is also committed to making efficient and rational use of its limited investigative and prosecutorial resources. In general, United States Attorneys are vested with "plenary authority with regard to federal criminal matters" within their districts. USAM 9-2.001. In exercising this authority, United States Attorneys are "invested by statute and delegation from the Attorney General with the broadest discretion in the exercise of such authority." *Id.* This authority should, of course, be exercised consistent with Department priorities and guidance.

The prosecution of significant traffickers of illegal drugs, including marijuana, and the disruption of illegal drug manufacturing and trafficking networks continues to be a core priority in the Department's efforts against narcotics and dangerous drugs, and the Department's investigative and prosecutorial resources should be directed towards these objectives. As a general matter, pursuit of these priorities should not focus federal resources in your States on

individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana. For example, prosecution of individuals with cancer or other serious illnesses who use marijuana as part of a recommended treatment regimen consistent with applicable state law, or those caregivers in clear and unambiguous compliance with existing state law who provide such individuals with marijuana, is unlikely to be an efficient use of limited federal resources. On the other hand, prosecution of commercial enterprises that unlawfully market and sell marijuana for profit continues to be an enforcement priority of the Department. To be sure, claims of compliance with state or local law may mask operations inconsistent with the terms, conditions, or purposes of those laws, and federal law enforcement should not be deterred by such assertions when otherwise pursuing the Department's core enforcement priorities.

Typically, when any of the following characteristics is present, the conduct will not be in clear and unambiguous compliance with applicable state law and may indicate illegal drug trafficking activity of potential federal interest:

- unlawful possession or unlawful use of firearms;
- violence;
- sales to minors;
- financial and marketing activities inconsistent with the terms, conditions, or purposes of state law, including evidence of money laundering activity and/or financial gains or excessive amounts of cash inconsistent with purported compliance with state or local law;
- amounts of marijuana inconsistent with purported compliance with state or local law;
- illegal possession or sale of other controlled substances; or
- ties to other criminal enterprises.

Of course, no State can authorize violations of federal law, and the list of factors above is not intended to describe exhaustively when a federal prosecution may be warranted. Accordingly, in prosecutions under the Controlled Substances Act, federal prosecutors are not expected to charge, prove, or otherwise establish any state law violations. Indeed, this memorandum does not alter in any way the Department's authority to enforce federal law, including laws prohibiting the manufacture, production, distribution, possession, or use of marijuana on federal property. This guidance regarding resource allocation does not "legalize" marijuana or provide a legal defense to a violation of federal law, nor is it intended to create any privileges, benefits, or rights, substantive or procedural, enforceable by any individual, party or witness in any administrative, civil, or criminal matter. Nor does clear and unambiguous compliance with state law or the absence of one or all of the above factors create a legal defense to a violation of the Controlled Substances Act. Rather, this memorandum is intended solely as a guide to the exercise of investigative and prosecutorial discretion.

Finally, nothing herein precludes investigation or prosecution where there is a reasonable basis to believe that compliance with state law is being invoked as a pretext for the production or distribution of marijuana for purposes not authorized by state law. Nor does this guidance preclude investigation or prosecution, even when there is clear and unambiguous compliance with existing state law, in particular circumstances where investigation or prosecution otherwise serves important federal interests.

Your offices should continue to review marijuana cases for prosecution on a case-by-case basis, consistent with the guidance on resource allocation and federal priorities set forth herein, the consideration of requests for federal assistance from state and local law enforcement authorities, and the Principles of Federal Prosecution.

cc: All United States Attorneys

Lanny A. Breuer
Assistant Attorney General
Criminal Division

B. Todd Jones
United States Attorney
District of Minnesota
Chair, Attorney General's Advisory Committee

Michele M. Leonhart
Acting Administrator
Drug Enforcement Administration

H. Marshall Jarrett
Director
Executive Office for United States Attorneys

Kevin L. Perkins
Assistant Director
Criminal Investigative Division
Federal Bureau of Investigation

EXHIBIT 2

Los Angeles Times ARTICLE COLLECTIONS

http://articles.latimes.com/2009/oct/20/nation/na-medical-marijuana20

A federal about-face on medical marijuana

New Justice Department guidelines order federal drug agents to cease arresting or charging patients, caregivers or suppliers who are conforming with state law.

October 20, 2009 | Josh Meyer

WASHINGTON — The Obama administration on Monday told federal authorities not to arrest or prosecute medical marijuana users and suppliers who aren't violating local laws, paving the way for some states to allow dispensaries to provide the drug as relief for some maladies.

The Justice Department's guidelines ended months of uncertainty over how far the Obama White House planned to go in reversing the Bush administration's position, which was that federal drug laws should be enforced even in states like California, with medical marijuana laws on the books.

The new guidelines tell prosecutors and federal drug agents they have more important things to do than to arrest people who are obeying state laws that allow some use or sale of medical marijuana.

"It will not be a priority to use federal resources to prosecute patients with serious illnesses or their caregivers who are complying with state laws on medical marijuana, but we will not tolerate drug traffickers who hide behind claims of compliance with state law to mask activities that are clearly illegal," Atty. Gen. Eric H. Holder Jr. said in a statement.

Advocates say marijuana helps relieve pain and nausea and stimulates appetite in patients suffering from cancer and some other diseases.

The guidelines clarify what some critics had said was an ambiguous position by the Obama administration, especially in California, where authorities raided numerous clinics and made arrests over the years. Some of those raids followed Obama's inauguration in January, after, as a presidential candidate, he had pledged to stop them.

Holder had telegraphed the change in March.

On Monday, he said the guidelines were adopted, in part, because federal agencies must reserve their limited resources for urgent needs. One priority is countering the violent Mexican drug cartels, which use vast profits from their U.S. marijuana sales to support other criminal activities, the guidelines say.

The Justice Department will continue to prosecute people whose claims of compliance with state and local law conceal operations that are "inconsistent" with the terms, conditions or purposes of those laws, according to Holder and Deputy Atty. Gen. David Ogden.

The guidelines urge authorities to pursue cases involving violence, illegal use of firearms, selling marijuana to minors, excessive financial gains and ties to criminal enterprises.

The American Civil Liberties Union and other groups welcomed the decision as an important step toward a comprehensive national policy on medical marijuana that will allow states to implement their laws without fear of federal interference.

But many law enforcement advocates, some conservative groups and members of Congress criticized it.

In all, 14 states have medical marijuana laws. But some, such as New Mexico, Rhode Island and Michigan, have been reluctant to create programs lest they be struck down by courts or shut down by federal authorities, said Graham Boyd, director of the ACLU's California-based Drug Law Reform Project.

Boyd said he hoped the new policy would spur local governments with well-established medical marijuana programs to weed out fly-by-night dispensaries that are in it for the huge potential profits.

"The big news outside of California is that this will get the states off the dime," Boyd said.

In California, he said, it would "clarify the line between what is legal and illegal and reduce some of the chaos that exists, and that's a good thing."

But opponents warned of consequences.

"By directing federal law enforcement officers to ignore federal drug laws, the administration is tacitly condoning the use of marijuana in the U.S.," said Rep. Lamar Smith (R-Texas), ranking member of the House Judiciary Committee.

He said the decision undermined the administration's plan to attack the Mexican drug cartels, which he said were growing marijuana in U.S. national parks and fueling drug-related violence along the U.S.-Mexico border.

Other states that allow marijuana for medical purposes are Alaska, Colorado, Hawaii, Maine, Maryland, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont and Washington.

California is unusual in allowing dispensaries to sell marijuana and advertise their services.

In Los Angeles, however, Dist. Atty. Steve Cooley said last week that he would continue to prosecute dispensaries for over-the-counter sales.

josh.meyer@latimes.com

EXHIBIT 3

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

MARCUS CONANT, Dr.; DONALD NORTHFELT, Dr.; DEBU TRIPATHY, Dr.; NEIL FLYNN, Dr.; STEPHEN POLLANSBEE, Dr.; STEPHEN O'BRIEN, Dr.; MILTON ESTES, Dr.; JO DALY; KEITH VINES; JUDITH CUSHNER; VALERIE CORRAL; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; BEING ALIVE: PEOPLE WITH AIDS/ HIV ACTION COALITION, INC.; HOWARD MCCABEE; DANIEL KANE; ALLAN FLACH, Dr.,

Plaintiffs-Appellees,

v.

JOHN P. WALTERS,*, Director of the White House Office of National Drug Control Policy; ASA HUTCHINSON,** Administrator, US DEA; JOHN ASHCROFT,*** Attorney General of the United States;

No. 00-17222

D.C. No. CV-97-00139-WHA

OPINION

*John P. Walters is substituted for his predecessor, Barry R. McCaffrey, as Director of the White House Office of National Drug Control Policy. Fed. R. App. P. 43(c)(2).

**Asa Hutchinson is substituted for his predecessor, Thomas A. Constantine, as Administrator of the US DEA. Fed. R. App. P. 43(c)(2).

***John Ashcroft is substituted for his predecessor, Janet Reno, as Attorney General of the United States. Fed. R. App. P. 43(c)(2).

TOMMY G. THOMPSON,****
Secretary of the Department of
Health and Human Services,
Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of California
William H. Alsup, District Judge, Presiding

Argued and Submitted
April 8, 2002—San Francisco, California

Filed October 29, 2002

Before: Mary M. Schroeder, Chief Judge, Betty B. Fletcher
and Alex Kozinski, Circuit Judges.

Opinion by Chief Judge Schroeder;
Concurrence by Judge Kozinski

****Tommy G. Thompson is substituted for his predecessor, Donna E. Shalala, as Secretary of the Department of Health and Human Services. Fed. R. App. P. 43(c)(2).

COUNSEL

Mark B. Stern, Department of Justice, Washington, D.C., for the defendants-appellants.

Graham A. Boyd, ACLU Drug Policy Litigation, New Haven, Connecticut, for the plaintiffs-appellees.

Stephen C. Willey, Latham & Watkins, Menlo Park, California, for amici American Public Health Association, et al.

Julie M. Carpenter, Robert M. Portman, and Janis C. Kestenbaum, Jenner & Block, Washington, D.C., for amici California Medical Association, et al.

OPINION

SCHROEDER, Chief Judge:

This is an appeal from a permanent injunction entered to protect First Amendment rights. The order enjoins the federal government from either revoking a physician's license to prescribe controlled substances or conducting an investigation of a physician that might lead to such revocation, where the basis for the government's action is solely the physician's professional "recommendation" of the use of medical marijuana. The district court's order and accompanying opinion are at *Conant v. McCaffrey*, 2000 WL 1281174 (N.D. Cal. Sept. 7, 2000). The history of the litigation demonstrates that the injunction is not intended to limit the government's ability to investigate doctors who aid and abet the actual distribution and possession of marijuana. 21 U.S.C. § 841(a). The government has not provided any empirical evidence to demonstrate that this injunction interferes with or threatens to interfere with any legitimate law enforcement activities. Nor is there any evidence that the similarly phrased preliminary injunction that preceded this injunction, *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997), which the government did not appeal, interfered with law enforcement. The district court, on the other hand, explained convincingly when it entered both the earlier preliminary injunction and this permanent injunction, how the government's professed enforcement policy threatens to interfere with expression protected by the First Amendment. We therefore affirm.

I. The Federal Marijuana Policy

The federal government promulgated its policy in 1996 in response to initiatives passed in both Arizona and California decriminalizing the use of marijuana for limited medical purposes and immunizing physicians from prosecution under state law for the "recommendation or approval" of using marijuana for medical purposes. *See* Cal. Health & Safety Code

§ 11362.5. The federal policy declared that a doctor's "action of recommending or prescribing Schedule I controlled substances is not consistent with the 'public interest' (as that phrase is used in the federal Controlled Substances Act)" and that such action would lead to revocation of the physician's registration to prescribe controlled substances.[1] The policy relies on the definition of "public interest" contained in 21 U.S.C. § 823(f), which provides:

> In determining the public interest, the following factors shall be considered: (1) The recommendation of the appropriate State licensing board or professional disciplinary authority. (2) The applicant's experience in dispensing, or conducting research with respect to controlled substances. (3) The applicant's conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances. (4) Compliance with applicable State, Federal, or local laws relating to controlled substances. (5) Such other conduct which may threaten the public health and safety.

The policy also said that the DOJ and the HHS would send a letter to practitioner associations and licensing boards informing those groups of the policy. The federal agencies sent a letter two months later to national, state, and local practitioner associations outlining the Administration's position ("Medical Leader Letter"). The Medical Leader Letter cautioned that physicians who "intentionally provide their

[1]The policy was entitled "The Administration's Response to the Passage of California Proposition 215 and Arizona Proposition 200" and was released on December 30, 1996, by Barry R. McCaffrey, the Director of the Office of National Drug Control Policy ("ONDCP") at the time. The Administration's Response was promulgated by an interagency working group that included the ONDCP; the Drug Enforcement Administration ("DEA"); the Department of Justice ("DOJ"); the Department of Health and Human Services ("HHS"); the Nuclear Regulatory Commission; and the Departments of Treasury, Defense, Transportation, and Education.

patients with oral or written statements in order to enable them to obtain controlled substances in violation of federal law . . . risk revocation of their DEA prescription authority."

II. Litigation History

Plaintiffs are patients suffering from serious illnesses, physicians licensed to practice in California who treat patients with serious illnesses, a patient's organization, and a physician's organization. The patient organization is Being Alive: People with HIV/AIDS Action Coalition, Inc. The physician's organization is the Bay Area Physicians for Human Rights. Plaintiffs filed this action in early 1997 to enjoin enforcement of the government policy insofar as it threatened to punish physicians for communicating with their patients about the medical use of marijuana. The case was originally assigned to District Judge Fern Smith, who presided over the case for more than two years. After Judge Smith received the parties' briefs, she issued a temporary restraining order, certified a plaintiff class, denied the government's motion to dismiss, issued a preliminary injunction, awarded interim attorney's fees to plaintiffs, and set the briefing schedule for discovery.

Judge Smith entered the preliminary injunction on April 30, 1997. It provided that the government "may not take administrative action against physicians for recommending marijuana unless the government in good faith believes that it has substantial evidence" that the physician aided and abetted the purchase, cultivation, or possession of marijuana, 18 U.S.C. § 2, or engaged in a conspiracy to cultivate, distribute, or possess marijuana, 21 U.S.C. § 846. *Id.* at 700. Judge Smith specifically enjoined the "defendants, their agents, employees, assigns, and all persons acting in concert or participating with them, from threatening or prosecuting physicians, [or] revoking their licenses . . . based upon conduct relating to medical marijuana that does not rise to the level of a criminal offense." *Id.* at 701. The preliminary injunction covered not only "recommendations," but also "non-criminal activity related to

those recommendations, such as providing a copy of a patient's medical chart to that patient or testifying in court regarding a recommendation that a patient use marijuana to treat an illness." *Id.* at 701 n.8.

The government did not appeal the preliminary injunction, and it remained in effect after the case was transferred more than two years later to Judge Alsup on August 19, 1999. Judge Alsup in turn granted a motion to modify the plaintiff class, held a hearing on motions for summary judgment, granted in part and denied in part the cross-motions for summary judgment, dissolved the preliminary injunction, and entered a permanent injunction. The class was modified to include only those patients suffering from specific symptoms related to certain illnesses and physicians who treat such patients. The permanent injunction appears to be functionally the same as the preliminary injunction that Judge Smith originally entered. It provides that the government is permanently enjoined from:

> (i) revoking any physician class member's DEA registration merely because the doctor makes a recommendation for the use of medical marijuana based on a sincere medical judgment and (ii) from initiating any investigation solely on that ground. The injunction should apply whether or not the doctor anticipates that the patient will, in turn, use his or her recommendation to obtain marijuana in violation of federal law.

Conant, 2000 WL 1281174, at *16.

In explaining his reasons for entering the injunction, Judge Alsup pointed out that there was substantial agreement between the parties as to what doctors could and could not do under the federal law. *Id.* at *11. The government agreed with plaintiffs that revocation of a license was not authorized where a doctor merely discussed the pros and cons of mari-

juana use. *Id.* The court went on to observe that the plaintiffs agreed with the government that a doctor who actually prescribes or dispenses marijuana violates federal law. The fundamental disagreement between the parties concerned the extent to which the federal government could regulate doctor-patient communications without interfering with First Amendment interests. *Id.* This appeal followed.

III. Discussion

It is important at the outset to observe that this case has been litigated independently of contemporaneous litigation concerning whether federal law exempts from prosecution the dispensing of marijuana in cases of medical necessity. The Supreme Court in that litigation eventually held that it does not, reversing this court. *See United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483 (2001), *rev'g United States v. Oakland Cannabis Buyers' Coop.*, 190 F.3d 1109 (9th Cir. 1999). When the district court entered the permanent injunction in this case, it pointed out that it was doing so without regard to this Circuit's decision in the *Oakland Cannabis* litigation. *Conant*, 2000 WL 1281174, at *15 n.7.

The dispute in the district court in this case focused on the government's policy of investigating doctors or initiating proceedings against doctors only because they "recommend" the use of marijuana. While the government urged that such recommendations lead to illegal use, the district court concluded that there are many legitimate responses to a recommendation of marijuana by a doctor to a patient. There are strong examples in the district court's opinion supporting the district court's conclusion. For example, the doctor could seek to place the patient in a federally approved, experimental marijuana-therapy program. *Id.* at *15. Alternatively, the patient upon receiving the recommendation could petition the government to change the law. *Id.* at *14. By chilling doctors' ability to recommend marijuana to a patient, the district court

held that the prohibition compromises a patient's meaningful participation in public discourse. *Id.* The district court stated:

> Petitioning Congress or federal agencies for redress of a grievance or a change in policy is a time-honored tradition. In the marketplace of ideas, few questions are more deserving of free-speech protection than whether regulations affecting health and welfare are sound public policy. In the debate, perhaps the status quo will (and should) endure. But patients and physicians are certainly entitled to urge their view. To hold that physicians are barred from communicating to patients sincere medical judgments would disable patients from understanding their own situations well enough to participate in the debate. As the government concedes, . . . many patients depend upon discussions with their physicians as their primary or only source of sound medical information. Without open communication with their physicians, patients would fall silent and appear uninformed. The ability of patients to participate meaningfully in the public discourse would be compromised.

Id.

On appeal, the government first argues that the "recommendation" that the injunction may protect is analogous to a "prescription" of a controlled substance, which federal law clearly bars. We believe this characterizes the injunction as sweeping more broadly than it was intended or than as properly interpreted. If, in making the recommendation, the physician intends for the patient to use it as the means for obtaining marijuana, as a prescription is used as a means for a patient to obtain a controlled substance, then a physician would be guilty of aiding and abetting the violation of federal law. That, the injunction is intended to avoid. Indeed the predecessor preliminary injunction spelled out what the injunction did not

bar; it did not enjoin the government from prosecuting physicians when government officials in good faith believe that they have "probable cause to charge under the federal aiding and abetting and/or conspiracy statutes." 172 F.R.D. at 701.

The plaintiffs themselves interpret the injunction narrowly, stating in their brief before this Court that, "the lower court fashioned an injunction with a clear line between protected medical speech and illegal conduct." They characterize the injunction as protecting "the dispensing of information," not the dispensing of controlled substances, and therefore assert that the injunction does not contravene or undermine federal law.

As Judge Smith noted in the preliminary injunction order, conviction of aiding and abetting requires proof that the defendant "associate[d] himself with the venture, that he participate[d] in it as something that he wishe[d] to bring about, that he [sought] by his actions to make it succeed." 172 F.R.D. at 700 (quoting *Cent. Bank of Denver, N.A. v. First Interstate Bank of Denver, N.A.*, 511 U.S. 164, 190 (1994) (internal quotation marks and citation omitted)). This is an accurate statement of the law. We have explained that a conviction of aiding and abetting requires the government to prove four elements: "(1) that the accused had the specific intent to facilitate the commission of a crime by another, (2) that the accused had the requisite intent of the underlying substantive offense, (3) that the accused assisted or participated in the commission of the underlying substantive offense, and (4) that someone committed the underlying substantive offense." *See United States v. Gaskins*, 849 F.2d 454, 459 (9th Cir. 1988). The district court also noted that conspiracy requires that a defendant make "an agreement to accomplish an illegal objective and [that he] knows of the illegal objective and intends to help accomplish it." 172 F.R.D. at 700-01 (citing *United States v. Gil*, 58 F.3d 1414, 1423 & n.5 (9th Cir. 1995)).

The government on appeal stresses that the permanent injunction applies "whether or not the doctor anticipates that the patient will, in turn, use his or her recommendation to obtain marijuana in violation of federal law," and suggests that the injunction thus protects criminal conduct. A doctor's anticipation of patient conduct, however, does not translate into aiding and abetting, or conspiracy. A doctor would aid and abet by acting with the specific intent to provide a patient with the means to acquire marijuana. *See Gaskins*, 849 F.2d at 459. Similarly, a conspiracy would require that a doctor have knowledge that a patient intends to acquire marijuana, agree to help the patient acquire marijuana, and intend to help the patient acquire marijuana. *See Gil*, 58 F.3d at 1423. Holding doctors responsible for whatever conduct the doctor could anticipate a patient *might* engage in after leaving the doctor's office is simply beyond the scope of either conspiracy or aiding and abetting.

The government also focuses on the injunction's bar against "investigating" on the basis of speech protected by the First Amendment and points to the broad discretion enjoyed by executive agencies in investigating suspected criminal misconduct. The government relies on language in the permanent injunction that differs from the exact language in the preliminary injunction. The permanent injunction order enjoins the government "from initiating any investigation solely on" the basis of "a recommendation for the use of medical marijuana based on a sincere medical judgment." *Conant*, 2000 WL 1281174, at *16. The preliminary injunction order provided that "the government may not take administrative action against physicians for recommending marijuana unless the government in good faith believes that it has substantial evidence of [conspiracy or aiding and abetting]." 172 F.R.D. at 701.

[1] The government, however, has never argued that the two injunctive orders differ in any material way. Because we read the permanent injunction as enjoining essentially the

same conduct as the preliminary injunction, we interpret this portion of the permanent injunction to mean only that the government may not initiate an investigation of a physician solely on the basis of a recommendation of marijuana within a bona fide doctor-patient relationship, unless the government in good faith believes that it has substantial evidence of criminal conduct. Because a doctor's recommendation does not itself constitute illegal conduct, the portion of the injunction barring investigations solely on that basis does not interfere with the federal government's ability to enforce its laws.

[2] The government policy does, however, strike at core First Amendment interests of doctors and patients. An integral component of the practice of medicine is the communication between a doctor and a patient. Physicians must be able to speak frankly and openly to patients. That need has been recognized by the courts through the application of the common law doctor-patient privilege. *See* Fed. R. Evid. 501.

[3] The doctor-patient privilege reflects "the imperative need for confidence and trust" inherent in the doctor-patient relationship and recognizes that "a physician must know all that a patient can articulate in order to identify and to treat disease; barriers to full disclosure would impair diagnosis and treatment." *Trammel v. United States*, 445 U.S. 40, 51 (1980). The Supreme Court has recognized that physician speech is entitled to First Amendment protection because of the significance of the doctor-patient relationship. *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 884 (1992) (plurality) (recognizing physician's First Amendment right not to speak); *Rust v. Sullivan*, 500 U.S. 173, 200 (1991) (noting that regulations on physician speech may "impinge upon the doctor-patient relationship").

This Court has also recognized the core First Amendment values of the doctor-patient relationship. In *Nat'l Ass'n for the Advancement of Psychoanalysis v. California Bd. of Psychology*, 228 F.3d 1043 (9th Cir. 2000), we recognized that com-

munication that occurs during psychoanalysis is entitled to First Amendment protection. *Id.* at 1054. We upheld California's mental health licensing laws that determined when individuals qualified as mental health professionals against a First Amendment challenge. *Id.* at 1053-56. Finding the laws content-neutral, we noted that California did not attempt to "dictate the content of what is said in therapy" and did not prevent licensed therapists from utilizing particular "psychoanalytical methods." *Id.* at 1055-56.

Being a member of a regulated profession does not, as the government suggests, result in a surrender of First Amendment rights. *See Thomas v. Collins*, 323 U.S. 516, 531 (1945) ("the rights of free speech and a free press are not confined to any field of human interest"). To the contrary, professional speech may be entitled to "the strongest protection our Constitution has to offer." *Florida Bar v. Went-For-It, Inc.*, 515 U.S. 618, 634 (1995). Even commercial speech by professionals is entitled to First Amendment protection. *See Bates v. Arizona*, 433 U.S. 350, 382-83 (1977). Attorneys have rights to speak freely subject only to the government regulating with "narrow specificity." *NAACP v. Button*, 371 U.S. 415, 433, 438-39 (1963).

In its most recent pronouncement on regulating speech about controlled substances, *Thompson v. Western States Medical Ctr.*, 122 S. Ct. 1497 (2002), the Supreme Court found that provisions in the Food and Drug Modernization Act of 1997 that restricted physicians and pharmacists from advertising compounding drugs violated the First Amendment. *Id.* at 1500. The Court refused to make the "questionable assumption that doctors would prescribe unnecessary medications" and rejected the government's argument that "people would make bad decisions if given truthful information about compounded drugs." *Id.* at 1507. The federal government argues in this case that a doctor-patient discussion about marijuana might lead the patient to make a bad decision, essentially asking us to accept the same assumption

rejected by the Court in *Thompson*. *Id.* We will not do so. Instead, we take note of the Supreme Court's admonition in *Thompson*: "If the First Amendment means anything, it means that regulating speech must be a last—not first—resort. Yet here it seems to have been the first strategy the Government thought to try." *Id.*

[4] The government's policy in this case seeks to punish physicians on the basis of the content of doctor-patient communications. Only doctor-patient conversations that include discussions of the medical use of marijuana trigger the policy. Moreover, the policy does not merely prohibit the discussion of marijuana; it condemns expression of a particular viewpoint, i.e., that medical marijuana would likely help a specific patient. Such condemnation of particular views is especially troubling in the First Amendment context. "When the government targets not subject matter but particular views taken by speakers on a subject, the violation of the First Amendment is all the more blatant." *Rosenberger v. Rector*, 515 U.S. 819, 829 (1995). Indeed, even content-based restrictions on speech are "presumptively invalid." *R.A.V. v. St. Paul*, 505 U.S. 377, 382 (1992).

[5] The government's policy is materially similar to the limitation struck down in *Legal Services Corp. v. Velazquez*, 531 U.S. 533 (2001), that prevented attorneys from "present[ing] all the reasonable and well-grounded arguments necessary for proper resolution of the case." 531 U.S. at 545. In *Velazquez*, a government restriction prevented legal assistance organizations receiving federal funds from challenging existing welfare laws. *Id.* at 537-38. Like the limitation in *Velazquez*, the government's policy here "alter[s] the traditional role" of medical professionals by "prohibit[ing] speech necessary to the proper functioning of those systems." *Id.* at 544.

The government relies upon *Rust* and *Casey* to support its position in this case. *Rust*, 500 U.S. 173; *Casey*, 505 U.S. 833. However, those cases did not uphold restrictions on speech

itself. *Rust* upheld restrictions on federal funding for certain types of activity, including abortion counseling, referral, or advocacy. *See Rust*, 500 U.S. at 179-80. In *Casey*, a plurality of the Court upheld Pennsylvania's requirement that physicians' advice to patients include information about the health risks associated with an abortion and that physicians provide information about alternatives to abortion. 505 U.S. at 883-84. The plurality noted that physicians did not have to comply if they had a reasonable belief that the information would have a "severely adverse effect on the physical or mental health of the patient," and thus the statute did not "prevent the physician from exercising his or her medical judgment." *Id.* The government's policy in this case does precisely that.

The government seeks to justify its policy by claiming that a doctor's "recommendation" of marijuana may encourage illegal conduct by the patient, which is not unlike the argument made before, and rejected by, the Supreme Court in a recent First Amendment case. *See Ashcroft v. Free Speech Coalition, Inc.*, 122 S. Ct. 1389, 1403 (2002). In *Free Speech Coalition*, the government defended the Child Pornography Prosecution Act of 1996 by arguing that, although virtual child pornography does not harm children in the production process, it threatens them in "other, less direct, ways." *Id.* at 1397. For example, the government argued pedophiles might use such virtual images to encourage children to participate in sexual activity. *Id.* The Supreme Court rejected such justifications, holding that the potential harms were too attenuated from the proscribed speech. "Without a significantly stronger, more direct connection, the Government may not prohibit speech on the ground that it may encourage . . . illegal conduct." *Id.* at 1403. The government's argument in this case mirrors the argument rejected in *Free Speech Coalition.*

The government also relies on a case in which a district court refused to order an injunction against this federal drug policy. *See Pearson v. McCaffrey*, 139 F. Supp. 2d 113, 125 (D.D.C. 2001). The court did so, however, because the plain-

tiffs in that case did not factually support their claim that the policy chilled their speech. *See id.* at 120. In this case, the record is replete with examples of doctors who claim a right to explain the medical benefits of marijuana to patients and whose exercise of that right has been chilled by the threat of federal investigation. The government even stipulated in the district court that a "reasonable physician would have a genuine fear of losing his or her DEA registration to dispense controlled substances if that physician were to recommend marijuana to his or her patients."

[6] To survive First Amendment scrutiny, the government's policy must have the requisite "narrow specificity." *See Button*, 371 U.S. at 433. Throughout this litigation, the government has been unable to articulate exactly what speech is proscribed, describing it only in terms of speech the patient believes to be a recommendation of marijuana. Thus, whether a doctor-patient discussion of medical marijuana constitutes a "recommendation" depends largely on the meaning the patient attributes to the doctor's words. This is not permissible under the First Amendment. *See Thomas v. Collins*, 323 U.S. 516, 535 (1945). In *Thomas*, the court struck down a state statute that failed to make a clear distinction between union membership, solicitation, and mere "discussion, laudation, [or] general advocacy." The distinction rested instead on the meaning the listeners attributed to spoken words. *Id.* The government's policy, like the statute in *Thomas*, leaves doctors and patients "no security for free discussion." *Id.* As Judge Smith appropriately noted in granting the preliminary injunction, "when faced with the fickle iterations of the government's policy, physicians have been forced to suppress speech that would not rise to the level of that which the government constitutionally may prohibit." 172 F.R.D. at 696.

Our decision is consistent with principles of federalism that have left states as the primary regulators of professional conduct. *See Whalen v. Roe*, 429 U.S. 589, 603 n.30 (1977) (recognizing states' broad police powers to regulate the

administration of drugs by health professionals); *Linder v. United States*, 268 U.S. 5, 18 (1925) ("direct control of medical practice in the states is beyond the power of the federal government"). We must "show[ ] respect for the sovereign States that comprise our Federal Union. That respect imposes a duty on federal courts, whenever possible, to avoid or minimize conflict between federal and state law, particularly in situations in which the citizens of a State have chosen to serve as a laboratory in the trial of novel social and economic experiments without risk to the rest of the country." *Oakland Cannabis*, 532 U.S. at 501 (Stevens, J., concurring) (internal quotation marks omitted).

[7] For all of the foregoing reasons, we affirm the district court's order entering a permanent injunction.

AFFIRMED.

KOZINSKI, Circuit Judge, concurring:

I am pleased to join Chief Judge Schroeder's opinion. I write only to explain that for me the fulcrum of this dispute is not the First Amendment right of the doctors. That right certainly exists and its impairment justifies the district court's injunction for the reasons well explained by Chief Judge Schroeder. But the doctors' interest in giving advice about the medical use of marijuana is somewhat remote and impersonal; they will derive no direct *benefit* from giving this advice, other than the satisfaction of doing their jobs well. At the same time, the *burden* of the federal policy the district court enjoined falls directly and personally on the doctors: By speaking candidly to their patients about the potential benefits of medical marijuana, they risk losing their license to write prescriptions, which would prevent them from functioning as

doctors. In other words, they may destroy their careers and lose their livelihoods.[1]

This disparity between benefits and burdens matters because it makes doctors peculiarly vulnerable to intimidation; with little to gain and much to lose, only the most foolish or committed of doctors will defy the federal government's policy and continue to give patients candid advice about the medical uses of marijuana.[2] Those immediately and directly

---

[1]Dr. Neil M. Flynn, Professor at the University of California at Davis School of Medicine, offers one perspective:

> AIDS medicine is my profession and my passion. I have dedicated myself to this disease since 1983 when I opened the Clinic at U.C. Davis. Thus, I am deeply concerned about civil and criminal sanctions that loom over me . . . . If I lost my Schedule II license, my ability to provide care for people with AIDS—80% of my patients—would be severely compromised. I write 30-50 narcotic prescriptions per month for my seriously ill patients. I would no longer be able to do so if my DEA license were revoked.

[2]As Alice Pasetta Mead explained in her expert report:

> [P]hysicians are particularly easily deterred by the threat of governmental investigation and/or sanction from engaging in conduct that is entirely lawful and medically appropriate . . . . [A] physician's practice is particularly dependent upon the physician's maintaining a reputation of unimpeachable integrity. A physician's career can be effectively destroyed merely by the fact that a governmental body has investigated his or her practice . . . .

The federal government's policy had precisely this effect before it was enjoined by the district court. Dr. Milton N. Estes, Associate Clinical Professor in the Department of Obstetrics, Gynecology and Reproductive Medicine at the University of California-San Francisco (UCSF), reports:

> As a result of the government's public threats, I do not feel comfortable even discussing the subject of medical marijuana with my patients. I feel vulnerable to federal sanctions that could strip me of my license to prescribe the treatments my patients depend upon, or even land me behind bars . . . . Because of these fears, the discourse about medical marijuana has all but ceased at my medical office . . . . My patients bear the brunt of this loss in communication.

affected by the federal government's policy are the patients, who will be denied information crucial to their well-being, and the State of California, whose policy of exempting certain patients from the sweep of its drug laws will be thwarted. In my view, it is the vindication of these latter interests—those of the patients and of the state—that primarily justifies the district court's highly unusual exercise of discretion in enjoining the federal defendants from even investigating possible violations of the federal criminal laws.

In 1996, the people of California, acting by direct initiative, adopted a narrow exemption from their laws prohibiting the cultivation, sale and use of marijuana. The exemption applies only to patients whose physicians recommend or prescribe the drug for medical purposes. To those unfamiliar with the issue, it may seem faddish or foolish for a doctor to recommend a drug that the federal government finds has "no currently accepted medical use in treatment in the United States," 21 U.S.C. § 812(b)(1)(B). But the record in this case, as well as the public record, reflect a legitimate and growing division of informed opinion on this issue. A surprising number of health care professionals and organizations have concluded that the use of marijuana may be appropriate for a small class of patients who do not respond well to, or do not tolerate, available prescription drugs.[3]

And Dr. Stephen O'Brien, former co-director of UCSF HIV Managed Care, similarly notes:

> Due to fear caused by these threats, I feel compelled and coerced to withhold information, recommendations, and advice to patients regarding use of medical marijuana . . . . I am fearful and reluctant to engage in even limited communications regarding medical marijuana.

[3]I am indebted to the brief of amici American Public Health Association et al. for its lucid and forceful analysis of this issue. Much of the discussion in the text is plagiarized from that brief. For ease of readability, I dispense with further attribution.

Following passage of the California initiative, the White House Office of National Drug Control Policy commissioned the National Institute of Medicine of the National Academy of Sciences (IOM) to review the scientific evidence of the therapeutic application of cannabis. *See* Inst. of Med., *Marijuana and Medicine: Assessing the Science Base* (Janet E. Joy et al. eds., 1999) [hereinafter IOM Report], *available at* http://www.nap.edu/books/0309071550/html. The year-long study included scientific workshops, analysis of relevant scientific literature and extensive consultation with biomedical and social scientists. *Id.* at 15. It resulted in a 250-plus-page report which concluded that "[s]cientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation," *id.* at 179.

The IOM Report found that marijuana can provide superior relief to patients who suffer these symptoms as a result of certain illnesses and disabilities, in particular metastic cancer, HIV/AIDS, multiple sclerosis (MS), spinal cord injuries and epilepsy, and those who suffer the same symptoms as side effects from the aggressive treatments for such conditions. *See id.* at 53, 142, 153-54, 157, 160. As a consequence, the IOM Report cautiously endorsed the medical use of marijuana. *See id.* at 179.[4]

[4]The IOM Report concluded:

> Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting) must meet the following conditions: failure of all approved medications to provide relief has been documented, the symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs, such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness, and [the treatment] involves an oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use.

At about the time the IOM study got underway, the British House of Lords—a body not known for its wild and crazy views—opened public hearings on the medical benefits and drawbacks of cannabis. Like the IOM, the Lords concluded that "cannabis almost certainly does have genuine medical applications, especially in treating the painful muscular spasms and other symptoms of MS and in the control of other forms of pain." Select Comm. on Sci. & Tech., House of Lords, Sess. 1997-98, Ninth Report, *Cannabis: The Scientific and Medical Evidence: Report* § 8.2 (Nov. 4, 1998), *available at* http://www.publications.parliament.uk/pa/ld199798/ldselect/ldsctech/151/15101.htm. The Lords recommended that the British government act immediately "to allow doctors to prescribe an appropriate preparation of cannabis, albeit as an unlicensed medicine." *Id.* § 8.6.

In June 2001, Canada promulgated its Marihuana Medical Access Regulations after an extensive study of the available evidence. *See* Marihuana Medical Access Regulations, SOR 2001-227 (June 14, 2001), *available at* http://laws.justice.gc.ca/en/C-38.8/SOR-2001-227/index.html. The new regulations allow certain persons to cultivate and possess marijuana for medical use, and authorize doctors to

---

Id. at 179.

The IOM limited its recommendation to six months primarily because of health concerns about damage from smoking the drug for a prolonged period of time. *See id.* at 126, 179. This concern may be less alarming to patients suffering critical or terminal illnesses. As Dr. Debasish Tripathy, Assistant Clinical Professor of Medicine at UCSF, explains, "Any discussion of adverse consequences appears to focus on the effects of long-term use (*e.g.*, adverse effects on the lungs), and even those concerns are speculative . . . . In populations with short life expectancies, the risks become less imminent and the benefits more paramount." *See also* Jerome P. Kassirer, M.D., Editorial, *Federal Foolishness and Marijuana*, New Eng. J. Med., Jan. 30, 1997, at 366, 366 ("Marijuana may have long-term adverse effects and its use may presage serious addictions, but neither long-term side effects nor addiction is a relevant issue in such patients.").

recommend and prescribe marijuana to patients who are suffering from severe pain, muscle spasms, anorexia, weight loss or nausea, and who have not found relief from conventional therapies. *See* Office of Cannabis Med. Access, Health Canada, *Medical Access to Marijuana—How the Regulations Work*, *at* http://www.hc-sc.gc.ca/hecs-sesc/ocma/bckdr_1-0601.htm (last visited Aug. 23, 2002).[5]

Numerous other studies and surveys support the use of medical marijuana in certain limited circumstances.[6] The fed-

[5]In 1988, an Administrative Law Judge of the Drug Enforcement Administration similarly concluded that certain patients should have access to medical marijuana. *See In re Marijuana Rescheduling Petition*, No. 86-22 (Drug Enforcement Admin. Sept. 6, 1988). ALJ Young found:

> The evidence in this record clearly shows that marijuana has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record.

Id. at 68. The DEA Administrator did not endorse the ALJ's findings. *See* 54 Fed. Reg. 53,767 (Dec. 29, 1989).

[6]*See, e.g.*, Clive Cookson, *High Hopes for Cannabis To Relieve Pain*, Fin. Times, Sept. 4, 2001, National News, at 4 ("Cannabis extract is proving remarkably effective at relieving severe pain in patients with multiple sclerosis and spinal injury . . . ."); David Baker et al., *Cannabinoids Control Spasticity and Tremor in a Multiple Sclerosis Model*, 404 Nature 84 (2000) (finding therapeutic potential in the use of cannabis to control the debilitating symptoms of MS); William J. Martin, *Basic Mechanisms of Cannabinoid-Induced Analgesia*, Int'l Ass'n for the Study of Pain Newsletter, Summer 1999, *available at* http://www.halcyon.com/iasp/TC99Summer.html (noting that cannabinoids can reduce pain); Richard E. Doblin & Mark A.R. Kleiman, *Marijuana as Antiemetic Medicine: A Survey of Oncologists' Experiences and Attitudes*, 9 J. Clinical Oncology 1314 (1991) (reporting that a majority of oncologists surveyed thought marijuana should be available by prescription); H.M. Meinck et al., *Effect of Cannabinoids on Spasticity and Ataxia in Multiple Sclerosis*, 236 J. Neurology 120 (1989) (concluding from a neurological study that herbal cannabis provided relief from both muscle spasms and ataxia, a combined benefit not found in other available medications); Vincent Vinciguerra et al., *Inhalation Marijuana as an Antiemetic for Cancer Chemotherapy*, 88 N.Y. St. J. Med. 525 (1988) (finding that 78% of patients who were unresponsive to standard antiemetics responded positively to cannabis).

eral government itself has conducted studies on the subject, and continues to fund and provide the marijuana for studies conducted by private researchers. *See, e.g.*, Bill Workman, *Pot Study in Spotlight: San Mateo County's Clinical Trial Is a First in U.S.*, S.F. Chron., July 25, 2001, at A13; *see also* University of California Center for Medicinal Cannabis Research, *Research*, *at* http://www.cmcr.ucsd.edu/geninfo/research.htm (last visited Aug. 23, 2002) (listing eleven studies, nine of which have received regulatory approval, that will use federally supplied marijuana). Finally, the medical histories of individuals who have received and continue to receive medical marijuana from the federal government (reproduced in the Appendix) provide compelling support for the view that medical marijuana can make the difference between a relatively normal life and a life marred by suffering.

No doubt based on this and similar evidence, seven states (Alaska, Arizona, Colorado, Maine, Nevada, Oregon and Washington) have followed California in enacting medical marijuana laws by voter initiative, *see* Alaska Stat. Ann. §§ 11.71.090, 17.37.010-.080; Ariz. Rev. Stat. § 13-3412.01; Colo. Const. art. XVIII, § 14; Me. Rev. Stat. Ann. tit. 22, § 2383-B5; Nev. Const. art. 4, § 38; Or. Rev. Stat. §§ 475.300-.346; Wash. Rev. Code §§ 69.51A.005-.902; one other state (Hawaii) has done so by legislative enactment, *see* Haw. Rev. Stat. §§ 329-121 to -128. The total number of states that have approved marijuana for medical purposes now stands at nine.

The evidence supporting the medical use of marijuana does not prove that it is, in fact, beneficial. There is also much evidence to the contrary, and the federal defendants may well be right that marijuana provides no additional benefit over approved prescription drugs, while carrying a wide variety of serious risks.[7] What matters, however, is that there is a genu-

[7]*See* 66 Fed. Reg. 20,038 (Apr. 18, 2001) (citing sources).

ine difference of expert opinion on the subject, with significant scientific and anecdotal evidence supporting both points of view. *See (Medical) MarijuanaInfo.org, at* http://www.marijuanainfo.org (last visited Aug. 27, 2002) (exhaustive catalog of information and expert opinion on both sides of the medical marijuana debate). For the great majority of us who do not suffer from debilitating pain, or who have not watched a loved one waste away as a result of AIDS-induced anorexia, *see* IOM Report at 154, it doesn't much matter who has the better of this debate. But for patients suffering from MS, cancer, AIDS or one of the other afflictions listed in the IOM report, and their loved ones, obtaining candid and reliable information about a possible avenue of relief is of vital importance.

It is well established that the right to hear—the right to receive information—is no less protected by the First Amendment than the right to speak. *See, e.g., Bd. of Educ.* v. *Pico*, 457 U.S. 853, 866-67 (1982); *Va. State Bd. of Pharmacy* v. *Va. Citizens Consumer Council, Inc.*, 425 U.S. 748, 756-57 (1976); *Kleindienst* v. *Mandel*, 408 U.S. 753, 762-63 (1972). Indeed, the right to hear and the right to speak are flip sides of the same coin. As Justice Brennan put it pithily, "It would be a barren marketplace of ideas that had only sellers and no buyers." *Lamont* v. *Postmaster General*, 381 U.S. 301, 308 (1965) (Brennan, J., concurring), *quoted with approval in Pico*, 457 U.S. at 867. This does not mean, however, that the right to speak and the right to listen always carry the same weight when a court exercises its equitable discretion. In this case, for instance, it is perfectly clear that the harm to patients from being denied the right to receive candid medical advice is far greater than the harm to doctors from being unable to deliver such advice.[8] While denial of the right to speak is

[8]Dr. Stephen Eliot Follansbee, Chief of Staff at Davies Medical Center, noted the importance of this information to patients:

> Patients who seek my advice regarding the benefits of medical marijuana are evidence that there is hope. They have a very

never trivial, the simple fact is that if the injunction were denied, the doctors would be able to continue practicing medicine and go on with their lives more or less as before. It is far different for patients who suffer from horrible disabilities, such as plaintiff Judith Cushner, a mother of two and the director of a preschool program, who has fought breast cancer since 1989, and who only found relief from the debilitating effects of chemotherapy by smoking cannabis to counteract nausea, retching and chronic mouth sores; plaintiff Keith Vines, an Assistant District Attorney, decorated Air Force officer and father, whose bout with AIDS had caused him to lose more than 40 pounds of lean body mass, which he was only able to recover by using cannabis to stimulate his appetite; and many others like them. Enforcement of the federal policy will cut such patients off from competent medical advice and leave them to decide on their own whether to use marijuana to alleviate excruciating pain, nausea, anorexia or similar symptoms. But word-of-mouth and the Internet are poor substitutes for a medical doctor; information obtained from chat rooms and tabloids cannot make up for the loss of individualized advice from a physician with many years of training and experience.

A few patients may be deterred by the lack of a doctor's recommendation from using marijuana for medical purposes, but I suspect it would be very few indeed, because the penal-

> strong desire to survive their illness and to function as normally and productively as possible . . . . These patients ask me about marijuana not because they want to get high, but because they are fighting for their lives, which includes an honest search for the best available means to do so. Government threats against the physicians who struggle with these patients will inevitably thwart the patients' efforts. They may, in fact, remove their doctors from the healing process when vulnerable individuals are most in need of their counsel. Denying information and treatment advice to a seriously ill patient, when that medicine could promote and facilitate critical medical treatment, may needlessly hasten the patient's death.

ties under state law for possession of small amounts of the drug are trivial. *See* Cal. Health & Safety Code § 11357(b) (making small-quantity possession a misdemeanor carrying a maximum $100 fine). A far more likely consequence is that, in the absence of sound medical advice, many patients desperate for relief from debilitating pain or nausea would self-medicate, and wind up administering the wrong dose or frequency, or use the drug where a physician would advise against it. Whatever else the parties may disagree about, they agree that marijuana is a powerful and complex drug, the kind of drug patients should *not* use without careful professional supervision.[9] The unintended consequence of the federal government's policy—a policy no doubt adopted for laudable reasons—will be to dry up the only reliable source of advice and supervision critically ill patients have, and drive them to use this powerful and dangerous drug on their own.

Which points to the second important interest impaired by the federal government's policy: California's interest in legal-

[9]Patients who use marijuana for medical purposes must strike a delicate balance; they must take enough of the drug so that they get needed relief from pain or other symptoms, but not so much as to induce the drug's well-known hallucinogenic side-effects, which interfere with daily life activities. Valerie A. Corral, who suffered from severe seizures before using medical marijuana, explains that she only needs "a few puffs of marijuana" to find relief that over fifteen pills a day could not provide. Judith Cushner recalls that smoking small amounts of marijuana as part of her cancer treatment was neither "a regular part of [her] day, nor did it become a habit." She states: "I smoked it only when nausea or retching commenced or worsened, usually in conjunction with a treatment session. There were weeks when I smoked it every few days. There were also periods when I didn't smoke for weeks at a time. Each time I felt a wave of nausea coming on, I inhaled just two or three puffs and it subsided." Similarly, Assistant District Attorney Keith Vines, countering AIDS-induced wasting syndrome, found that "it took only two or three puffs from a marijuana cigarette for my appetite to return . . . . Because I only required a small dose to stimulate my appetite, I did not need to get stoned in order to eat." Patients lacking the benefit of medical guidance may well take more than appropriate to alleviate their symptoms, unnecessarily suffering the drug's powerful side-effects.

izing the use of marijuana in certain limited circumstances, so that critically ill patients may use it if and only if it is medically advisable for them to do so. The state relies on the recommendation of a state-licensed physician to define the line between legal and illegal marijuana use. The federal government's policy deliberately undermines the state by incapacitating the mechanism the state has chosen for separating what is legal from what is illegal under state law. Normally, of course, this would not be a problem, because where state and federal law collide, federal law prevails. *See Gade* v. *Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 108 (1992); *cf. United States* v. *Oakland Cannabis Buyers' Coop.*, 532 U.S. 483 (2001). In the circumstances of this case, however, I believe the federal government's policy runs afoul of the "commandeering" doctrine announced by the Supreme Court in *New York* v. *United States*, 505 U.S. 144 (1992), and *Printz* v. *United States*, 521 U.S. 898 (1997).

New York and *Printz* stand for the proposition that "[t]he Federal Government may neither issue directives requiring the States to address particular problems, nor command the States' officers, or those of their political subdivisions, to administer or enforce a federal regulatory program." *Printz*, 521 U.S. at 935. Applied to our situation, this means that, much as the federal government may prefer that California keep medical marijuana illegal,[10] it cannot force the state to do

[10]Following the passage of California's medical marijuana initiative, federal officials expressed concern that the measure would seriously affect the federal government's drug enforcement effort. They explained that federal drug policies rely heavily on the states' enforcement of their own drug laws to achieve federal objectives. In hearings before the Senate Judiciary Committee, DEA Administrator Thomas A. Constantine stated:

> I have always felt . . . that the federalization of crime is very difficult to carry out; that crime, just in essence, is for the most part a local problem and addressed very well locally, in my experience. We now have a situation where local law enforcement is unsure . . . . The numbers of investigations that you would talk

so. Yet, the effect of the federal government's policy is precisely that: By precluding doctors, on pain of losing their DEA registration, from making a recommendation that would legalize the patients' conduct under state law, the federal policy makes it impossible for the state to exempt the use of medical marijuana from the operation of its drug laws. In effect, the federal government is forcing the state to keep medical marijuana illegal. But preventing the state from repealing an existing law is no different from forcing it to pass a new one; in either case, the state is being forced to regulate conduct that it prefers to leave unregulated.

It is true that by removing state penalties for the use of marijuana, a doctor's recommendation may embolden patients to buy the drug, and others to sell it to them, in violation of federal law. But the doctors *only* help patients obtain the drug by removing state penalties for possession and sale; they do not purport to exempt patients or anyone else from federal law, nor could they. If the federal government could make it illegal under federal law to remove a state-law penalty, it could then accomplish exactly what the commandeering doctrine prohibits: The federal government could force the state to criminal-

---

> about that might be presently being conducted by the [Arizona state police] at the gram level or the milligram level would be beyond our capacity to conduct those types of individual investigations without abandoning the major organized crime investigations.

Prescription for Addiction? The Arizona and California Medical Drug Use Initiatives: Hearing Before the S. Comm. on the Judiciary, 104th Cong. 42-43, 45 (1996) [hereinafter Judiciary Hearing] (statement of Thomas A. Constantine); *see also* Tim Golden, *Doctors Are Focus of Plan To Fight New Drug Laws: Officials Deal with Narcotics' Medical Use*, N.Y. Times, Dec. 23, 1996, at A10 ("Federal agents and prosecutors in fact pursue only a small fraction of the country's drug cases. In most districts, officials said, United States Attorneys bring Federal charges only if a marijuana case involves the cultivation of at least 500 plants grown indoors, 1,000 plants grown outdoors, or the possession of more than 1,000 pounds.").

ize behavior it has chosen to make legal.[11] That patients may be more likely to violate federal law if the additional deterrent of state liability is removed may worry the federal government, but the proper response—according to *New York* and *Printz*—is to ratchet up the federal regulatory regime, *not* to commandeer that of the state.

Nor does the state have another mechanism available to distinguish lawful from unlawful conduct. The state law in question does not legalize use of marijuana by anyone who believes he has a medical need for it. Rather, state law is closely calibrated to exempt from regulation only patients who have consulted a physician. And the physician may only recommend marijuana when he has made an individualized and bona fide determination that the patient is within the small group that may benefit from its use. If medical doctors are unable or unwilling to make this determination because they fear losing their DEA registration, there is no one who can take their place. Nurses and paramedics aren't qualified to do it, which is why they don't have authority to write prescriptions in the first place. Lawyers, judges and police can't do it, except by asking the advice of physicians. State administrators can't do it. If doctors are taken out of the picture—as the federal policy clearly aims to do—the state's effort to withdraw its criminal sanctions from marijuana use by the small group of patients who could benefit from such use is bound to be frustrated. The federal government's attempt to target doctors—eliminating the only viable mechanism for distinguishing between legal and illegal drug use—is a back-

[11]Federal defendants concede that this is their goal, arguing that the doctors' actions are illegal because "[w]ithout [the doctors'] clinical recommendation or approval, patients and their primary caregivers are unable to invoke [Proposition 215's] protections from criminal prosecution or sanction *under state law*." Appellants' Reply Br. at 6 (internal quotation marks omitted) (emphasis added). General Barry McCaffrey, Director of the Office of National Drug Control Policy, made the same point: "Federal law is not at stake; the actions of local law enforcement are." Judiciary Hearing, *supra*, at 40.

door attempt to "control or influence the manner in which States regulate private parties." *Reno* v. *Condon*, 528 U.S. 141, 150 (2000) (internal quotation marks omitted).

This is not a situation like *United States* v. *Moore*, 423 U.S. 122 (1975), where a doctor used his prescriptions license to circumvent the federal drug laws. Moore conducted inadequate or no medical examinations, ignored the results of the few tests he did perform, prescribed however many tablets the "patient" asked for and graduated his fee according to the number he prescribed. *See id.* at 142-43. The Court concluded that Moore had abandoned his professional role and effectively become a drug dealer. Here, by contrast, doctors are performing their normal function as doctors and, in so doing, are determining who is exempt from punishment under state law. If a doctor abuses this privilege by recommending marijuana without examining the patient, without conducting tests, without considering the patient's medical history or without otherwise following standard medical procedures, he will run afoul of state as well as federal law. But doctors who recommend medical marijuana to patients after complying with accepted medical procedures are not acting as drug dealers; they are acting in their professional role in conformity with the standards of the state where they are licensed to practice medicine. The doctor-patient relationship is an area that falls squarely within the states' traditional police powers. The federal government may not force the states to regulate that relationship to advance federal policy.

The commandeering problem becomes even more acute where Congress legislates at the periphery of its powers. The Constitution authorizes Congress to regulate activities that affect interstate commerce. But that authority is not boundless. As the Supreme Court recently reminded us, Congress must exercise its power so as to preserve "the Constitution's distinction between national and local authority." *United States* v. *Morrison*, 529 U.S. 598, 615 (2000). That distinction, in turn, was designed "so that the people's rights would

be secured by the division of power." *Id.* at 616 n.7; *see also U.S. Term Limits, Inc.* v. *Thornton*, 514 U.S. 779, 838 (1995) (Kennedy, J., concurring) ("The Framers split the atom of sovereignty. It was the genius of their idea that our citizens would have two political capacities, one state and one federal, each protected from incursion by the other."). The Supreme Court's recent Commerce Clause jurisprudence is cut from the same cloth as the commandeering principle; both protect the duality of our unique system of government. The Commerce Clause limits the scope of national power, while the commandeering doctrine limits how Congress may use the power it has. These checks work in tandem to ensure that the federal government legislates in areas of truly national concern, while the states retain independent power to regulate areas better suited to local governance.

Medical marijuana, when grown locally for personal consumption, does not have any direct or obvious effect on interstate commerce. *Cf. Oakland Cannabis Buyers' Coop.*, 532 U.S. at 495 n.7 (reserving "whether the Controlled Substances Act exceeds Congress' power under the Commerce Clause"). Federal efforts to regulate it considerably blur the distinction between what is national and what is local. But allowing the federal government, already nearing the outer limits of its power, to act through unwilling state officials would "obliterate the distinction" entirely. *United States* v. *Lopez*, 514 U.S. 549, 557 (1995) (internal quotation marks omitted).[12]

It may well be, as our opinion holds, that interference with the rights of doctors to speak is sufficient to support the district court's injunction. Nevertheless, it remains a significant

[12]The reluctance of state officials to enforce federal drug policies against medical marijuana patients is not merely theoretical. *See* William Booth, *Santa Cruz Defies U.S. on Marijuana: City Officials Vow To Defend Medical Uses*, Wash. Post, Sept. 18, 2002, at A3. It is precisely such conflicts between state and federal officials that the commandeering doctrine is designed in part to prevent.

step for a court to enjoin the prosecution and even investigation of what federal officials believe may be a violation of federal law. *See, e.g.*, *Bresgal* v. *Brock*, 843 F.2d 1163, 1171 (9th Cir. 1987); *Jett* v. *Castaneda*, 578 F.2d 842, 845 (9th Cir. 1978). In affirming the district court, I therefore find comfort in knowing that the interests of the patients, and those of the state, provide significant additional support for the district court's exercise of discretion.

Appendix

From 1978 to 1992, the federal government conducted its own medical marijuana program. Today, the government continues to supply individuals who participated in this program with marijuana under its Compassionate Care program; they are among the few people in the country who can use the drug legally. Together with the American Public Health Association and other health care and medical organizations, individuals in this group filed an amicus brief supporting the plaintiffs. The following are their personal statements, taken from that brief.

Barbara M. Douglass was diagnosed with Multiple Sclerosis in 1988 at the age of 22. In 1991, Ms. Douglass began receiving herbal cannabis from the United States government upon the advice and assistance of her physician. Prior to this date, Ms. Douglass had never tried cannabis. Each month, the government provides her physician with one can containing three hundred cannabis cigarettes, each weighing 7/10 oz. Ms. Douglass and her physician report that herbal cannabis provides relief from pain and spasms and stimulates her appetite to counteract the effects of wasting syndrome from which she suffered prior to using cannabis. Ms. Douglass has never experienced any adverse side effects from marijuana. Without cannabis, Ms. Douglass believes she would not be alive today.

George Lee McMahon was born July 22, 1950, with Nail Patella Syndrome, a rare genetic disorder that causes severe pain, nausea and muscle spasms. Mr. McMahon tried conventional medications to treat his symptoms, but found the side effects of these medications to be intolerable. In the early 1980s, Mr. McMahon discovered that herbal cannabis alleviated his pain, nausea and spasms, stimulated his appetite and allowed him to sleep through the night. In 1988, Mr. McMahon informed his physician that he was successfully self-medicating with cannabis. His physician ordered him to cease his cannabis use and return to prescription medications. Over the following six months, Mr. McMahon's health progressively degenerated. Mr. McMahon's physician then helped Mr. McMahon apply to the federal government's Compassionate Care IND Program. In March 1990, Mr. McMahon was accepted into the program and for the past decade has received 300 cannabis cigarettes each month from the United States government. Mr. McMahon and his physician believe that without cannabis Mr. McMahon would not be alive today.

Elvy Musikka was diagnosed with glaucoma in 1975 at the age of 36. She tried conventional medications to treat her condition, but could not tolerate them. Reluctantly, in 1976, she decided to try herbal cannabis at the advice of her physician. The cannabis provided her immediate relief, substantially lowering her intraocular pressure as no other medication had, with few side effects. Ms. Musikka ingests cannabis by smoking it, as well as eating it in baked goods and olive oil. Fearful of the legal consequences of smoking cannabis, Ms. Musikka underwent several risky surgeries in an attempt to correct her condition, but they were unsuccessful and left her blind in one eye. In 1988, Ms. Musikka was arrested in Florida and charged with cannabis possession. She challenged her conviction in the Florida Supreme Court, where she prevailed, becoming the first person in that state to establish a medical necessity defense for cannabis. Shortly thereafter, the federal government enrolled Ms. Musikka in its medical cannabis

program and has provided her with one and one-half pounds of herbal cannabis on a quarterly basis ever since. Ms. Musikka and her physician believe that if she were deprived of cannabis she would go blind.

Irvin Henry Rosenfeld was diagnosed at age 10 with multiple congenital cartilaginous exostosis, a disease causing the continuous growth of bone tumors, and the generation of new tumors, on ends of most of the long bones in his body. He was told he would not survive into adulthood. In an attempt to treat the painful symptoms of this disease, he was prescribed high doses of opioid analgesics, muscle relaxants and anti-inflammatory medications, which he took on a daily basis, but which had minimal efficacy and produced debilitating side effects. In 1971, Mr. Rosenfeld began using smoked herbal cannabis with the approval and under the supervision of a team of physicians. Mr. Rosenfeld found the cannabis highly efficacious in alleviating pain, reducing swelling, relaxing muscles and veins that surround the bone tumors, and preventing hemorrhaging. In 1982, the United States government, operating under the Compassionate Care IND Program, at the request of his physicians, began supplying Mr. Rosenfeld with herbal cannabis to treat his condition. For the past 19 years, the government has consistently provided him with a 75-day supply of herbal cannabis, totaling 33 ounces per shipment. Mr. Rosenfeld smokes 12 marijuana cigarettes a day to control the symptoms of his disease. In the 30 years that Mr. Rosenfeld has used herbal cannabis as a medicine, he has experienced no adverse side effects (including no "high"), has been able to discontinue his prescription medications, and has worked successfully for the past 13 years as a stockbroker handling multi-million dollar accounts. Mr. Rosenfeld and his physicians believe that but for herbal cannabis, Mr. Rosenfeld might not be alive, or, at the very least, would be bed-ridden.

The Medical Use of Marijuana:

A guide to Hawai`i's law for physicians, patients and caregivers

EXHIBIT 4

sponsored by

the Drug Policy Forum of hawai`i

Second Edition

To the Reader

The purpose of this brochure is to help patients, their caregivers, and medical professionals understand the 2000 Hawai`i Medical Marijuana Act and all of the legal issues surrounding it.

This brochure provides the best and most accurate information available to us at this time. However, we do not intend to provide legal advice, especially since individual situations may vary. You should consult your own lawyer if you have any uncertainties or questions about the law regarding medical marijuana.

Information in this booklet is current as of July 2008.

Mahalo

Thanks to the Drug Policy Alliance and the Marijuana Policy Project for their generous support in the production and distribution of this booklet and to all those who helped in its creation.

A special thanks to the individuals and organizations whose efforts helped to ensure the passage of this historic legislation. Mahalo nui loa to Governor Benjamin Cayetano for his foresight in introducing this compassionate legislation.

Contents

Resources

The Drug Policy Alliance
www.drugpolicy.org

The Marijuana Policy Project
www.mpp.org

Patients Out of Time
www.medicalcannabis.com

Americans for Safe Access
www.safeaccessnow.org

NORML
www.norml.org

The Drug Policy Forum of Hawai`i
www.dpfhi.org

If you have questions about the current status of Hawai`i's law, contact a lawyer, call the Drug Policy Forum of Hawai`i at 808-988-4386 or email us at info@dpfhi.org.

Medical Marijuana and the Law

The Law in Hawai`i

In April 2000 Hawai`i became the first state to permit medicinal use of marijuana via an act of the state legislature. Governor Benjamin Cayetano signed Hawai`i's Act 228 into law on June 15, 2000. Rules for its administration, developed by the state Department of Public Safety, were approved in December of that year and the medical marijuana program has been in effect since that time. Since the implementation of the program, more than 4,000 patients are being registered every year to use medical marijuana under state law.

The National Situation

Hawai`i has thus joined with eleven other states which have passed laws for the medicinal use of marijuana since 1996: California, Oregon, Washington, Alaska, Colorado, Nevada, Maine, Montana, New Mexico, Rhode Island, and Vermont. (Arizona passed a voter initiative but the program is not active due to a problem with the wording of the initiative.)
In the states which have approved the medical use of marijuana, thousands of patients, doctors and caregivers are participating in programs protected from state or local prosecution.

Conflicts between State and Federal Laws

However, despite the progress that has been made toward creating safe and legal systems at the state and local level, federal laws banning any use of marijuana remain in effect (except for a narrow exception for participants in federally approved clinical trials.) In fact, on May 14, 2001 the United States Supreme Court issued a decision reaffirming that federal law prohibits the distribution of marijuana for any reason.

In 2005 the U.S. Supreme Court, in Gonzales v. Raich ruled that the federal government had the power under the commerce clause of the U. S. Constitution to enforce federal marijuana laws against patients who possess or cultivate marijuana. The ruling did not address any issues related to medical marijuana nor did it overturn any of the state laws on medical marijuana. The power of state governments to enact and enforce state medical marijuana laws was not affected by this decision.

From a practical point of view, federal prosecutors tend to act against large drug operations. Federal charges are rarely brought against patients for small-scale, personal possession or cultivation of marijuana, although this remains a possibility. In fact, arrests for marijuana in the U.S. over the last several years made by federal authorities account for only 1% of all marijuana arrests.

If a state like Hawai`i has removed criminal penalties for medical use of marijuana, then patients and physicians are protected from arrest by state or local authorities. It is important to note, however, that the protections of the Hawai`i medical marijuana act do not protect patients and physicians from possible federal prosecution. (See next page for further details.)

What Hawaii's Law Does

Protects Patients and Caregivers from Arrest at the State or Local Level

Patients and their "primary caregiver" who comply with this law (obtain certification from a physician and register with the Narcotics Enforcement Division) are protected against prosecution for marijuana-related crimes under Hawai`i law. In the unlikely event of being arrested, patients and their caregivers who follow the law have a new legal defense available to them. If they are arrested by state or local authorities on marijuana charges, a qualified patient or primary caregiver can claim this new defense under state law if they are following the Act's procedures and using the marijuana only for medical purposes. The law allows growing, transporting and possession of marijuana and "paraphernalia," but only for medical purposes. It does not speak to the question of whether the purchase and/or sale of marijuana for medical purposes permitted by the Act is decriminalized.

Protects Physicians at the State, Local and Federal Levels

The Act states that, if a physician complies with the procedures specified in the Act, she or he shall not be subject to arrest or prosecution, penalized in any manner, or denied any right or privilege for providing written recommendation for the medical use of marijuana for a qualifying patient. As of September 2001, the physician is protected from state prosecution and as of 2003, from federal prosecution.

On October 29, 2002 the Ninth Circuit Court of Appeals unanimously upheld the right of doctors to recommend marijuana to their patients The Justices ruled that it is the role of the states, not the federal government to regulate the practice of medicine. In October 2003 the U.S. Supreme Court let this ruling stand (Conant v. Walters, 309F.3d 629, 2002). At the heart of the Conant decision is the First Amendment's protection of a physician's right to speak openly and candidly about marijuana's potential risks and its therapeutic benefits.

Physicians may therefore recommend medical marijuana to patients free from federal threats or interference as long as they do not do more than is required of them by the Act.

Limits Qualifying Medical Conditions

In order to use marijuana as medicine, a patient must be diagnosed by a physician licensed to practice in Hawai`i as having one or more of the following "debilitating" medical conditions:

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

2. A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:

a) Cachexia or wasting syndrome (severe weakness, malnutrition or weight loss)
b) Severe pain;
c) Severe nausea;
d) Seizures, including those characteristic of epilepsy; or
e) Severe and persistent muscle spasms, including those characteristic of multiple sclerosis or Crohn's disease;
f) Additional conditions which may be added by the state Department of Health.

Sets Limits on a Patient's Protected Supply of Medical Marijuana

Under the Hawai`i medical marijuana act, "adequate supply" means an amount of marijuana possessed by the qualifying patient and the primary caregiver *together* that is "not more than is reasonably necessary" to alleviate the symptoms or effects of a debilitating medical condition.

An "adequate supply" must not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant at any given time. Hawai`i's state Narcotics Enforcement Division (NED) is interpreting this to mean that a patient (and/or caregiver) can have 7 plants and/or 3 ounces of useable marijuana on hand at any given time.

Requires a Doctor's Certificate

The Act protects only patients whose physician has filled out and submitted a written certification to the state Department of Public Safety for use of medical marijuana. A physician, licensed in Hawai`i, must diagnose one of the above conditions and certify in writing that the potential benefits of medical marijuana use would likely outweigh the health risks for the particular patient. *Simply having a qualifying disease or symptoms does not automatically qualify anyone for protection under the Hawai`i medical marijuana act.*

States What Doctors Should Do To Certify a Patient for Medical Marijuana Use

To certify a patient for medical marijuana use, a physician must do the following:

1) Complete a full assessment of the patient' s medical history and current medical condition;

2) Diagnose the patient as having a debilitating medical condition covered by the medical marijuana act;

3) Explain the potential risks and benefits of medical marijuana use to the patient or his/her guardian; and

4) Certify, in writing, that in the physician's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks to that particular patient. This should all be documented in the patient's medical record.

States What Patients Should Do to Obtain a Medical Marijuana Certificate

After discussing medical marijuana with their physician as outlined above, patients and their caregivers should:

1) Ask their physician to request a written certification form from the Narcotics Enforcement Division of the state Department of Public Safety 808-837-8470;

2) With the physician's completed certification form, send a copy of the patient's official identification with a photo;

3) Include a check for the annual registration fee ($25 for the patient plus $25 for the primary caregiver, if any);

4) Mail or deliver the registration form completed by the patient, physician and primary caregiver, if any, to the:

Narcotics Enforcement Division (NED)
3375 Koapaka St., Suite D-100
Honolulu, HI 96819

Permits Patients to Name a "Primary Caregiver"

Patients may appoint a "primary caregiver" who can be any person at least 18 years old other than their physician, who has agreed to undertake responsibility for managing the well-being of only one qualifying patient with respect to the medical use of marijuana. The primary caregiver must also register with NED. When registered, the primary caregiver is also granted a defense from any prosecution for possession and/or cultivation of medical marijuana brought under state law.

In the case of a patient who is a minor (under 18) or an adult lacking legal capacity, a primary caregiver *must* be designated. This person can be one of the parents of a minor, his or her guardian, or a person having legal custody.

What Hawaii's Law Does NOT Do

Does Not Legalize Marijuana

Federal laws banning marijuana remain in effect and the Hawai`i Act does not permit the recreational use of marijuana.

Does Not Allow Just Anyone to Claim "Medical Use" of Marijuana

To be covered under Hawai`i's medical marijuana law, a patient must register and must have one of the listed medical conditions and have been certified by his/her doctor for medical marijuana use. If a doctor does not provide a written certification, that person does not qualify.

Does Not Allow Unlimited Supplies of Medical Marijuana

Even patients who qualify under the law must still adhere to strict limits on the quantity of medical marijuana they possess. This is limited to an "adequate supply" which shall not exceed three mature marijuana plants, four immature marijuana

plants, and one ounce of usable marijuana per each mature plant (i.e. three ounces in total).

Does Not Permit the Sale of Marijuana

The medical marijuana act defense will not protect someone who sells any amount of marijuana. Any evidence of sale of marijuana can result in prosecution and years of prison time, regardless of the buyer's or seller's medical condition or medical authorization to use marijuana.

Does Not Allow the Use of Medical Marijuana in a Public Place, Workplace or in a Moving Vehicle

Even with a doctor's certification, the Act specifically prohibits use of medical marijuana in any bus or moving vehicle, in the workplace, on school grounds, any use that endangers the health or well being of another person, or in any public place.

Does Not Force a Doctor to Give a Certification for Medical Marijuana

No doctor is required to authorize the medical use of marijuana. Even patients who qualify under the law must still adhere to strict limits on the quantity of medical marijuana they possess.

What Doctors Can NOT Do:

- "Prescribe" medical marijuana; this includes writing a recommendation on a prescription form.
- Assist patients in obtaining marijuana by doing more than that required by the Act.
- Cultivate or possess marijuana for patient use.
- Physically assist patients in using marijuana.
- Recommend marijuana without a justifiable medical cause.

Frequently Asked Questions

Q What Is Medical Marijuana?

Medical marijuana is the same as any other form of marijuana or cannabis except that it is used as medicine.

Q What if I Have a Medical Condition Covered by the Medical Marijuana Act but Don't Have a Statement from My Doctor?

You do not receive the protections of the Act unless you have followed its requirements and procedures and obtained a certification from your physician.

Q What If My Doctor Isn't Willing To Give Me a Certification or Says I Don't Qualify?

The Act does not force physicians to offer certifications for medical marijuana use. It's a new law and it takes a while for physicians to become comfortable with it. You may ask more than one physician.

Q Is There a List of Doctors Who Are Willing to Advise Me on the Medical Use of Marijuana?

No, because the names of doctors who have sent written certifications to the Narcotics Enforcement Division are confidential. The Drug Policy Forum of Hawai`i may be able to assist you in finding a physician.

Q If My Doctor Wants More Information on the Medical Uses of Marijuana Where Can He/She Get It?

In March of 1999 the Institute of Medicine of the National Academy of Sciences released a comprehensive study on medical marijuana: "Marijuana And Medicine-Assessing the Science Base." It can be ordered from the National Academy Press website at www.nap.edu (enter "medical marijuana" in search field) or from l-888-624-8373. More scientific background can be found at the Marijuana Policy Project's website: www.mpp.org and at NORML's website: www.norml.org.

Q How Long Does My Doctor's Certification Last?

The certification lasts for one year from the time of the physician's signing for both patients and primary caregivers. After one year, the doctor must re-certify the patient. Patients must keep track of the expiration date on their own as notices are NOT sent out.

Q Does the Narcotics Enforcement Division Require a Registration Fee?

Yes, there is an annual fee of $25 for registration. If the patient has a primary caregiver, that person must also pay a $25 annual fee. There is a charge of $10 for a duplicate registration certificate.

Q Can My Physician Assistant or Family Nurse Practitioner Authorize Medical Use of Marijuana?

No, Physician Assistants and Nurse Practitioners are not covered by the Hawai`i medical marijuana act. The only people who can meet the certification requirements of the Act are physicians licensed by the state of Hawai`i.

Q Why Can't I Get Medical Marijuana at a Pharmacy?

Pharmacies are federally regulated and can only dispense medications that are approved by the FDA and prescribed by a physician. Because marijuana continues to be classified by the federal government as a "Schedule I" drug, it cannot be prescribed by any healthcare professional. There are efforts underway to convince federal lawmakers to allow medical marijuana to be rescheduled and treated the same as other controlled medicines.

Q Where Can I Obtain Medical Marijuana?

At this time there's no recognized legal source for marijuana used for medicinal purposes. The Hawai`i law states, however, that the "acquisition, possession, cultivation, use, distribution [defined as only the transfer of marijuana and paraphernalia from the primary caregiver to the qualifying patient], or transportation of marijuana" for medicinal use is specifically protected.

Q What If My Condition or Illness Is Not Covered by Hawaii's Law?

Hawai`i's law provides that the state Department of Health set up a procedure for physicians and potentially qualifying patients to request that other medical conditions and diseases be added to the list of those debilitating medical conditions currently covered in the Act. As of this writing, the Health Department has yet to establish the necessary procedure, but you can contact the Health Department at 808-586-4400 to check the current status.

Q What Is the Definition of "Mature" or "Usable" as It Relates to the Amount of Marijuana a Patient or Caregiver Is Allowed To Possess?

"Usable marijuana" is defined in the Act as any mixture of the dried leaves and flowers of the Cannabis plant that is appropriate for the medical use of marijuana. Useable marijuana does not include the seeds, stalks, and roots of the plant.

Although not defined in the Act, a "mature" marijuana plant is generally understood to mean plants in which the flowers are visible to the naked eye.

Q Do Physicians Risk Losing Their License To Prescribe Controlled Substances If They Participate in the Program?

No. As a practical matter, participating physicians should be protected from loss of their licenses to prescribe controlled substances if they confine their actions to those required by the Act. Of the thousands of certifications that have assisted Hawai`i citizens in acquiring marijuana for medical purposes since the program began, none has resulted in the loss of a physician's DEA license to prescribe controlled substances.

Q Is My Use of Medical Marijuana Covered by Insurance?

No. The Act explicitly states that insurance companies are not required to pay for medical marijuana.

Q Is a Patient's Confidentiality Protected?

Yes. However, upon an inquiry by a law enforcement agency, the Department of Public Safety will verify whether a particular qualifying patient has registered with the Department and may provide reasonable access to the registry information for official law enforcement purposes.

Q Why Is Getting the Registration Card Important?

The registration card is evidence of compliance with the law and should ordinarily prevent an arrest. Without the card, the patient or caregiver may be arrested and held under arrest until the patient' s right to use medical marijuana is confirmed.

Q What Should a Patient Do If Accused of an Marijuana Related Offense?

Politely show the officer your registration card. They may then contact the Narcotics Enforcement Division to verify your registration. If the officer still questions the validity of your registration, you may wish to contact an attorney. If you do not have and cannot afford a lawyer, ask to call the state Public Defender's office. The phone number on Oahu is 586-2200. On the Neighbor Islands the numbers are: Hilo 974-4571; Kona 323-7562; Kaua'i 274-3418; and Maui 984-5018.

Q Can Minors Use Cannabis Under Hawai`i's Act?

Yes, Minors under 18 are protected under Hawai`i's law if their physician has explained the potential risks and benefits to both the qualifying patient and to their parent or legal guardian, and if the parent or legal guardian has consented in writing to allow the use; to serve as the minor's caregiver; and to control the minor's acquisition, dosage and frequency of use of the marijuana. A parent or guardian must serve as the minor's primary caregiver and follow the certification and registration procedures outlined above.

Q What Should I Tell My Employer If I Am Subjected to a Drug Test?

The Act prohibits use of medical marijuana in the workplace but is silent regarding the employer's rights and duties

regarding medical marijuana. It is suggested that employers treat medical marijuana like any other prescription drug that might impair ability.

Q Can Patients Living in Rental Units or Federally Subsidized Housing Participate in The Program?

As noted earlier, despite Hawai`i's medical marijuana act, federal law or federal rules and regulations still prohibit the use, possession, cultivation, or distribution of marijuana. Any federal laws or rules prohibiting the use of marijuana in federally subsidized housing would likely override Hawai`i's law. Patients occupying rental units or federally subsidized housing who wish to use medical marijuana should seek legal guidance on this issue.

Q Are There Any Limits on Where Marijuana To Be Used for Medical Purposes Can Be Cultivated?

The State's medical marijuana act contains no requirements or limitations on where marijuana for medical use can be grown. However, the regulations of the Department of Public Safety limit the places where marijuana can be grown to:

(1) the qualifying patient's home address;
(2) the primary caregiver's home address; or
(3) "(an) other location owned or controlled by the qualifying patient or the primary caregiver that is approved by the administrator and designated on the registry certificate issued by the department."

These limitations may be challenged in court since the law does not specify that the Department has authority to limit the place of cultivation.

Q If I'm Covered under the Hawai`i Medical Marijuana Act Can I Use Medical Marijuana in Other States?

At this time Montana is the only state to honor the Hawai`i law. Hawai`i does not recognize medical marijuana certification from any of the other eleven states with medical marijuana programs.

The Hawai`i Medical Marijuana Act

CHAPTER 329. [NEW] UNIFORM CONTROLLED SUBSTANCES ACT

PART IX. MEDICAL USE OF MARIJUANA

[§329-121]. Definitions

As used in this part:

"Adequate supply" means an amount of marijuana jointly possessed between the qualifying patient and the primary caregiver that is not more than is reasonably necessary to assure the uninterrupted availability of marijuana for the purpose of alleviating the symptoms or effects of a qualifying patient' s debilitating medical condition; provided that an "adequate supply" shall not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

"Debilitating medical condition" means:

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

(2) A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:

(A) Cachexia or wasting syndrome;

(B) Severe pain;

(C) Severe nausea;

(D) Seizures, including those characteristic of epilepsy; or

(E) Severe and persistent muscle spasms, including those characteristic of multiple sclerosis or Crohn's disease; or

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

"Marijuana" shall have the same meaning as "marijuana" and "marijuana concentrate" as provided in sections 329-1 and 712-1240.

"Medical use" means the acquisition, possession, cultivation, use, distribution, or transportation of marijuana or paraphernalia relating to the administration of marijuana to alleviate the symptoms or effects of a qualifying patient' s debilitating medical condition. For the purposes of "medical use", the term distribution is limited to the transfer of marijuana and paraphernalia from the primary caregiver to the qualifying patient.

"Physician" means a person who is licensed under chapters 453 and 460, and is licensed with authority to prescribe drugs and is registered under section 329-32. "Physician" does not include physician's assistant as described in section 453-5.3.

"Primary caregiver" means a person, other than the qualifying patient and the qualifying patient's physician, who is eighteen-years-of-age or older who has agreed to undertake responsibility for managing the well-being of the qualifying patient with respect to the medical use of marijuana. In the case of a minor or an adult lacking legal capacity, the primary caregiver shall be a parent, guardian, or person having legal custody.

"Qualifying patient" means a person who has been diagnosed by a physician as having a debilitating medical condition.

"Usable marijuana" means the dried leaves and flowers of the plant Cannabis family Moraceae, and any mixture of preparation thereof, that are appropriate for the medical use of marijuana. "Usable marijuana" does not include the seeds, stalks, and roots of the plant.

"Written certification" means the qualifying patient's medical records or a statement signed by a qualifying patient's physician, stating that in the physician's professional opinion, the qualifying patient has a debilitating medical condition and the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient. The department of public safety may require, through its rulemaking authority, that all written certifications comply with a designated form. "Written certifications" are valid for only one year from the time of signing.

[§329-122]. Medical use of marijuana; conditions of use

(a) Notwithstanding any law to the contrary, the medical use of marijuana by a qualifying patient shall be permitted only if:

(1) The qualifying patient has been diagnosed by a physician as having a debilitating medical condition;

(2) The qualifying patient's physician has certified in writing that, in the physician's professional opinion the potential benefits of the medical use of marijuana would likely outweigh the health risks for the particular qualifying patient; and

(3) The amount of marijuana does not exceed an adequate supply.

(b) Subsection (a) shall not apply to a qualifying patient under the age of eighteen years, unless:

(1) The qualifying patient's physician has explained the potential risks and benefits of the medical use of marijuana to the qualifying patient and to a parent, guardian, or person having legal custody of the qualifying patient; and

(2) A parent, guardian, or person having legal custody consents in writing to:

(A) Allow the qualifying patient's the medical use of marijuana;

(B) Serve as the qualifying patient's primary caregiver; and

(C) Control the acquisition of the marijuana, the dosage, and the frequency of the medical use of marijuana by the qualifying patient.

(c) The authorization for the medical use of marijuana in this section shall not apply to:

(1) The medical use of marijuana that endangers the health or well-being of another person;

(2) The medical use of marijuana:

(A) In a school bus, public bus, or any moving vehicle;

(B) In the workplace of one's employment;

(C) On any school grounds;

(D) At any public park, public beach, public recreation center, recreation or youth center; or

(E) Other place open to the public; and

(3) The use of marijuana by a qualifying patient, parent, or primary caregiver for purposes other than medical use permitted by this chapter.

[§329-123]. Registration requirements

(a) Physicians who issue written certification shall register the names, addresses, patient identification numbers, and other identifying information of the patients issued written certifications with the department of public safety.

(b) Qualifying patients shall register with the department of public safety. Such registration shall be effective until the expiration of the certificate issued by the physician. Every qualifying patient shall provide sufficient identifying information to establish personal identity of the qualifying patient and the primary caregiver. Qualifying patients shall report changes in information within five working days. Every qualifying patient shall have only one primary caregiver at any given time. The department shall then issue to the qualifying patient a registration certificate, and may charge a reasonable fee not to exceed $25.

(c) Primary caregivers shall register with the department of public safety. Every primary caregiver shall be responsible for the care of only one qualifying patient at any given time.

(d) Upon an inquiry by a law enforcement agency, the department of public safety shall verify whether the particular qualifying patient has registered with the department and may provide reasonable access to the registry information for official law enforcement purposes.

[§329-124]. Insurance not applicable

This part shall not be construed to require insurance coverage for the medical use of marijuana.

[§329-125]. Protections afforded to a qualifying patient or primary caregiver

(a) A qualifying patient or the primary caregiver may assert the medical use of marijuana as an affirmative defense to any prosecution involving marijuana under this chapter or chapter 712; provided that the qualifying patient or the primary caregiver strictly complied with the requirements of this part.

(b) Any qualifying patient or primary caregiver not

complying with the permitted scope of the medical use of marijuana shall not be afforded the protections against searches and seizures pertaining to the misapplication of the medical use of marijuana.

(c) No person shall be subject to arrest or prosecution for simply being in the presence or vicinity of the medical use of marijuana as permitted under this part.

[§329-126]. Protections afforded to a treating physician

No physician shall be subject to arrest or prosecution, penalized in any manner or denied any right or privilege for providing written certification for the medical use of marijuana for a qualifying patient; provided that:

(1) The physician has diagnosed the patient as having a debilitating medical condition, as defined in section 329-121;

(2) The physician has explained the potential risks and benefits of the medical use of marijuana, as required under section 329-122;

(3) The written certification is based upon the physician's professional opinion after having completed a full assessment of the patient's medical history and current medical condition made in the course of a bona fide physician-patient relationship; and

(4) The physician has complied with the registration requirements of section 329-123.

[§329-127]. Protection of marijuana and other seized property

Marijuana, paraphernalia, or other property seized from a qualifying patient or primary caregiver in connection with a claimed medical use of marijuana under this part shall be returned immediately upon the determination by a court that the qualifying patient or primary caregiver is entitled to the protections of this part, as evidenced by a decision not to prosecute, dismissal of charges, or an acquittal; provided that law enforcement agencies seizing live plants as evidence shall not be responsible for the care and maintenance of such plants.

[§329-128]. Fraudulent misrepresentation; penalty

(a) Notwithstanding any law to the contrary, fraudulent misrepresentation to a law enforcement official of any fact or circumstance relating to the medical use of marijuana to avoid arrest or prosecution under this part or c1apter 712 shall be a petty misdemeanor and subject to a fine of $500.

(b) Notwithstanding any law to the contrary, fraudulent misrepresentation to a law enforcement official of any fact or circumstance relating to the issuance of a written certificate by a physician not covered under section 329-126 for the medical use of marijuana shall be a misdemeanor. This penalty shall be in addition to any other penalties that may apply for the non-medical use of marijuana. Nothing in this section is intended to preclude the conviction of any person under section 710-1060 or for any other offense under part V of chapter 710.

CHAPTER 453. MEDICINE AND SURGERY

PART I. GENERALLY

§ 453-8. Revocation, limitation, suspension, or denial of licenses

(a) In addition to any other actions authorized by law, any license to practice medicine and surgery may be revoked, limited, or suspended by the board at any time in a proceeding before the board, or may be denied, for any cause authorized by law, including but not limited to the following:

****

(13) Violation of chapter 329, the uniform controlled substances act, or any rule adopted thereunder except as provided in section 329-122;

****

§ 712-1240.1. Defense to promoting

* * * * (2) It is an affirmative defense to prosecution for any marijuana-related offense defined in this part that the person who possessed or distributed the marijuana was authorized to possess or distribute the marijuana for medical purposes pursuant to part IX of chapter 329.

At a glance:
Information for Physicians

HOW TO CERTIFY PATIENTS FOR MEDICAL MARIJUANA USE

To certify a patient for medical marijuana use, a physician must do the following:

1. Request a written certification form from the Narcotics Enforcement Division of the state Department of Public Safety 808-837-8470;

2. Complete a full assessment of the patient's medical history and current medical condition;

3. Diagnose the patient as having a debilitating medical condition covered by the medical marijuana act (see page 7);

4. Explain the potential risks and benefits of medical marijuana use to the patient or his/her guardian; and

5. Certify, in writing, that in the physician's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks to that particular patient. This should all be documented in the patient's medical record.

6. It then is the patient's responsibility to:

- provide a copy of his or her official identification with photo;
- include a check made out to the "Narcotics Enforcement Division" for the annual registration fee ($25 for the patient plus $25 for the primary caregiver, if any), then;
- either the patient or the physician can mail or deliver 1) the copy of the i.d., 2) the check, and 3) the registration form completed by the patient, physician and primary caregiver (if any) to: the Narcotics Enforcement Division (NED) at 3375 Koapaka St., Suite D -100, Honolulu, HI 96819. The phone number there is 808-837-8470.

the Drug Policy Forum
of hawai'i
P.O. Box 61233
Honolulu, HI 96839
Phone/Fax: 808-988-4386
info@dpfhi.org
website: www.dpfhi.org

About Us

The Drug Policy Forum of Hawai`i (DPFH) is a non-profit membership organization founded in 1993 to encourage the development of effective drug policies that minimize economic, social, and human costs, and to promote the consideration of pragmatic approaches to drug policy based on:

* Scientific principles
* Effective outcomes
* Public health considerations
* Concern for human dignity
* Enhancing the well-being of individuals and communities

DPFH sponsors local, national, and international drug-policy professionals at community forums and conferences on topics such as medical marijuana, the impact of crystal methamphetamine, effective drug education and sentencing reform. DPFH also presents films and videos, maintains a reference library on drug policy, acts as a resource for the media on drug policy issues, sustains an active speakers' bureau, and publishes newsletters.

For more information about the Drug Policy Forum of Hawai`i or to obtain additional copies of this brochure, please contact our office at 808-988-4386 or e-mail us at info@dpfhi.org. This complete brochure is also available on our website: www.dpfhi.org.

EXHIBIT 5

The Budgetary Implications of Marijuana Prohibition

June 2005

Jeffrey A. Miron
Visiting Professor of Economics
Department of Economics
Harvard University
Cambridge, MA 02138
781-856-0086
miron@fas.harvard.edu

The Marijuana Policy Project provided funding for the research discussed in this report. Daniel Egan provided excellent research assistance.

Executive Summary

- Government prohibition of marijuana is the subject of ongoing debate.
- One issue in this debate is the effect of marijuana prohibition on government budgets. Prohibition entails direct enforcement costs and prevents taxation of marijuana production and sale.
- This report examines the budgetary implications of legalizing marijuana – taxing and regulating it like other goods – in all fifty states and at the federal level.
- The report estimates that legalizing marijuana would save $7.7 billion per year in government expenditure on enforcement of prohibition. $5.3 billion of this savings would accrue to state and local governments, while $2.4 billion would accrue to the federal government.
- The report also estimates that marijuana legalization would yield tax revenue of $2.4 billion annually if marijuana were taxed like all other goods and $6.2 billion annually if marijuana were taxed at rates comparable to those on alcohol and tobacco.
- Whether marijuana legalization is a desirable policy depends on many factors other than the budgetary impacts discussed here. But these impacts should be included in a rational debate about marijuana policy.

I. Introduction

Government prohibition of marijuana is the subject of ongoing debate. Advocates believe prohibition reduces marijuana trafficking and use, thereby discouraging crime, improving productivity and increasing health. Critics believe prohibition has only modest effects on trafficking and use while causing many problems typically attributed to marijuana itself.

One issue in this debate is the effect of marijuana prohibition on government budgets. Prohibition entails direct enforcement costs, and prohibition prevents taxation of marijuana production and sale. If marijuana were legal, enforcement costs would be negligible and governments could levy taxes on the production and sale of marijuana. Thus, government expenditure would decline and tax revenue would increase.

This report estimates the savings in government expenditure and the gains in tax revenue that would result from replacing marijuana prohibition with a regime in which marijuana is legal but taxed and regulated like other goods. The report is not an overall evaluation of marijuana prohibition; the magnitude of any budgetary impact does not by itself determine the wisdom of prohibition. But the costs required to enforce prohibition, and the transfers that occur because income in a prohibited sector is not taxed, are relevant to rational discussion of this policy.

The policy change considered in this report, marijuana legalization, is more substantial than marijuana decriminalization, which means repealing criminal penalties against possession but retaining them against trafficking. The budgetary implications of legalization exceed those of decriminalization for three reasons.[1] First, legalization eliminates arrests for trafficking in addition to eliminating arrests for possession. Second, legalization saves prosecutorial, judicial, and incarceration expenses; these savings are minimal in the case of decriminalization. Third, legalization allows taxation of marijuana production and sale.

This report concludes that marijuana legalization would reduce government expenditure by $7.7 billion annually. Marijuana legalization would also generate tax revenue of $2.4 billion

[1] See, for example, the estimates in Miron (2002) versus those in Miron (2003c).

annually if marijuana were taxed like all other goods and $6.2 billion annually if marijuana were taxed at rates comparable to those on alcohol and tobacco. These budgetary impacts rely on a range of assumptions, but these probably bias the estimated expenditure reductions and tax revenues downward.

The remainder of the report proceeds as follows. Section II estimates state and local expenditure on marijuana prohibition. Section III estimates federal expenditure on marijuana prohibition. Section IV estimates the tax revenue that would accrue from legalized marijuana. Section V discusses caveats and implications.

II. State and Local Expenditure for Drug Prohibition Enforcement

The savings in state and local government expenditure that would result from marijuana legalization consists of three main components: the reduction in police resources from elimination of marijuana arrests; the reduction in prosecutorial and judicial resources from elimination of marijuana prosecutions; and the reduction in correctional resources from elimination of marijuana incarcerations.[2] There are other possible savings in government expenditure from legalization, but these are minor or difficult to estimate with existing data.[3] The omission of these items biases the estimated savings downward.

To estimate the state savings in criminal justice resources, this report uses the following procedure. It estimates the percentage of arrests in a state for marijuana violations and multiplies this by the budget for police. It estimates the percentage of prosecutions in a state for marijuana violations and multiplies this by the budget for prosecutors and judges. It estimates the percentage of incarcerations in a state for marijuana violations and multiplies this by the budget for prisons. It then sums these components to estimate the overall reduction in government expenditure. Under plausible assumptions, this procedure yields a reasonable estimate of the cost savings from marijuana legalization.[4]

---

[2] This report addresses only the criminal justice costs of enforcing marijuana prohibition; it does not address any possible changes in prevention, education, or treatment expenses that might accompany marijuana legalization. The narrower approach is appropriate because the decision to prohibit marijuana is separate from the decision to subsidize prevention, education and treatment activities. Marijuana legalization might nevertheless cause some reduction in government expenditure for demand-side policies. For example, legalization would likely mean reduced criminal justice referrals of marijuana offenders to treatment; this category accounted for 58.1% of marijuana treatment referrals in 2002 (U.S. Department of Health and Human Services (2004, Table 4, p.15)). Thus, the approach adopted here implies a conservative estimate of the reduction in government expenditure from marijuana legalization.

[3] For example, under current rules regarding parole and probation, a positive urine test for marijuana can send a parolee or probationer to prison, regardless of the original offense. These rules might change under legalization, implying additional reductions in government expenditure.

[4] The key assumption is that the technology is constant-returns to scale, so that average costs equal marginal costs. This equivalence is not necessarily accurate in the short-run or for very small communities but is likely a good approximation overall.

The Police Budget Due to Marijuana Prohibition

The first cost of marijuana prohibition is the portion of state police budgets devoted to marijuana arrests.

Table 1 calculates the fraction of arrests in each state due to marijuana prohibition. Column 1 gives the total number of arrests for the year 2000.[5] Column 2 gives the number of arrests for marijuana possession violations. Column 3 gives the number of arrests for marijuana sale/manufacturing violations. Columns 4 and 5 give the ratio of Column 2 to Column 1 and Column 3 to Column 1, respectively; these are the percentages of arrests for possession and sale/manufacture of marijuana, respectively.

The information in Columns 4 and 5 is what is required in the subsequent calculations, subject to one modification. Some arrests for marijuana violations, especially those for possession, occur because the arrestee is under suspicion for a non-drug crime but possesses marijuana that is discovered by police during a routine search. This means an arrest for marijuana possession is recorded, along with, or instead of, an arrest on the other charge. If marijuana possession were not a criminal offense, the suspects in such cases would still be arrested on the charge that led to the search, and police resources would be used to approximately the same extent as when marijuana possession is criminal.[6]

In determining which arrests represents a cost of marijuana prohibition, therefore, it is appropriate to count only those that are "stand-alone," meaning those in which a marijuana violation rather than some other charge is the reason for the arrest. This issue arises mainly for

---

[5] This part of the report relies on data for 2000 since that is the last year for which complete information on arrests is available. After estimating expenditure for 2000, the report adjusts for inflation between 2000 and 2003.

[6] To the extent it takes additional resources to process an arrestee on multiple charges rather than on a single charge, there is still a net utilization of police resources in such cases due to prohibition. In addition, there is typically a lab test to determine the precise content of any drugs seized when there is an arrest on drugs charges, implying utilization of additional resources due to prohibition. A different issue is that in some cases, police stops for non-drug charges that discover drugs and produce an arrest on drugs charges might not have led to any arrest in the absence of the drug charge (e.g., because of insufficient evidence).

possession rather than for trafficking. There are few hard data on the fraction of "stand-alone" possession arrests, but the information in Miron (2002) and Reuter, Hirschfield and Davies (2001) suggests it is between 33% and 85%.[7] To err on the conservative side, this report assumes that 50% of possession arrests are due solely to marijuana possession rather than being incidental to some other crime. Thus, the resources utilized in making these arrests would be available for other purposes if marijuana possession were legal. Column 6 of Table 1 therefore indicates the fraction of possession arrests attributable to marijuana prohibition, taking this adjustment into account.[8]

The first portion of Table 2 uses this information to calculate the police budget due to marijuana prohibition in each state. Column 1 gives the total expenditure in 2000 on police, by state. Column 2 gives the product of Column 1 with the sum of Columns 5 and 6 from Table 1. This is the amount spent on arrests for marijuana violations. For 2000, the amount is $1.71 billion.

The Judicial and Legal Budget Due to Marijuana Prohibition

The second main cost of marijuana prohibition is the portion of the prosecutorial and judicial budget devoted to marijuana prosecutions. A reasonable indicator of this percentage is the fraction of felony convictions in state courts for marijuana offenses. Data on this percentage are not available on a state-by-state basis, so this report uses the national percentage. Data on the percentage of possession convictions attributable to marijuana are also not available, so this report assumes it equals the percentage for trafficking convictions.

[7] Lewis (2004) reports that the fraction of stand-alone arrests on all drug charges in the city of Syracuse, NY was 90.5% in 2002.

[8] Gettman and Fuller (2003) obtain a similar estimate to that reported here for Virginia in 2001.

In 2000 the percent of felony convictions in state courts due to any type of trafficking violation was 22.0%.[9] Of this total, 2.7% was due to marijuana, 5.9% was due to other drugs, and 13.4% was unspecified. This report assumes that the fraction of marijuana convictions in the unspecified category equals the fraction for those in which a specific drug is given, or 31.4% [=2.7%/(2.7%+5.9%)]. The report also assumes that the percentage of possession convictions due to marijuana equals this same fraction. These assumptions jointly imply that the percentage of felony convictions due to marijuana equals the fraction of felony convictions due to any drug offense (34.6%) multiplied by the percentage of trafficking violations due to marijuana (31.4%). This yields 10.9% (=34.6%*31.4%).[10]

The second portion of Table 2 uses this information to calculate the judicial and legal budget due to marijuana prohibition. Column 3 gives the judicial and legal budget, by state. Column 4 gives the product of Column 3 and 10.9%, the percentage of felony convictions due to marijuana violations. This is the judicial and legal budget due to marijuana prosecutions. For 2000, the amount is $2.94 billion.

The Corrections Budget Due to Marijuana Prohibition

The third main cost of marijuana prohibition is the portion of the corrections budget devoted to incarcerating marijuana prisoners. A reasonable indicator of this portion is the fraction of prisoners incarcerated for marijuana offenses.

As with the percentage of prosecutions due to marijuana, state-by-state information on the percentage of prisoners incarcerated for marijuana offenses is not available. Appropriate data do exist for a few states, however, and this percentage is likely to be similar across states. This report therefore computes a population-weighted average based on the few states for which

[9] The data on felony convictions are from Durose and Langan (2003, Table 1, p.2).

[10] The fraction of felony convictions for any type of drug is from Durose and Langan (2003, Table 1, p.2).

data exist; it then imposes this percentage on all states. This percentage is 1.0%, as documented in Appendix A.

The third portion of Table 2 calculates the corrections budget due to marijuana prohibition.[11] Column 5 gives the overall corrections budget, by state. Column 6 gives the product of Column 5 and 1.0%, the estimated fraction of prisoners incarcerated on marijuana charges. This is the corrections budget devoted to marijuana prisoners. For 2000, the amount is $484 million.

Overall State and Local Expenditure for Enforcement of Marijuana Prohibition

As shown at the bottom of Table 2, total state and local government expenditure for enforcement of marijuana prohibition was $5.1 billion for 2000. This is an overstatement of the savings in government expenditure that would result from legalization, however, for two reasons. First, under prohibition the police sometimes seize assets from those arrested for marijuana violations (financial accounts, cars, boats, land, houses, and the like), with the proceeds used to fund police and prosecutors.[12] Second, under prohibition some marijuana offenders pay fines, which partially offsets the expenditure required to arrest, convict and incarcerate these offenders. The calculations in Appendix B, however, show that this offsetting revenue has been at most $100 million per year in recent years at the state and local level. This implies a net savings of criminal justice resources from marijuana legalization of $5.0 billion in 2000. Adjusting for inflation implies savings of $5.3 billion in 2003.[13] [14] [15]

---

[11] This report excludes the capital outlays portion of the corrections budget, since the available data do not indicate the average rate of such expenditures. This biases the estimates downward.

[12] Most seized assets are ultimately forfeited.

[13] Inflation rate data are for the CPI - All Urban Consumers (Bureau of Labor Statistics, U.S. Department of Labor, http://www.bls.gov/cpi/home.htm#data).

[14] The figure here for Massachusetts exceeds that in Miron (2003c) because this report assumes 50% of possession arrests are due to marijuana prohibition while the earlier report assumed 33%. The 50% figure is more appropriate here because the analysis covers all states rather than just Massachusetts.

III. Federal Expenditure for Marijuana Prohibition Enforcement

This section estimates federal expenditure on marijuana prohibition enforcement. There are no data available on expenditure for marijuana interdiction *per se;* existing data report expenditure on interdiction of all drugs, without separately identifying expenditure aimed at marijuana versus other drugs. It is nevertheless possible to estimate the portion due to marijuana prohibition using the following procedure:

1. Estimate federal expenditure for all drug interdiction;
2. Estimate the fraction of this expenditure due to marijuana interdiction based on the fraction of federal prosecutions for marijuana;
3. Multiply the first estimate by the second estimate.

This provides a reasonable estimate of federal expenditure for marijuana interdiction so long as this expenditure is roughly proportional to the variable being used to determine the fraction of total interdiction devoted to marijuana.[16]

Table 3 displays federal expenditure for drug interdiction. This was $13.6 billion in 2002 (Miron 2003b), and it is the figure that applies for all drugs.[17] [18] [19] To determine expenditure for

---

[15] As a check, it is useful to compare the $5.1 billion figure provided here to that derived from an alternative methodology. ONDCP (1993) reports survey evidence on drug prohibition enforcement by state and local authorities for the years 1990/1991. Adjusting these data for inflation and the percent attributable to marijuana prohibition yields an estimate similar to that reported above.

[16] The approach utilized here differs from that employed in the case of state and local expenditure because of differences in the kinds of data available. Utilizing an approach that is similar to the extent possible yields an estimate of federal marijuana enforcement expenditure that is similar to the estimate provided in the text.

[17] This consists of expenditure in the following categories: DC Court Services and Offender Supervision ($86.4 million); Department of Defense ($1,008.5 million); Intelligence Community Management Account ($42.8 million); The Judiciary ($819.7 million); Department of Justice ($8,140.1 million); ONDCP ($533.3 million); Department of State ($832.6 million); Department of Transportation ($591.4 million); and Department of Treasury ($1,546.8 million). See ONDCP (2002), p.29-31.

[18] Murphy, Davis, Liston, Thaler and Webb (2000) examine the methods used by ONDCP to estimate this expenditure. They conclude that methodological problems render parts of the estimates biased, in some cases by substantial amounts. These issues do not imply major qualifications to the data considered here, however. Murphy et al. find that the anti-drug budgets of the Coast Guard and the Bureau of Prisons are

marijuana interdiction, it is necessary to adjust for the fraction of federal expenditure devoted to marijuana as opposed to other drugs.

Table 3 next shows possible indicators of the relative magnitude of marijuana interdiction as compared to other-drug interdiction. These indicators include use rates, arrest rates, and felony convictions for marijuana versus other drugs. For the purposes here, the most appropriate indicator is the percentage of DEA arrests or convictions for marijuana as opposed to other drugs.[20]

The data therefore indicate that $2.6 billion is a reasonable estimate of the federal government expenditure to enforce marijuana prohibition in 2002.

As with state and local revenue, this figure must be adjusted downward by the revenue from seizures and fines. Appendix B indicates that this amount has been at most $214.2 million in recent years, implying a net savings of about $2.39 million. Adjusting for inflation implies federal expenditure for enforcement of marijuana prohibition of $2.4 billion in 2003.[21]

---

accurate reflections of the resources expended while the reported expenditure of the Department of Defense probably underestimates its anti-drug budget. The overestimates that they identify occur for demand-side activities.

[19] The 2003 *National Drug Control Strategy* adopts a new methodology for estimating the federal drug control budget. This new methodology implies a substantial reduction in supply side expenditure (ONDCP (2002, pp.33-34)). For the purposes of this report, the old methodology is more appropriate. For example, the new approach excludes expenditures on incarceration of persons imprisoned for drug crimes.

[20] The percentage of prisoners whose primary offense was a marijuana charge would also be relevant, but data are not readily available. Since most convictions at the federal level result in prison terms, incarceration data would imply a similar result to that provided above.

[21] Inflation rate data are for the CPI - All Urban Consumers (Bureau of Labor Statistics, U.S. Department of Labor, http://www.bls.gov/cpi/home.htm#data).

IV. The Tax Revenue from Legalized Marijuana

In addition to reducing government expenditure, marijuana legalization would produce tax revenue from the legal production and sale of marijuana. To estimate this revenue, this report employs the following procedure. First, it estimates current expenditure on marijuana at the national level. Second, it estimates the expenditure likely to occur under legalization. Third, it estimates the tax revenue that would result from this expenditure based on assumptions about the kinds of taxes that would apply to legalized marijuana. Fourth, it provides illustrative calculations of the portion of the revenue that would accrue to each state.

Expenditure on Marijuana under Current Prohibition

The first step in determining the tax revenue under legalization is to estimate current expenditure on marijuana. ONDCP (2001a, Table 1, p.3) estimates that in 2000 U.S. residents spent $10.5 billion on marijuana. This estimate relies on a range of assumptions about the marijuana market, and modification of these assumptions might produce a higher or lower estimate. There is no obvious reason, however, why alternative assumptions would imply a dramatically different estimate of current expenditure on marijuana. This report therefore uses the $10.5 billion figure as the starting point for the revenue estimates presented below.

Expenditure on Marijuana under Legalization

The second step in estimating the tax revenue that would occur under legalization is to determine how expenditure on marijuana would change as the result of legalization. A simple framework in which to consider various assumptions is the standard supply and demand model. To use this model to assess legalization's impact on marijuana expenditure, it is necessary to state what effect legalization would have on the demand and supply curves for marijuana.

This report assumes there would be no change in the demand for marijuana.[22] This assumption likely errs in the direction of understating the tax revenue from legalized marijuana, since the penalties for possession potentially deter some persons from consuming. But any increase in demand from legalization would plausibly come from casual users, whose marijuana use would likely be modest. Any increase in use might also come from decreased consumption of alcohol, tobacco or other goods, so increased tax revenue from legal marijuana would be partially offset by decreased tax revenue from other goods. And there might be a forbidden fruit effect from prohibition that tends to offset the demand decreasing effects of penalties for possession. Thus, the assumption of no change in demand is plausible, and it likely biases the estimated tax revenue downward.

Under the assumption that demand does not shift due to legalization, any change in the quantity and price would result from changes in supply conditions. There are two main effects that would operate (Miron 2003a). On the one hand, marijuana suppliers in a legal market would not incur the costs imposed by prohibition, such as the threat of arrest, incarceration, fines, asset seizure, and the like. This means, other things equal, that costs and therefore prices would be lower under legalization. On the other hand, marijuana suppliers in a legal market would bear the costs of tax and regulatory policies that apply to legal goods but that black market suppliers normally avoid.[23] This implies an offset to the cost reductions resulting from legalization. Further, changes in competition and advertising under legalization can potentially yield higher prices than under prohibition.

It is thus an empirical question as to how prices under legalization would compare to prices under current prohibition. The best evidence available on this question comes from

---

[22] To be explicit, the assumption is that there is no shift in the demand curve. If the supply curve shifts, there will be a change in the quantity demanded.

[23] The underlying assumption is that the marginal costs of evading tax and regulatory costs is zero for black market suppliers who are already conducting their activities in secret.

comparisons of marijuana prices between the U.S. and the Netherlands. Although marijuana is still technically illegal in the Netherlands, the degree of enforcement is substantially below that in the U.S., and the sale of marijuana in coffee shops is officially tolerated. The regime thus approximates *de facto* legalization. Existing data suggest that retail prices in the Netherlands are roughly 50-100 percent of U.S. prices.[24] [25]

The effect of any price decline that occurs due to legalization depends on the elasticity of demand for marijuana. Evidence on this elasticity is limited because appropriate data on marijuana price and consumption are not readily available. Existing estimates, however, suggest an elasticity of at least -0.5 and plausibly more than -1.0 (Nisbet and Vakil 1972).[26] [27]

If the price decline under legalization is minimal, then expenditure will not change regardless of the demand elasticity. If the price decline is noticeable but the demand elasticity is greater than or equal to 1.0 in absolute value, then expenditure will remain constant or increase. If the price decline is noticeable and the demand elasticity is less than one, then expenditure will

---

[24] MacCoun and Reuter (1997) report gram prices of $2.50-$12.50 in the Netherlands and $1.50 - $15.00 in the U.S. They speculate that the surprisingly high prices in the Netherlands might reflect enforcement aimed at large-scale trafficking. Harrison, Backenheimer, and Inciardi (1995) note that ONDCP data on drug prices in the U.S. are very similar to prices charged in Dutch coffeeshops. ONDCP (2001b) reports a price per gram for small-scale purchases of roughly $9 per gram in the second quarter of 2000, while EMCDDA (2002) suggests a price of 2-8 Euros per gram, which is roughly $6 on average. Various web sites that discuss the coffee shops in Amsterdam suggest prices of $5 - $11 per gram in recent years. These comparisons do not adjust for potency or other dimensions of quality.

[25] Clements and Daryal (2001) report marijuana prices for Australia that are similar to or higher than those in the United States. Since Australian marijuana policy is noticeably less strict than U.S. policy, this observation is consistent with the view that legalization would not produce a dramatic fall in price.

[26] The Nisbet and Vakil estimates that use survey data imply price elasticities of -0.365 or -0.51 in the log and linear specifications, respectively, while the purchase data imply price elasticities of -1.013 and -1.51. The estimates based on purchase data are plausibly more reliable. Moreover, as they note, these estimates are likely biased downward by standard simultaneous equations bias. Clemens and Daryal (1999) estimate a price elasticity of -0.5 for marijuana using Australian data. Estimates of the demand for "similar" goods (e.g., alcohol, cocaine, heroin, or tobacco) suggest similar elasticities.

[27] Pacula, Grossman, Chaloupka, O'Malley, Johnston and Farrelly (2000) summarize the literature on the relation between marijuana use and factors that can affect use, such as legal penalties. They conclude the evidence is mixed but overall indicates a moderate response of marijuana consumption to "price." The papers summarized do not provide measures of the price elasticity. The results reported by Pacula et al. suggest an elasticity of marijuana participation between 0.0 and -0.5; this understates the total elasticity, which includes any change in consumption conditional on participation. The literature since Nisbet and Vakil is thus consistent with the elasticity estimate assumed above.

decline. Since the decline in price is unlikely to exceed 50% and the demand elasticity is likely at least -0.5, the plausible decline in expenditure is approximately 25%. Given the estimate of $10.5 billion in expenditure on marijuana under current prohibition, this implies expenditure under legalization of about $7.9 billion.[28]

Tax Revenue from Legalized Marijuana

To estimate the tax revenue that would result from marijuana legalization, it is necessary to assume a particular tax rate. This report considers two assumptions that plausibly bracket the range of reasonable possibilities.

The first assumption is that tax policy treats legalized marijuana identically to other goods. In that case tax revenue as a fraction of expenditure would be approximately 30%, implying tax revenue from legalized marijuana of $2.4 billion.[29] The amount of revenue would be lower if substantial home production occurred under legalization.[30] The evidence suggests, however, that the magnitude of such production would be minimal. In particular, alcohol production switched mostly from the black market to the licit market after repeal of Alcohol Prohibition in 1933.

The second assumption is that tax policy treats legalized marijuana similarly to alcohol or tobacco, imposing a "sin tax" in excess of any tax applicable to other goods.[31] Imposing a high

---

[28] Given the uncertainties involved in calculating the tax revenue from marijuana legalization and the possibility that declines in marijuana prices have offset general inflation since 2000, this report omits any adjustment of the tax revenue for inflation. Such an adjustment would make only a small difference in any case.

[29] In 2001, total government receipts divided by GDP equaled 29.7%. See the *2003 Economic Report of the President* on-line, http://w3.access.gpo.gov/usbudget/fy2004/pdf/2003_erp.pdf, Tables B-1 and B-92, pp. 276 and 373.

[30] Whether such production is illicit depends on the details of a legalization law. Plausibly, growing small amounts for personal use would not be subject to taxation or regulation, just as growing small amounts of vegetables or herbs is not subject to taxation or regulation.

[31] Schwer, Riddel and Henderson (2002) estimate the tax revenue from marijuana legalization in Nevada assuming "sin taxation." Their estimates are not readily comparable to those presented here because they

sin tax can force a market underground, thereby reducing rather than increasing tax revenue. Existing evidence, however, suggests that relatively high rates of sin taxation are possible without generating a black market. For example, cigarette taxes in many European countries account for 75–85 percent of the price (US Department of Health and Human Services 2000).

One benchmark, therefore, is to assume that an excise tax on legalized marijuana doubles the price. If general taxation accounts for 30% of the price, this additional tax would then make tax revenue account for 80% of the price. This doubling of the price, given an elasticity of -0.5, would cause roughly a 50% increase in expenditure, implying total expenditure on marijuana would be $11.85 billion (=$7.9 x 1.5). Tax revenue would equal 80% of this total, or $9.5 billion. This includes any standard taxation applied to marijuana income as well as the sin tax on marijuana sales.

The $9.5 billion figure is not necessarily attainable given the characteristics of marijuana production, however. Small scale, efficient production is possible and occurs widely now, so the imposition of a substantial tax wedge might encourage a substantial fraction of the market to remain underground. The assumption of a constant demand elasticity in response to a price change of this magnitude is also debatable; more plausibly, the elasticity would increase as the price rose, implying a larger decline in consumption and thus less revenue from excise taxation. The $9.5 figure should therefore be considered an upper bound.

These calculations nevertheless indicate the potential for substantial revenue from marijuana taxation. A more modest excise tax, such as one that raises the price 50%, would produce revenue on legalized marijuana of $6.2 billion per year.

---

consider the situation in which one state legalizes marijuana while other states and the federal government prohibit marijuana. The same comment applies to Bates (2004), who estimates the tax revenue from marijuana legalization in Alaska. Easton (2004) estimates the tax revenue from marijuana legalization in Canada under the assumption of sin taxation. His estimates are comparable but modestly higher than those presented here, adjusted for the different size of the U.S. and Canadian economies. Caputo and Ostrom (1994) provide estimates for the overall economy that are similar to those obtained here.

Distribution of the Marijuana Tax Revenue

The estimates of tax revenue discussed so far indicate the total amount that could be collected summing over all levels of government. In practice this total would be divided between state and federal governments. It is therefore useful to estimate how much revenue would accrue to each state, and to state governments versus the federal government, under plausible assumptions.

Table 4a indicates the tax revenue that would accrue to each state and to the federal government under the assumption that each state collected revenue equal to 10% of the income generated by legalized marijuana and the federal government collected income equal to 20%. This is approximately what occurs now for the economy overall, except that the ratio of tax revenues to income varies across states from the 10% figure assumed here. The table indicates that under these assumptions, the federal government would collect $1.6 billion in additional revenue while on average each state would collect $16 million in additional tax revenue.

These calculations ignore the fact that marijuana use rates differ across states, so application of identical policies would yield different amounts of revenue per capita. Wright (2002, Table A.4, p.82), for example, indicates that the percent of those 12 and over reporting marijuana use in the past month ranged in 1999-2000 from a low of 2.79% in Iowa to a high of 9.03% in Massachusetts. Table 4b therefore shows the breakdown of revenue by state under the assumption that tax revenue is proportional to state marijuana use rates. A third possibility, which cannot easily be examined with existing data, is that revenue by state differs depending on the distribution of marijuana production.

V. Summary

This report has estimated the budgetary implications of legalizing marijuana and taxing and regulating it like other goods. According to the calculations here, legalization would reduce government expenditure by $5.3 billion at the state and local level and by $2.4 billion at the federal level. In addition, marijuana legalization would generate tax revenue of $2.4 billion annually if marijuana were taxed like all other goods and $6.2 billion annually if marijuana were taxed at rates comparable to those on alcohol and tobacco.

References

Baicker, Katherine and Mireille Jacobson (2004), "Finders Keepers: Forfeiture Laws, Policing Incentives, and Local Budgets," manuscript, Department of Economics, Dartmouth College.

Bates, Scott W. (2004), "The Economic Implications of Marijuana Legalization in Alaska," Report for *Alaskans For Rights & Revenues,* Fairbanks, Alaska.

Caputo, Michael R. and Brian J. Ostrom (1994), "Potential Tax Revenue from a Regulated Marijuana Market: A Meaningful Revenue Source," *American Journal of Economics and Sociology*, **53**, 475-490.

Clements, Kenneth W. and Mert Daryal (2001), "Marijuana Prices in Australia in 1990s," manuscript, Economic Research Centre, Department of Economics, The University of Western Australia.

Durose, Matthew and Patrick A. Langan (2003), *Felony Sentences in State Courts, 2000*, Bureau of Justice Statistics, Office of Justices Programs, U.S. Department of Justice, NCJ 198821.

Easton, Stephen T. (2004), "Marijuana Growth in British Columbia," *Public Policy Sources*, Fraser Institute Occasional Paper #74.

European Monitoring Centre for Drugs and Drug Addiction (2002), *Annual Report 2002*, available at (http://annualreport.emcdda.eu.int/pdfs/2002_0458_EN.pdf).

Gettman, Jon B. and Stephen S. Fuller (2003), "Estimation of the Budgetary Costs of Marijuana Possession Arrests in the Commonwealth of Virginia," Center for Regional Analysis, George Mason University.

Harrison, Lana D., Michael Backenheimer, and James A. Inciardi (1995), "Cannabis use in the United States: Implications for Policy," in Peter Cohen and Arjan Sas, eds., *Cannabisbeleid in Duitsland, Frankrijk en do Verenigde Staten*, Amerstdamn: Centrum voor Drugsonderzoek, Universiteit van Amsterdamn, 231-236.

Lewis, Minchin (2004), *Report on the Syracuse Police Department Activity for the Year Ended June 30, 2002,* Department of Audit, City of Syracuse.

MacCoun, Robert and Peter Reuter (1997), "Interpreting Dutch Cannabis Policy: Reasoning by Analogy in the Legalization Debate," *Science*, **278**, 47-52.

Miron, Jeffrey A. (2002), "The Effect of Marijuana Decriminalization on the Budgets of Massachusetts Governments, With a Discussion of Decriminalization's Effect on Marijuana Use," *Report to the Drug Policy Forum of Massachusetts*, October.

Miron, Jeffrey A. (2003a), "Do Prohibitions Raise Prices? Evidence from the Markets for Cocaine and Heroin," *Review of Economics and Statistics*, **85**(3), 522-530.

Miron, Jeffrey A. (2003b), "A Critique of Estimates of the Economic Costs of Drug Abuse," *Report to the Drug Policy Alliance*, July.

Miron, Jeffrey A. (2003c), "The Budgetary Implications of Marijuana Legalization in Massachusetts," *Report to Change the Climate*, August.

Murphy, Patrick, Lynn E. Davis, Timothy Liston, David Thaler, and Kathi Webb (2000), *Improving Anti-Drug Budgeting*: Santa Monica, CA: Rand.

Nisbet, Charles T. and Firouz Vakil (1972), "Some Estimates of Price and Expenditure Elasticites of Demand for Marijuana Among U.C.L.A. Students," *Review of Economics and Statistics*, 54, 473-475.

Office of National Drug Control Policy (1993), *State and Local Spending on Drug Control Activities*, Washington, D.C.: ONDCP

Office of National Drug Control Policy (2001a), *What America's Users Spend on Illegal Drugs*, Cambridge, MA: Abt Associates.

Office of National Drug Control Policy (2001b), *The Price of Illicit Drugs: 1981 through Second Quarter of 2000*, Washington, D.C: Abt Associates.

Office of National Drug Control Policy (2002), *National Drug Control Strategy*, Washington, D.C.: ONDCP.

Pacula, Rosalie Liccardo, Michael Grossman, Frank J. Chaloupka, Patrick M. O'Malley, Lloyd D. Johnston, and Matthew C. Farrelly (2000), "Marijuana and Youth," NBER WP #7703.

Reuter, Peter, Paul Hirschfield, and Curt Davies (2001), "Assessing the Crack-Down on Marijuana in Maryland," manuscript, University of Maryland.

Schwer, R. Keith, Mary Riddel, and Jason Henderson (2002), "Fiscal Impact of Question 9: Potential State-Revenue Implications," Center for Business and Economic Research, University of Nevada, Las Vegas.

US Department of Health and Humans Services (2000), *Reducing Tobacco Use: A Report of the Surgeon General, Tobacco Taxation Fact Sheet.* Accessed at http://www.cdc.gov/tobacco/sgr/sgr_2000/factsheets/factsheets_taxation.htm.

U.S. Department of Health and Human Services (2004), *Treatment Episode Data Set (TEDS) Highlights – 2002*, Washington, D.C.: Substance Abuse and Mental Health Services Administration, Office of Applied Statistics.

Wright, D. (2002), *State Estimates of Substance Use from the 2000 National Household Survey on Drug Abuse: Volume I, Findings* (DHHS Publication No. SMA 02-3731, NHSDA Series H-15), Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Statistics.

Table 1: Percentage of Arrests Due to Marijuana Prohibition

	Total Arrests	MJ Possession	MJ Sale/Man.	Poss %	S/M %	Poss % /2
	1	2	3	4	5	6
Alabama	215587	11501	258	0.053	0.001	0.027
Alaska	40181	1239	200	0.031	0.005	0.015
Arizona	304142	16288	1233	0.054	0.004	0.027
Arkansas	218521	6846	928	0.031	0.004	0.016
California	1428248	50149	12338	0.035	0.009	0.018
Colorado	282787	12067	604	0.043	0.002	0.021
Connecticut	146992	6751	773	0.046	0.005	0.023
Delaware	41515	2151	131	0.052	0.003	0.026
D.C.*	4009	32	0	0.008	0.000	0.004
Florida*	0	0	0	0.043	.006	0.022
Georgia	429674	24321	4093	0.057	0.010	0.028
Hawaii	64463	1110	167	0.017	0.003	0.009
Idaho	76032	2949	219	0.039	0.003	0.019
Illinois*	319920	0	0	0.043	0.006	0.000
Indiana	270022	14484	1806	0.054	0.007	0.027
Iowa	113394	6054	551	0.053	0.005	0.027
Kansas	78285	3277	594	0.042	0.008	0.021
Kentucky*	160899	10669	1188	0.066	0.007	0.033
Louisiana	297098	14941	2526	0.050	0.009	0.025
Maine	57203	3294	554	0.058	0.010	0.029
Maryland	318056	17113	2711	0.054	0.009	0.027
Massachusetts	160342	8975	1365	0.056	0.009	0.028
Michigan	413174	14629	2050	0.035	0.005	0.018
Minnesota	269010	9325	6782	0.035	0.025	0.017
Mississippi	202007	9925	1054	0.049	0.005	0.025
Missouri	322775	13202	1338	0.041	0.004	0.020

Table 1: Percentage of Arrests Due to Marijuana Prohibition, continued

	Total Arrests	MJ Possession	MJ Sale/Man.	Poss %	S/M %	Poss % /2
	1	2	3	4	5	6
Montana	30396	384	35	0.013	0.001	0.006
Nebraska	97324	6787	326	0.070	0.003	0.035
Nevada	148656	3828	933	0.026	0.006	0.013
New Hampshire	50830	3706	550	0.073	0.011	0.036
New Jersey	375049	20285	3058	0.054	0.008	0.027
New Mexico	112829	2966	325	0.026	0.003	0.013
New York	1295374	101739	11309	0.079	0.009	0.039
North Carolina	523920	21179	2539	0.040	0.005	0.020
North Dakota	27846	896	137	0.032	0.005	0.016
Ohio	533364	25420	1863	0.048	0.003	0.024
Oklahoma	166004	11198	1302	0.067	0.008	0.034
Oregon	157748	6336	283	0.040	0.002	0.020
Pennsylvania	493339	16471	5057	0.033	0.010	0.017
Rhode Island	35733	2200	293	0.062	0.008	0.031
South Carolina	216451	14348	2370	0.066	0.011	0.033
South Dakota	41615	2449	153	0.059	0.004	0.029
Tennessee	232486	12869	2586	0.055	0.011	0.028
Texas	1074909	55509	1926	0.052	0.002	0.026
Utah	125553	4192	311	0.033	0.002	0.017
Vermont	17565	632	65	0.036	0.004	0.018
Virginia	303203	13140	1443	0.043	0.005	0.022
Washington	298474	13146	1329	0.044	0.004	0.022
West Virginia	51452	2618	248	0.051	0.005	0.025
Wisconsin	322877	45	16	0.000	0.000	0.000
Wyoming	34243	1633	164	0.048	0.005	0.024

* Quoting http://fisher.lib.virginia.edu/collections/stats/crime/2000cb.pdf : "(3) No arrest data were provided for Washington, DC, and Florida. Limited arrest data were available for Illinois and Kentucky."

Source: FBI Uniform Crime Reports accessed at http://fisher.lib.virginia.edu/collections/stats/crime/.

Table 2: Expenditures Attributable to Marijuana Prohibition ($ in millions)

	Police Budget		Judicial Budget		Corrections Budget		Total	
State	*Total:*	*MJ Prohib:*	*Total*	*MJ Prohib:*	*Total*	*MJ Prohib.*	*Total*	*MJ Prohib.*
Alabama	656	18.28	262	28.56	404	4.04	1,322	51
Alaska	177	3.61	130	14.17	175	1.75	482	20
Arizona	1096	33.79	611	66.60	955	9.55	2,662	110
Arkansas	351	6.99	156	17.00	328	3.28	835	27
California	8703	227.97	6255	681.80	7170	71.70	22,128	981
Colorado	830	19.48	329	35.86	820	8.20	1,979	64
Connecticut	682	19.25	430	46.87	554	5.54	1,666	72
Delaware	166	4.82	90	9.81	228	2.28	484	17
Florida	3738	103.19	1396	152.16	3272	32.72	8,406	288
Georgia	1279	48.38	525	57.23	1375	13.75	3,179	119
Hawaii	222	2.49	180	19.62	153	1.53	555	24
Idaho	207	4.61	102	11.12	191	1.91	500	18
Illinois	3053	84.28	961	104.75	1763	17.63	5,777	207
Indiana	843	28.25	325	35.43	727	7.27	1,895	71
Iowa	426	13.44	253	27.58	298	2.98	977	44
Kansas	430	12.26	206	22.45	349	3.49	985	38
Kentucky	488	19.78	290	31.61	610	6.10	1,388	57
Louisiana	829	27.89	359	39.13	780	7.80	1,968	75
Maine	164	6.31	69	7.52	123	1.23	356	15
Maryland	1120	39.68	489	53.30	1104	11.04	2,713	104
Massachusetts	1479	53.98	628	68.45	795	7.95	2,902	130
Michigan	1792	40.62	905	98.65	1853	18.53	4,550	158
Minnesotta	874	37.18	442	48.18	591	5.91	1,907	91
Mississippi	404	12.03	154	16.79	292	2.92	850	32
Missouri	886	21.79	359	39.13	627	6.27	1,872	67
Montana	136	1.02	66	7.19	125	1.25	327	9
Nebraska	235	8.98	96	10.46	231	2.31	562	22
Nevada	539	10.32	248	27.03	471	4.71	1,258	42
New Hampshire	187	8.84	92	10.03	115	1.15	394	20
New Jersey	2231	78.52	948	103.33	1480	14.80	4,659	197

Table 2: Expenditures Attributable to Marijuana Prohibition ($ in millions), continued

	Police Budget		Judicial Budget		Corrections Budget		Total	
State	*Total*	*MJ Prohib.*	*Total*	*MJ Prohib.*	*Total*	*MJ Prohib*	*Total*	*MJ Prohib.*
New Mexico	382	6.12	167	18.20	315	3.15	864	27.47
New York	5717	274.42	2262	246.56	4392	43.92	12,371	564.90
North Carolina	1318	33.03	470	51.23	1159	11.59	2,947	95.85
North Dakota	68	1.43	55	6.00	40	0.40	163	7.82
Ohio	2124	58.03	1158	126.22	1937	19.37	5,219	203.63
Oklahoma	518	21.53	193	21.04	511	5.11	1,222	47.68
Oregon	696	15.23	356	38.80	747	7.47	1,799	61.50
Pennsylvania	2220	59.82	1067	116.30	2221	22.21	5,508	198.33
Rhode Island	211	8.23	105	11.45	139	1.39	455	21.06
South Carolina	653	28.79	179	19.51	559	5.59	1,391	53.89
South Dakota	88	2.91	40	4.36	81	0.81	209	8.08
Tennessee	940	36.47	399	43.49	604	6.04	1,943	86.00
Texas	3204	88.47	1355	147.70	3755	37.55	8,314	273.71
Utah	381	7.30	202	22.02	351	3.51	934	32.83
Vermont	78	1.69	39	4.25	66	0.66	183	6.60
Virginia	1176	31.08	513	55.92	1246	12.46	2,935	99.46
Washington	1007	26.66	470	51.23	1053	10.53	2,530	88.42
West Virginia	171	5.17	108	11.77	184	1.84	463	18.79
Wisconsin	1124	0.13	440	47.96	1030	10.30	2,594	58.39
Wyoming	99	2.83	50	5.45	98	0.98	247	9.26
	56,398	1,707.41	26,984	2941.26	48447	484.47	131,829	5,133

Arrest Data: http://fisher.lib.virginia.edu/collections/stats/crime/
Budget Data: http://www.census.gov/govs/www/state00.html
Judicial Percent: Pastore and Maguire (2003), Table 5.42, p.444
Incarceration Percent: Pastore and Maguire (2003), Table 6.30, p.499

Table 3: Federal Expenditure on Marijuana Prohibition, 2002

1. Prohibition Enforcement, All Drugs		$13.6 billion
2. Marijuana Use Rate, Past Year, 2002	11.0%	
3. Any Illicit Drug Use Rate, Past Year, 2002	14.9%	
4. Ratio	74%	
5. Ratio x Line 1		$10.0 billion
6. Percent of All Drug Arrests for MJ, 2001	46.0%	
7. Line 6 x Line 1		$6.3 billion
8. Percent of All Trafficking Arrests for MJ, 2001	26%	
9. Line 8 x Line 1		$3.6 billion
10. Percent of DEA Drug Arrests for MJ, 2002	18.6%	
11. Line 10 x Line 1		$2.5 billion
12. Percent of DEA Drug Convictions for MJ, 2002	19.9%	
13. Line 12 x Line 1		$2.7 billion

Sources:

Line 1: Miron (2003b, p.10).

Lines 2-3: SAMHSA, Office of Applied Statistics, National Survey on Drug Use and Health, 2002, http://www.samhsa.gov/oas/nhsda/2k2nsduh/Results/apph.htm#tabh.2.

Lines 6 and 8: Sourcebook of Criminal Justice Statistics Online, http://www.albany.edu/sourcebook/1995/pdf/t429.pdf/

Line 10: Sourcebook of Criminal Justice Statistics Online, http://www.albany.edu/sourcebook/1995/pdf/t440.pdf/

Line 12: Sourcebook of Criminal Justice Statistics Online, http://www.albany.edu/sourcebook/1995/pdf/t538.pdf

Table 4a: State Marijuana Tax Revenue – Population Method

	Population	*Proportion*	*Tax Revenue*
Alabama	4,447,100	0.016	12.6
Alaska	626,932	0.002	1.8
Arizona	5,130,632	0.018	14.6
Arkansas	2,673,400	0.009	7.6
California	33,871,648	0.120	96.3
Colorado	4,301,261	0.015	12.2
Connecticut	3,405,565	0.012	9.7
Delaware	783,600	0.003	2.2
Dist. Columbia	572,059	0.002	1.6
Florida	15,982,378	0.057	45.4
Georgia	8,186,453	0.029	23.3
Hawaii	1,211,537	0.004	3.4
Idaho	1,293,953	0.005	3.7
Illinois	12,419,293	0.044	35.3
Indiana	6,080,485	0.022	17.3
Iowa	2,926,324	0.010	8.3
Kansas	2,688,418	0.010	7.6
Kentucky	4,041,769	0.014	11.5
Louisiana	4,468,976	0.016	12.7
Maine	1,274,923	0.005	3.6
Maryland	5,296,486	0.019	15.1
Massachusetts	6,349,097	0.023	18.0
Michigan	9,938,444	0.035	28.3
Minnesota	4,919,479	0.017	14.0
Mississippi	2,844,658	0.010	8.1
Missouri	5,595,211	0.020	15.9
Montana	902,195	0.003	2.6
Nebraska	1,711,263	0.006	4.9
Nevada	1,998,257	0.007	5.7
New Hampshire	1,235,786	0.004	3.5
New Jersey	8,414,350	0.030	23.9
New Mexico	1,819,046	0.006	5.2
New York	18,976,457	0.067	53.9
North Carolina	8,049,313	0.029	22.9
North Dakota	642,200	0.002	1.8
Ohio	11,353,140	0.040	32.3
Oklahoma	3,450,654	0.012	9.8
Oregon	3,421,399	0.012	9.7
Pennsylvania	12,281,054	0.044	34.9
Rhode Island	1,048,319	0.004	3.0
South Carolina	4,012,012	0.014	11.4
South Dakota	754,844	0.003	2.1
Tennessee	5,689,283	0.020	16.2
Texas	20,851,820	0.074	59.3
Utah	2,233,169	0.008	6.3
Vermont	608,827	0.002	1.7
Virginia	7,078,515	0.025	20.1
Washington	5,894,121	0.021	16.8
West Virginia	1,808,344	0.006	5.1
Wisconsin	5,363,675	0.019	15.2
Wyoming	493,782	0.002	1.4

State Populations: http://www.census.gov/popest/states/NST-EST2003-ann-est.html

Table 4b: State Marijuana Tax Revenue – Consumption Method

	Use Rate†	*User Population*	*Use Proportion*	*Tax Revenue*
Alabama	0.044	193,449	0.011	8.9
Alaska	0.098	61,251	0.004	2.8
Arizona	0.055	284,237	0.016	13.0
Arkansas	0.054	145,166	0.008	6.7
California	0.068	2,296,498	0.132	105.4
Colorado	0.089	383,672	0.022	17.6
Connecticut	0.063	213,529	0.012	9.8
Delaware	0.068	53,206	0.003	2.4
Dist. Columbia	0.108	61,897	0.004	2.8
Florida	0.066	1,051,640	0.060	48.2
Georgia	0.051	420,784	0.024	19.3
Hawaii	0.072	87,110	0.005	4.0
Idaho	0.056	72,461	0.004	3.3
Illinois	0.056	689,271	0.040	31.6
Indiana	0.064	388,543	0.022	17.8
Iowa	0.046	135,489	0.008	6.2
Kansas	0.053	143,024	0.008	6.6
Kentucky	0.055	221,489	0.013	10.2
Louisiana	0.064	284,227	0.016	13.0
Maine	0.069	88,352	0.005	4.1
Maryland	0.057	302,959	0.017	13.9
Massachusetts	0.063	401,263	0.023	18.4
Michigan	0.071	705,630	0.040	32.4
Minnesota	0.063	311,403	0.018	14.3
Mississippi	0.050	142,802	0.008	6.6
Missouri	0.061	339,070	0.019	15.6
Montana	0.087	78,581	0.005	3.6
Nebraska	0.064	109,179	0.006	5.0
Nevada	0.086	172,450	0.010	7.9
New Hampshire	0.099	121,725	0.007	5.6
New Jersey	0.050	420,718	0.024	19.3
New Mexico	0.059	106,596	0.006	4.9
New York	0.075	1,427,030	0.082	65.5
North Carolina	0.056	448,347	0.026	20.6
North Dakota	0.056	35,771	0.002	1.6
Ohio	0.067	759,525	0.044	34.8
Oklahoma	0.052	180,469	0.010	8.3
Oregon	0.090	306,557	0.018	14.1
Pennsylvania	0.054	664,405	0.038	30.5
Rhode Island	0.095	99,485	0.006	4.6
South Carolina	0.050	198,996	0.011	9.1
South Dakota	0.057	42,875	0.002	2.0
Tennessee	0.047	266,827	0.015	12.2
Texas	0.049	1,015,484	0.058	46.6
Utah	0.046	102,502	0.006	4.7
Vermont	0.100	61,126	0.004	2.8
Virginia	0.064	455,149	0.026	20.9
Washington	0.081	479,192	0.027	22.0
West Virginia	0.050	90,056	0.005	4.1
Wisconsin	0.054	291,784	0.017	13.4
Wyoming	0.052	25,578	0.001	1.2

†Marijuana Use Rates: http://oas.samhsa.gov/2k2State/html/appA.htm#taba.1

Appendix A: Percentage of Corrections Population Incarcerated on Marijuana Charges

State-by-state data on the fraction of prisoners incarcerated on marijuana charges are not available, but data for a few states provide reasonable estimates of this fraction. This appendix displays the available information.

Appendix Table A1

State	Year	% Incarcerated for MJ Violation	Population	Pop %	Weighted Share
California	2003	0.008	33,871,648	0.568	0.005
Georgia	2000	0.014	8,186,453	0.137	0.002
Massachusetts	2000	0.017	6,349,097	0.107	0.002
Michigan	2001	0.006	9,938,444	0.167	0.001
New Hampshire	2002	0.016	1,235,786	0.021	0.000
Total		0.061	59,581,428		
Average:		**0.012**			
			Weighted Average		**0.010**

Sources:
New Hampshire: http://www.state.nh.us/doc/population.html.
California: http://www.corr.ca.gov/OffenderInfoServices/Reports/Annual/CensusArchive.asp.
Michigan: http://www.michigan.gov/documents/2001Stat_79881_7.pdf
Georgia: http://www.dcor.state.ga.us/pdf/inms03-12.pdf
Massachusetts: Miron (2002, pp.4-5).

Appendix B: Revenue Under Prohibition from Seizures and Fines

State-by-state data on fines and seizures are not available. There is sufficient information, however, to estimate an upper bound on the revenue from fines and seizures. There are also data on federal fines and seizures.

Seizures:

The two main sources of federal seizure revenue are the Drug Enforcement Administration (DEA) and the U.S. Customs Service. In 2002, the DEA made seizures totaling $438 million.[32] In 2001, the U.S. Customs Service seized property valued at $592 million.[33] These figures overstate revenue since some defendants recovered their seized property. The Customs seizures overstate revenue related to drugs because the figure includes seizures for all reasons, such as violation of gun laws, intellectual property laws, and the like. There may also be double-counting between the DEA seizures and the U.S. Customs seizures.

Summing together the two components yields $1,030 million (= $438+$592 million) as the seizure revenue that results from enforcement of drug laws. This figure must be adjusted downward, however, to separate out the portion due to violation of marijuana laws as opposed to other drug laws. As shown in Table 3, approximately 20% of the federal drug enforcement budget is attributable to marijuana, so it is reasonable to assume approximately 20% of the fines and seizures correspond to enforcement of marijuana laws.

Thus, seizure revenue at the federal level due to marijuana prosecutions is roughly $206.0 million annually.

State and local data on forfeiture revenue are not readily available for all states Baicker and Jacobson (2004), however, estimate using a sample of states that state forfeiture revenue per capita was roughly $1.14 during the 1994-2001 period. This implies aggregate state forfeiture revenue of $342 million. Deflating by 26%, the fraction of all drug trafficking arrests due to marijuana, implies that marijuana seizures yield $89 million to state governments.

Fines: In 2001, the total quantity of fines and restitutions ordered for drug offense cases in U.S. District Courts was just under $41 million.[34] Adjusting this by the 20% figure implies $8.2 million from marijuana cases. Assuming the ratio of state/local to federal fine revenue is similar to ratio of state/local to federal seizure revenue implies that state and local fines/restitution from marijuana cases is about $3.5 million.

[32] See http://www.albany.edu/sourcebook/1995/pdf/t442.pdf.

[33] See http://www.albany.edu/sourcebook/1995/pdf/t444.pdf.

[34] See http://www.albany.edu/sourcebook/1995/pdf/t531.pdf.