MOVING FORWARD WITH CANNABIS

A white paper to help guide the City of Davis in the creation and implementation of community-oriented policy for medical cannabis businesses and organizations

Commissioned by the Client
Prepared by Integrate Cal Community Partners, Benefit Corporation

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EXECUTIVE SUMMARY

The current policy landscape which defines the legality of cannabis reflects over 100 years of precipitous change, manifesting in all echelons of organized government. While federal law was the first to shape the directions of state law in California, the monumental progress made by our state's legislative determinations in 2015 with the passage of the Medical Cannabis Regulation and Safety Act (MCRSA) has firmly placed the onus on local governments to determine the next steps. Both the MCRSA laws and the Adult Use of Marijuana Act (AUMA) campaign have defined an entire generation of politics in the great state of California, but these historic series of advancements created an unprecedented local policy quagmire: hundreds of counties, cities, towns, and communities were caught off-guard by the sheer expeditious nature of these policy determinations. While many policy experts predicted this, the message was clear: local policy will make or break the future of cannabis in California. Since the passing of the Compassionate Use Act all the way back in 1996, lessons were being learned all across the state, while new attitudes and best practices were being developed for an even better system down-the-road. Within these last twenty years of gradual progressive reforms, one of the most important take-aways has been how properly regulated medical cannabis dispensaries have proven to be absolutely essential to the success of any well-written medical cannabis program.

In an effort to advise the City of Davis on how to proceed through the policy landscape of cannabis at the local level, Integrate Cal Community Partners investigated several comparable localities to serve as informative case studies which detail both good and bad practices. We've identified one of these cities to be Santa Cruz, having much to offer to those committed to improving municipal economic and social policies. Santa Cruz has issued at least seven ordinances relating to changes in local marijuana and/or cannabis policy since 1996. Despite changes, progress was slow and not altogether positive due to several ongoing regulatory issues that complicated an otherwise reasonable albeit limited dispensary model. Some of the newer measures the city adopted included requiring license holders to start providing operating manuals and annual reports to ensure regulatory compliance. While well intentioned, the viability of a two-dispensary model with compounding and increasingly restrictive rules ultimately wavered due to the inability of local policymakers to adequately address issues like patient access and privacy, dignified service, social justice restoration, and general community development.

An ideal arrangement for the City of Davis, as it pertains to the establishment and operation of medical cannabis dispensaries, is to first pursue a pilot program with two or three dispensaries. Accounting for the various successes and failures in other local policies (an exploration of Denver and Seattle in the full report) allows for the development of a progressive yet prudent framework that balances the interests of community stakeholders while providing Davis a way forward in this exciting policy space. Ultimately, emerging businesses in this developing industry must remain mindful of and connected to the advocacy movement that preceded it. Failure to do so has shown to result in short-sighted policy with limited durability for change, and it limits our communities from the full potential of a post-prohibition world.

Moving Forward with Cannabis

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ABOUT THIS REPORT

This report was produced by Integrate Cal Community Partners, Benefit Corporation (ICCP) better known as Integrate Cal or Integrate. Overall, ICCP is a business focused on creating and championing community development strategies for a maturing cannabis industry, offering sensible pathways for implementing durable cannabis policies. This report is one of many ways ICCP provides value to private clients and government entities alike. Feel free to reach out, to ask about our full service offerings!

BACKGROUND

A well-equipped journey down the path of discovery requires proper insight and preparation, among other things. As such, a journey to identify and recommend cannabis policies requires a thorough and sensible approach. And in order to understand how to best prepare for and create a markedly improved future, we must first revisit parts of the past. Although the full history of cannabis goes back thousands of years[1], the era that this report addresses begins with a 1913 amendment to the Poison Act of 1907, where the possession of "extracts, tinctures, or other narcotic preparations of hemp, or loco-weed, their preparations and compounds (except corn remedies containing not more than fifteen grains of the extract or fluid extract of hemp to the ounce, mixed with not less than five times its weight of salicylic acid combined with collodion)"[2] was made into a misdemeanor in California. Due to an apparent legislative drafting issue, the language was odd, being placed in a section primarily dedicated to opium paraphernalia. However, another amendment two years later in 1915 would somewhat correct the issue and expand the ban to the sale or possession of "flowering tops and leaves, extracts, tinctures and other narcotic preparations of hemp or loco weed (*Cannabis sativa*), [and] Indian hemp"[3] except with a prescription. And even though the updated language technically made an exception for "legally prescribed narcotics, the possession of hemp drugs other than corn remedies remained independently outlawed under the 1913 paraphernalia provision, which remained on the books until 1937."[4]

"Other states passed laws against cannabis before World War I: Massachusetts in 1911; Maine, Wyoming and Indiana in 1913; and Utah and Vermont in 1915. City ordinances were also enacted in New York City in 1914 and Portland, Oregon in 1915."[5] Similarly to what happened in California, these early laws were enacted by authorities as supposedly preventive measures to deter future use, not as a direct response to any sort of public outcry. In truth, the swelling of anti-narcotics sentiment throughout the Golden State only began after years of sensationalist reporting and misinformation primarily championed by yellow journalism pioneers like William Randolph Hearst.[6] Despite this increasing and unjustified demonization of "marihuana", the brunt of the anti-dope crusade was actually directed against opiates and cocaine.[7]

The next big round of prohibitive measures came in 1925, right around the time that a U.S.-led International Opium Convention was held in Geneva focused on imposing "global controls over a wider range of drugs, including, for the first time, cannabis, which was referred to as 'Indian hemp' in Article 11 of the Convention."[8] And so in California, the "illegal sale [of cannabis], which had initially been a misdemeanor punishable by a $100-$400 fine and/or 50-180 days in jail for first offenders, became punishable by 6 months to 6 years in 1925. Possession, which had previously been treated the same as sales, became punishable by up to 6 years in prison. In 1927, the law against opium dens was finally extended to Indian hemp, as originally envisioned

[1] www.ancient-origins.net/history/cannabis-journey-through-ages-003084
[2] Contemporary Drug Problems - The Origins of Cannabis Prohibition in California (2006), PDF p22
[3] Ibid., PDF p24
[4] Ibid., PDF p24
[5] Ibid., PDF p27
[6] en.wikipedia.org/wiki/Legal_history_of_cannabis_in_the_United_States#Marihuana_Tax_Act_.281937.29
[7] Contemporary Drug Problems - The Origins of Cannabis Prohibition in California (2006), PDF p29
[8] www.druglibrary.org/schaffer/library/studies/canadasenate/vol3/chapter19_1925_Geneva.htm

in the 1880 Walker bill. In 1929, second offenses for possession became punishable by sentences of 6 months - 10 years."[9] As the regulations kept piling on, industries like that of hemp fiber and even pharmaceuticals, which had significant vested interests in a variety of cannabis materials, were forced to either change their operations or cease certain activities entirely.

Moving ahead to 1937 and the Marihuana Tax Act, when cannabis cultivation became a separate offence along with the introduction of an excise tax on all sales of hemp, the word 'marihuana' was finally written into state law for the first time, as part of the new Health and Safety Code.[10] However, it wasn't until 1940 when the state did "finally publish a brief pamphlet, 'Marihuana: Our Newest Narcotic Menace'"[11], even though interest from the press regarding the drug seemed to have peaked in the early 1930s. Several years after the end of WWII, strong anti-narcotics efforts were reawakened, even though police arrest records showed cannabis use to be increasing. Despite this being one of the first clear times when public data showed that prohibition wasn't working, penalties continued to increased. The punishment for possession was raised "to a minimum 1 - 10 years in prison in 1954, and sale was made punishable by 5 - 15 years with a mandatory 3 years before eligibility for parole."[12] Even worse, was the fact that having two prior felonies raised the maximum sentences for either offense to life.

As enforcement and criminalization efforts increased, so did the usage rates, especially through the counterculture revolution of the 1960s. Whereas official arrests for cannabis-related crimes in 1935 totalled around 140, the number skyrocketed to a record 103,097 by 1974, most of which were considered felonies.[13] Interestingly enough, in 1972 most Californians voted against Proposition 19, which was an honest attempt to decriminalize marijuana. But in 1973, Oregon succeeded, becoming the first state to decriminalize the substance. Two years later, however, Senate Bill 95 (known as the Moscone Act) was passed, making "possession of one ounce (28.5 grams) of marijuana a misdemeanor punishable by a $100 fine (with the assessments added to fines in California, this will total about $480), with higher punishments for amounts greater than one ounce, for possession on school grounds, or for cultivation."[14]

So as our history has shown, the issues of cannabis decriminalization, legalization, and regulation have long been politically-charged and for the most part, poorly-handled in California. To the frustration of many good people throughout the state, the next big push for sensible cannabis policy reform only came about a staggering 21 years after the passing of the Moscone Act. Proposition 215, better known as the Compassionate Use Act of 1996, was the first medical marijuana initiative of its kind enacted at the state level. But despite this big step forward, the popular initiative marked the start of the modern legal-precedence conflict between California and United States laws as they pertained to drug policy. The few protections afforded by Prop 215 were vague and rudimentary, doing little to stop federal authorities from interfering.

[9] Contemporary Drug Problems - The Origins of Cannabis Prohibition in California (2006), PDF p29
[10] Ibid., PDF p31
[11] Ibid., PDF p31
[12] Ibid., PDF p31
[13] Ibid., PDF p31
[14] en.wikipedia.org/wiki/Cannabis_in_California#Decriminalization

A less-mentioned victory also occurred with the approval of Proposition 36, better known as the Substance Abuse and Crime Prevention Act of 2000. It readdressed an important issue originally lost in all the sensationalism of the early 20th century, promoted by early drug-control supporters like Henry Finger, who "had advocated that drug habitués be sent to state hospitals for treatment rather than [be] confined in prison."[15] In a similar vein, Prop 36 assisted with emphasizing civil rather than criminal penalties, requiring that "first- and second-offense drug violators be sent to drug treatment programs instead of facing trial and possible incarceration."[16]

In 2003, with support for medical marijuana continuing to grow, a sympathetic California State Senator named John Vasconcellos, who was also a vocal supporter of Prop 215, introduced Senate Bill 420, offering to clarify the scope and application of the Compassionate Use Act. The bill was successful and went into effect on January 1, 2004, becoming known as the Medical Marijuana Program (MMP) Act, and thereby improving the lives of many patients, caregivers, and others who had been besieged and harassed in the prior seven years of policy experimentation. In addition, the MPP required "the California Department of Public Health (DPH) to establish and maintain a program for the voluntary registration of qualified medical marijuana patients and their primary caregivers through a statewide identification card system." [17] The MPP "also [defined] certain terms, sets possession guidelines for cardholders, and [recognized] a qualified right to collective and cooperative cultivation of medical marijuana."[18] These new and more clearly defined rules gave many individuals serving in positions of authority such as the police, the confidence to walk away from someone properly enrolled in the program.

Jumping ahead to the next important development in regards to decriminalization efforts, is the signing of Senate Bill 1449 on September 30, 2010 by Governor Arnold Schwarzenegger. Becoming effective January 1, 2011, the new law "effectively [reduced] the charge of possession of up to one ounce of cannabis from a misdemeanor to a violation, similar to a traffic violation, with a $100 fine and no mandatory court appearance or criminal record."[19] But in November of that same year, California voters narrowly defeated a different proposal that would have legalized the possession, use, and cultivation of recreational marijuana. Proposition 19 also known as the Regulate, Control and Tax Cannabis Act, was the only one of three initiatives that qualified for the ballot. A separate bill introduced as the Marijuana Control, Regulation, and Education Act by State Assemblyman Tom Ammiano also failed to gain traction, both in its original 2009 (as AB-390) and updated 2010 (as AB-2254) forms.[20]

Good news would strike again in 2014 when Proposition 47, the spiritual successor to Prop 36 and SB 1449, would be approved by voters as an initiated state statute. Referred to by different names such as the Reduced Penalties for Some Crimes Initiative, it didn't just address cannabis consumption, but an entire gamut of low-level nonviolent offenses which could now be

[15] Contemporary Drug Problems - The Origins of Cannabis Prohibition in California (2006), PDF p29
[16] www.sfgate.com/politics/article/Money-Opinion-Propelled-Prop-36-Drug-2728249.php
[17] California Department of Justice - Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use (2008), PDF p2
[18] Ibid., PDF p2
[19] en.wikipedia.org/wiki/Cannabis_in_California#Decriminalization
[20] en.wikipedia.org/wiki/Marijuana_Control,_Regulation,_and_Education_Act

downgraded to misdemeanors, even retroactively.[21] Judges would now be offered lists to help them make more objective rulings after considering a variety of factors. And last but not least, Prop 47 set the stage for the prison system releasing thousands of prisoners, thereby saving the state tens of millions of dollars, some of which was mandated to be used in creating a Safe Neighborhoods and Schools Fund.

The very next year, in 2015, an even more impressive arrangement of legislation presented itself in the form of three separate bills that collectively would be known as the Medical Marijuana (later replaced by Cannabis) Regulation and Safety Act (MMRSA to MCRSA). The bulk of this report focuses on materials and information primarily pertaining to this landmark set of laws, the amendments that followed, private sector adjustments, and more. In particular, answering the many questions in regards to medical cannabis dispensaries will be a prime objective. Over twenty years of rigorous experimentation has shown that the involvement and operation of dispensaries in this growing industry is essential to ensure patient access and satisfaction as well as effective and inclusive governance.

UNDERSTANDING THE MCRSA

Before the introduction of the Compassionate Use Act of 1996, those seeking out cannabis products for personal use within the state California were forced to choose between a faulty medical system or the dangers of the black market. Technically speaking, “the prescription of marijuana for medical use remained legal until 1970, when the federal government enacted the Comprehensive Drug Abuse Prevention and Control Act (now know as the Federal Controlled Substance Act).”[22] Categorizing marijuana as a Schedule I controlled substance effectively made it illegal in every sense and setting since, among other reasons, the government reasoned that there was “no currently accepted medical use in treatment”. Even with the Moscone Act in place, the risks involved with seeking, obtaining, and using cannabis products were quite numerous, with various local, state, and federal authorities regularly cracking down on any sort of activity with impunity.

Although there were no legitimate dispensaries or sanctioned commercial enterprises outside of a very limited cultivation allowance for academic research, “medical marijuana had found support in various regions across California. In November 1991, the voters of San Francisco passed a measure known as Proposition P, which urged state lawmakers to make marijuana available for medical use. California’s elected officials seemed to be similarly inclined, approving laws in 1994 and 1995 that recognized the use of medical marijuana. Despite public support for the legislation, then-Governor Pete Wilson vetoed both measures, actions consistent with his strong stance against marijuana use for any purpose.”[23] It was these sort of roadblocks coupled with the lack of any foreseeable progress on the federal front that gave rise to entities like the National Organization for the Reform of Marijuana Laws (NORML) and activists like Dennis Peron, who led the fight for Prop 215.

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[21] ballotpedia.org/California_Proposition_47,_Reduced_Penalties_for_Some_Crimes_Initiative_(2014)

[22] web.stanford.edu/group/hopes/cgi-bin/hopes_test/medical-marijuana-policy-in-the-united-states/#brief-history-of-marijuana-in-us

[23] web.stanford.edu/group/hopes/cgi-bin/hopes_test/medical-marijuana-policy-in-the-united-states/#state-legalization-%e2%80%93-the-case-of-california

The passing of Prop 215 therefore marked a turning point, sparking somewhat of a revolution across the country in a relatively short amount of time. In quick succession, from that day in November all the way through the passing of the original MMRSA installment in California, an impressive 22 additional states implemented some form of medical cannabis policy reforms.[24] If counting 2016, then an additional three states (Louisiana, Ohio, Pennsylvania) can be added, with yet another three (Arkansas, Florida, North Dakota) still awaiting their turn to decide sometime later this year.[25] Of course there's also the adult-use side, with California having another chance this November after a six year wait since the last attempt.

But what about municipal and county efforts? In order to provide an answer, it will be necessary to outline and explain the major features and functions of the MCRSA. As mentioned earlier, the act was originally the amalgamation of three separate bills from the state legislature, though it has since been amended and supplemented several times. Before examining these changes, a technical overview of this troika of bills from an older internal white paper[26] (completed in December of 2015) has been provided to offer a sound legal foundation:

> "**AB 243** [came] first, having been introduced on February 5th by Assembly Member and Lead Author of the bill Jim Wood (Democrat, 2nd District), assisted by fellow Assembly Members Anthony Rendon (Democrat, 63rd District) as the Principal Co-Author and Das Williams (Democrat, 37th District) as the Co-Author, respectively. The official legislative status of the bill is 'An act to add Article 6 (commencing with Section 19331), Article 13 (commencing with Section 19350), and Article 17 (commencing with Section 19360) to Chapter 3.5 of Division 8 of the Business and Professions Code, to add Section 12029 to the Fish and Game Code, to add Sections 11362.769 and 11362.777 to the Health and Safety Code, and to add Section 13276 to the Water Code, relating to medical marijuana, and making an appropriation therefor.' Its primary goal [was] to establish a regulatory program for the cultivation of medical [cannabis].
>
> **AB 266** [came] next, having been introduced on February 10th by Assembly Members and Lead Authors Rob Bonta (Democrat, 18th District), Ken Cooley (Democrat, 8th District), Reginald B. Jones-Sawyer, Sr. (Democrat, 59th District), Tom Lackey (Republican, 36th District), and Jim Wood. The official legislative status of the bill is 'An act to amend Sections 27 and 101 of, to add Section 205.1 to, and to add Chapter 3.5 (commencing with Section 19300) to Division 8 of, the Business and Professions Code, to amend Section 9147.7 of the Government Code, to amend Section 11362.775 of the Health and Safety Code, to add Section 147.5 to the Labor Code, and to add Section 31020 to the Revenue and Taxation Code, relating to medical marijuana.' Its primary goal [was] to establish a comprehensive licensing and regulatory framework for the cultivation, manufacture, transportation, storage, distribution, and sale of medical [cannabis].
>
> **SB 643** [came] last, having been introduced on February 27th by Senator Mike McGuire (Democrat, 2nd District). The official legislative status of the bill is 'An act to add Article 6 (commencing with Section 19331), Article 13 (commencing with Section 19350), and

[24] medicalmarijuana.procon.org/view.resource.php?resourceID=000881
[25] medicalmarijuana.procon.org/view.resource.php?resourceID=002481
[26] Cal Heritage Policy Paper - Summary and Analysis of the 2015 CA MMRSA and 2016 CA Ballot Initiatives

> Article 17 (commencing with Section 19360) to Chapter 3.5 of Division 8 of the Business and Professions Code, to add Section 12029 to the Fish and Game Code, to add Sections 11362.769 and 11362.777 to the Health and Safety Code, and to add Section 13276 to the Water Code, relating to medical marijuana, and making an appropriation therefor.' Just like its companion bills, SB 643 [contributed] to the regulatory and oversight structure of the [MCRSA]…specifically [setting] forth standards for licensed medical physicians and doctors of osteopathy ('physicians') who recommend [cannabis] for medical use and…[delving] into the criminal background standards for applicants."

Then, as hinted at before, various cosmetic and substantive changes were applied to reflect new information, industry preferences, and corrections to mistakes found in the original legal language. Arranged alongside those "clean-up" bills are pieces of legislation that address marijuana/cannabis policy in a variety of other ways, which are presented below (while excluding miscellaneous or appropriation bills like AB-403, AB-1997, AB-93, AB-103, AB-1598, SB-69, SB-825 and SB-826). All of the following legislative items are ordered chronologically, by chaptered date:

- **AB-258**[27] - July 6, 2015
  - Relevant Specifics:
    - Establishes the prohibition of determining the ultimate recipient of an anatomical gift based solely upon a potential recipient's status as a qualified patient, except to the extent that the qualified patient's use of medical marijuana has been found by a physician and surgeon to be medically significant to the provision of the anatomical gift for hospitals, physicians, surgeons, procurement organizations, and other persons.
    - Only references "marijuana"
- **SB-303**[28] - October 9, 2015
  - Relevant Specifics:
    - Authorizes the law enforcement agency in charge of cases requiring the forfeiture and seizure of marijuana involved in, or purchased with the proceeds from, a controlled substance offense, to destroy those seized substances suspected to be growing or harvested marijuana in excess of 2 pounds instead of the previous allotment of 10 pounds, or the amount of marijuana a medical marijuana patient or designated caregiver is authorized to possess by ordinance in the city or county where the marijuana was seized, whichever is greater, subject to specified requirements. The agency will now also have to retain at least one 2-pound sample and 5 random and representative samples consisting of leaves or buds, for evidentiary purposes, from the total amount to be destroyed.
    - Only references "marijuana"
- **AB-21**[29] - February 3, 2016

[27] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB258
[28] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB303
[29] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB21

- Relevant Specifics:
  - Corrects a drafting error in the initial version of the MMRSA by removing an unclear potential March 1, 2016 deadline for localities to establish their own cultivation regulations or else forfeit that authority to the state
  - Removes language authorizing local governments to prohibit patients from cultivating, selling, distributing, donating, or providing cannabis for their own personal use

- **SB-837**[30] - June 27, 2016
  - Relevant Specifics:
    - Changes the name of the Medical Marijuana Regulation and Safety Act, the Bureau of Medical Marijuana Regulation, and the Medical Marijuana Regulation and Safety Act Fund to the Medical Cannabis Regulation and Safety Act (MCRSA), the Bureau of Medical Cannabis Regulation (BMCR), and the Medical Cannabis Regulation and Safety Act Fund (MCRSAF)
    - Changes the other references of marijuana to cannabis
    - Changes the responsibilities of state agencies[31]:
      - The BMCR has replaced the Department of Public Health (DPH) as the agency responsible for licensing testing laboratories
      - The Department of Food and Agriculture (DFA) has replaced the BMCR as the agency responsible for establishing appellations of origin for cultivated cannabis
      - The DPH's role in regulating manufacturing has been expanded to cover developing standards for the manufacturing and labeling of all manufactured medical cannabis products and not just edibles
      - The DPH will now identify and report any medical cannabis products that have been adulterated or misbranded
      - The agencies may now adopt emergency regulations to remain in effect for no longer than 180 days in order to carry out the purposes of the MCRSA, which should buy them enough time to prepare the final regulations while still commencing with state licensing in 2018
    - Changes the requirements and types of licenses[32]:
      - The Type 10A license for a "Dispensary" is now for a "Producing Dispensary"
      - The Type 8 license for "Testing" is now for a "Testing Laboratory"
        - Infused butters are now excluded from the state Milk and Milk Products Act of 1947
      - New cultivation rules were added regarding the source and diversion of water

[30] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB837
[31] www.cannalawblog.com/from-marijuana-to-cannabis-changes-to-californias-state-regulations/
[32] Ibid.

- The State Water Resources Control Board (SWRCB), in consultation with the Department of Fish and Wildlife (DFW), is tasked with adopting principles and guidelines for diversion and use of water for cannabis cultivation
- The ability of the SWRCB to issue cease and desist letters to cultivators who violate the rules has been expanded, and new fines for violations based on period of time and acreage have been added
- Cannabis seeds are now excluded from the state's Seed Law

» Distributors are no longer required to transport cannabis between cultivators and manufacturers for further manufacturing; in other words, cultivators are no longer required to send cannabis to distributors if the cannabis is to be used, sold, or otherwise distributed by manufacturers for further manufacturing

› All state license applicants will now need to provide proof of a bond to cover the costs of the destruction of their medical cannabis or medical cannabis products due to a violation of the licensing requirements, if such a violation was to occur

› Medical cannabis businesses operating in compliance with local laws on or before January 1, 2018 can continue to operate until their license application is either approved or denied, but only if those businesses:

1. continue to operate in compliance with local laws, and
2. submit a completed application with the appropriate licensing authority by the to-be-established deadlines

- **SB-1171**[33] - July 22, 2016
  - Relevant Specifics:
    - › Makes non-substantive changes (legislation necessary to maintain the state codes) in various provisions of law to effectuate the recommendations made by the Legislative Counsel to the Legislature:
      - » Addresses "marijuana" 15 times
      - » Addresses "cannabis" 4 times
- **SB-839**[34] - September 13, 2016
  - Relevant Specifics:
    - › Removes the requirement for medical cannabis cultivation license holders to obtain an agreement with the Department of Fish and Wildlife (DFW) to divert, obstruct, change, or use any material from a body of water for the term of the license if all of the following occurs:
      1. The licensee submits all of the following to the DFW, in accordance with the descriptions provided in Section 1602 of the Fish and Game Code:
         a. a proper written notification;

[33] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB1171
[34] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB839

b. a copy of the state license issued by the DFA (also in accordance with Section 19332.2 of the Business and Professions Code); and
c. the indicated fee;

2. The DFW determines that compliance will adequately protect existing fish and wildlife resources that may be substantially or adversely affected by the cultivation without the need for additional measures (in accordance with Section 1603 of the Fish and Game Code); and

3. The DFW notifies the licensee in writing that the exemption applies

- **SB-1478**[35] - September 22, 2016
  - Relevant Specifics:
    - Adjusts the roster of state-created bureaus, boards, and other bodies that have to disclose licensee information to the DCA when requested and in accordance with the Business and Professions Code, as well as the Government Code, and the Civil Code, to include the BMCR
    - Only references “cannabis”
- **AB-821**[36] - September 29, 2016
  - Relevant Specifics:
    - Acknowledges that current federal restrictions remove the ability of cannabis businesses to use federally regulated banks, which forces them to pay taxes in large amounts of cash instead of electronic funds transfers
    - Removes the 10% penalty charged by California’s Board of Equalization (BoE) for tax payments of $10,000 or more before January 1, 2022 for licensed individuals working in accordance with the MCRSA
    - Only references “cannabis”
- **SB-1174**[37] - September 29, 2016
  - Relevant Specifics:
    - Changes the categorical criteria used by the Medical Board of California (MBC), for prioritizing its investigative and prosecutorial resources so as to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined quickly, to include as the fourth most prioritized item:
      - repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation
    - Only references “cannabis”

[35] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB1478
[36] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB821
[37] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB1174

- **AB-2516**[38] - September 29, 2016
  - Relevant Specifics:
    - Outlines the respective governing powers of the DFA, the Department of Pesticide Regulation (DPA), and the SWRCB as it pertains to cultivation licensing, air quality control, natural water flow, and pesticide application
    - Adds the new 1C “cottage” license type for specialty cultivation in outdoor, indoor, and mixed-light settings, thus embracing small farmer practices
    - Only references “cannabis”
- **AB-2679**[39] - September 29, 2016
  - Relevant Specifics:
    - Changes the requirements of the annual report from the licensing authority to include the number of appeals from the denial of state licenses or other disciplinary actions taken by the licensing authority, the average time spent on these appeals, and the number of complaints submitted by citizens or representatives of cities or counties regarding licensees
    - Changes the purpose of the California Cannabis Research Program to include the option to also study how cannabis affects motor skills
    - Changes the exemptions given to cooperatives and collectives before licensing authorities commence issuing licenses, who cultivate medical cannabis for qualified patients from criminal sanctions for specified activities related to the growing, sale, and distribution of cannabis, to now also include the manufacturing of medical cannabis products

There are also those bills that address medical cannabis (and/or marijuana) but that have yet to be finalized or voted on. Though some are more promising and likely to pass than others, making a note of all contending legislation assures that there are no surprises later on. Only thirteen bills remain on the 2015-2016 docket, though most have been inactive for some time now; ordered below first by date of introduction and then by date of last update:

- **AB-26**[40] - Introduced on 12/01/14
  - Title Description: An act to amend Sections 19322 and 19323 of, and to add Section 19326.5 to, the Business and Professions Code, relating to medical cannabis.
  - Latest Update: 08/17/16
    “Re-referred to Com. on RLS.”
- **SB-140**[41] - Introduced on 01/26/15
  - Title Description: An act to amend Sections 22950.5, 22958, 22962, and 22971 of and 22962 of, to amend, repeal, and add Sections 22973 and 22980.2 of, and to add Section 22971.7 to, the Business and Professions Code, to amend Section 1947.5 of

[38] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2516
[39] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2679
[40] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB26
[41] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB140

the Civil Code, to amend Section 48901 of the Education Code, to amend Section 7597 of the Government Code, to amend Sections 1234, 1286, 1530.7, 1596.795, 104495, 114332.3, 114371, 118910, 118925, and 118948 of, and to repeal Section 119405 of, the Health and Safety Code, to amend Section 6404.5 of the Labor Code, to amend Section 308 of the Penal Code, to amend Sections 561 and 99580 of the Public Utilities Code, and to amend Section 12523 of the Vehicle Code, relating to electronic cigarettes.

  - Latest Update: 07/08/15
    "July 8 set for first hearing. Held in committee without recommendation."

- **SB-297**[42] - Introduced on 02/23/15
  - Title Description: An act relating to medical marijuana.
  - Latest Update: 02/01/16
    "Returned to Secretary of Senate pursuant to Joint Rule 56."
- **SB-435**[43] - Introduced on 02/25/15
  - Title Description: An act to amend Section 11362.777 of the Health and Safety Code, relating to medical marijuana.
  - Latest Update: 01/19/16
    "Joint Rule 62(a) suspended."
- **AB-1571**[44] - Introduced on 01/04/16
  - Title Description: An act to amend Section 11837 of the Health and Safety Code, and to amend Section 23538 of the Vehicle Code, relating to vehicles.
  - Latest Update: 05/27/16
    "In committee: Held under submission."
- **AB-1575**[45] - Introduced on 01/04/16 (the bill that would have allowed early for-profits)
  - Title Description: An act to amend Sections 19300.5, 19302, 19302.1, 19316, 19317, 19320, 19322, 19326, 19328, 19332, 19334, 19340, 19341, 19344, 19345, 19350, 19351, and 19360 of, to amend the heading of Article 5 (commencing with Section 19326) of Chapter 3.5 of Division 8 of, to add Sections 14235.5, 19310.5, 19319.5, 19322.5, and 19327.5 to, the Business and Professions Code, to amend Section 12029 of the Fish and Game Code, to amend Section 52334 of the Food and Agricultural Code, and to amend Sections 11362.765, 11362.775, and 11362.777 of the Health and Safety Code, relating to medical cannabis.
  - Latest Update: 08/11/16
    "In committee: Held under submission."
- **AB-1715**[46] - Introduced on 01/26/16

[42] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB297
[43] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB435
[44] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB1571
[45] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB1575
[46] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB1715

- Title Description: An act to amend Sections 27 and 2920 of, to amend, repeal, and add Sections 2922, 2923, and 2927 of, to add Chapter 6.7 (commencing with Section 2999.10) to Division 2 of, and to repeal Sections 2999.20, 2999.26, 2999.31, and 2999.33 of, the Business and Professions Code, relating to healing arts.
- Latest Update: 06/21/16
  "In committee: Set, first hearing. Hearing canceled at the request of author."

- **SB-1116**[47] - Introduced on 02/17/16
  - Title Description: An act to amend Section 19348 of the Business and Professions Code, relating to medical marijuana.
  - Latest Update: 02/25/16
    "Referred to Com. on GOV. & F."
- **AB-2149**[48] - Introduced on 02/17/16
  - Title Description: An act to add Part 13.5 (commencing with Section 31001) to Division 2 of the Revenue and Taxation Code, relating to medical cannabis, and making an appropriation therefor.
  - Latest Update: 08/11/16
    "In committee: Held under submission."
- **AB-2243**[49] - Introduced on 02/18/16
  - Title Description: An act to add and repeal Part 13.5 (commencing with Section 31001) of Division 2 of the Revenue and Taxation Code, relating to medical cannabis, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.
  - Latest Update: 08/11/16
    "In committee: Held under submission."
- **AB-2614**[50] - Introduced on 02/19/16
  - Title Description: An act to amend Section 19325 of the Business and Professions Code, relating to medical cannabis.
  - Latest Update: 03/10/16
    "Referred to Com. on B. & P."
- **AB-2545**[51] - Introduced on 02/19/16
  - Title Description: An act to add Article 18 (commencing with Section 19370) to Chapter 3.5 of Division 8 of the Business and Professions Code, relating to medical cannabis.

[47] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB1116
[48] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2149
[49] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2243
[50] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2614
[51] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2545

- Latest Update: 05/27/16
  "In committee: Held under submission."

- **AB-2672**[52] - Introduced on 02/19/16
  - Title Description: An act to amend Sections 19322 and 19323 of, and to add Section 19326.5 to, the Business and Professions Code, relating to medical cannabis.
  - Latest Update: 06/20/16
    "In committee: Set, first hearing. Hearing canceled at the request of author."

The following are those bills that were either made inactive without being chaptered, failed on the floor or in committee, died due to special rules, or were entirely vetoed by the governor:

- **AB-34**[53] (12/01/14-01/31/16; died)
- **AB-567**[54] (02/24/15-09/29/16; vetoed)
- **AB-1351**[55] (02/27/15-10/08/15; vetoed)
- **AB-1548**[56] (09/11/15-01/31/16; died)
- **AB-1609**[57] (01/07/16-08/23/16; inactive)
- **AB-1611**[58] (01/07/16-08/25/16; inactive)
- **SB-987**[59] (02/10/16-06/20/16; failed)
- **AB-2300**[60] (02/18/16-08/30/16; inactive)
- **AB-2385**[61] (02/18/16-09/29/16; vetoed)

The next category of information addresses the 17 different license types nested within the six general categories of the new MCRSA regulatory framework[62]:

- Cultivation - Specialty
  - **Type 1** - Outdoor
    - Allowing up to 5,000 sq ft or up to 50 mature plants on non-contiguous plots, exclusively using natural lighting
  - **Type 1A** - Indoor
    - Allowing between 501 and 5,000 sq ft, exclusively using artificial lighting
  - **Type 1B** - Mixed-Light
    - Allowing between 2,501 and 5,000 sq ft, using a combination of lighting

[52] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2672
[53] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB34
[54] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB567
[55] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB1351
[56] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB1548
[57] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB1609
[58] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB1611
[59] leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB987
[60] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2300
[61] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2385
[62] www.manzurilaw.com/mcrsa-licensing-roadmap/

    - **Type 1C** - Cottage[63]
        - Outdoor - Allowing up to 25 mature plants
        - Indoor - Allowing up to 500 sq ft
        - Mixed-Light - Allowing up to 2,500 sq ft
- Cultivation - Small Scale
    - **Type 2** - Outdoor
        - Allowing between 5,001 and 10,000 sq ft, exclusively using natural lighting
    - **Type 2A** - Indoor
        - Allowing between 5,001 and 10,000 sq ft, exclusively using artificial lighting
    - **Type 2B** - Mixed-Light
        - Allowing between 5,001 and 10,000 sq ft, using a combination of lighting
- Cultivation - Medium Scale
    - **Type 3** - Outdoor
        - Allowing between 10,001 sq ft and 1 acre, exclusively using natural lighting
        - Limited licensure by the DFA
    - **Type 3A** - Indoor
        - Allowing between 10,001 and 22,000 sq ft, exclusively using artificial lighting
        - Limited licensure by the DFA
    - **Type 3B** - Mixed-Light
        - Allowing between 10,001 and 22,000 sq ft, using a combination of lighting
        - Limited licensure by the DFA
- Cultivation - Other
    - **Type 4** - Nursery
        - Allowing cultivation of medical cannabis solely as a nursery
        - May also hold a Type 10A license to transport live plants
- Manufacturing
    - **Type 6** - If using non-volatile solvents
        - May also hold a Type 1, 1A, 1B, 1C, 2, 2A, or 2B license, and vice versa
        - May also hold a Type 10A license, and vice versa
- Manufacturing
    - **Type 7** - If using volatile solvents
        - May also hold a Type 1, 1A, 1B, 1C, 2, 2A, or 2B license, and vice versa
        - May also hold a Type 10A license, and vice versa
        - Limited licensure by the DPH
- Testing (Laboratories)
    - **Type 8**

[63] leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2516

    - Subject to standard methods established by the International Organization for Standardization that are approved by an accrediting body that is signatory to the International Laboratory Accreditation Cooperation Mutual Recognition Arrangement
    - Cannot hold any other type of license
    - Cannot hold an ownership interest in any other license-holding entity or facility
- Dispensing
  - **Type 10** - General (Dispensary)
    - When operating more than three retail sites
  - **Type 10A** - Producing (Dispensary)
    - When operating no more than three retail sites
- Distributing
  - **Type 11**[64]
    - Purchase medical cannabis from a licensed cultivator, and medical cannabis products from a licensed manufacturer, for sale to a licensed dispensary
    - Must ensure that products have been batch-tested and verified as safe
    - Must apply for a Type 12 license but cannot hold any other type[65]
- Transporting
  - **Type 12**[66]
    - Move medical cannabis and medical cannabis products between licensees
    - Must submit electronic shipping manifests prior to all transport activity, and update the traceability system at each point for supply chain integrity
    - May apply for a Type 11 license[67]

While Type 9 licenses are currently undefined (likely saved for future use), Type 5 (and 5A and 5B) licenses will be created, and parallel Type 10 (from Dispensary to Retailer) and Type 12 (from Transportation to Microbusiness) licenses will be redefined to address the recreational cannabis market, that is, if the Adult Use of Marijuana Act (AUMA)[68], now known as Proposition 64, succeeds at the ballot this November.

Type 5 licenses will be considered “large scale” and were devised for farms over the MCRSA limit of 1 acre outdoors or ½ an acre indoors. Type 5 licenses won’t be issued until January 1, 2023 in accordance with Section 26061(d) of the upcoming Ballot Initiative (15-0103).

The next important component to consider is the slate of deadlines woven into various phases and aspects of the new regulatory framework. A variation of the following is made available on the CA NORML website’s MCRSA page as compiled by Sarah Armstrong, Director of Industry Affairs for Americans for Safe Access[69]:

[64] www.rvrdc.com/blogs/media/113920579-distribution-transportation
[65] leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB266
[66] www.rvrdc.com/blogs/media/113920579-distribution-transportation
[67] leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB266
[68] www.canorml.org/Cal_NORML_Guide_to_AUMA
[69] www.canorml.org/news/A_SUMMARY_OF_THE_MEDICAL_MARIJUANA_REGULATION_AND_SAFETY_ACT

- **July 1, 2015**
  - Date by which those claiming vertical integration had to be operating a vertically integrated business
    - › AB-266, Section 19328(c)(1)
- **January 1, 2016**
  - Date on which AB-243, AB-266, and SB-643 went into effect
  - Date on which priority licensing status was determined for businesses already operating in good standing within a local jurisdiction
    - › AB-266, Section 19321(c)
- **January 1, 2017**
  - Date by which the Division of Occupational Safety and Health (DOSH) shall convene an advisory committee to evaluate whether there is a need to develop industry-specific regulations related to the activities of facilities that were issued licenses
    - › AB-266, Labor Code Amendment Sec. 7 147.5
- **July 1, 2017**
  - Date on which the aforementioned advisory committee shall present to the Board (currently unspecified) its findings and recommendations for consideration by the Board
    - › AB-266, Labor Code Amendment Sec. 7 147.5
  - Date by which the Board shall render a decision regarding the adoption of industry-specific regulations
    - › AB-266, Labor Code Amendment Sec. 7 147.5
- **January 1, 2018**
  - Date on which those facilities or entities that are operating in compliance with local zoning ordinances and other local and state requirements may continue operating until their applications for licensure are approved or denied
    - › AB-266, Section 19321(c)
- **January 1, 2020**
  - Date by which the DFA in conjunction with the BMCR shall make available a certified organic designation and organic certification program for medical cannabis, if permitted under federal law and the National Organic Program
    - › SB-643, Section 19332.5(a)
- **January 1, 2022**
  - Date by which the loan of up to $10,000,000.00 from the General Fund to establish the MCRSA has to be repaid; if the fees collected by that time don't repay the loan, then funds will come from imposing new penalties
    - › AB-243, Section 19351(b)(1)

- **March 1, 2023**
    - Date by which each following year, all licensing authorities involved in the MCRSA shall prepare and submit to the state legislature and post on their own websites, an annual report on all their activities that year
        - › AB-266, Section 19353
- **January 1, 2026**
    - Date on which the following provision becomes inoperative:
        - › "A Type 10A licensee may apply for a Type 6 or 7 state license and hold a 1, 1A, 1B, 2, 2A, 2B, 3, 3A, 3B, 4 or combination thereof if, under the 1, 1A, 1B, 2, 2A, 2B, 3, 3A, 3B, 4 or combination of licenses thereof, no more than four acres of total canopy size of cultivation by the licensee is occurring throughout the state during the period that the respective licenses are valid"
        - › AB-266, Section 19328(a)(9)
    - Date on which the vertical integration provision is automatically repealed
        - › AB-266, Section 19328(d)

While this exhaustive legal examination could continue, it is instead best to address those items that pertain primarily to the local (i.e. city and county) approach. Here are some important new regulations in that vein, as a segue into the next section of the report:

- Regarding local licensing:
    - No person shall engage in commercial activity without both a state license and a license, permit, or other authorization from their local government
        - › AB-243, Section 11362.777(b) & AB-266, Section 19320(a)
- Regarding lawful actions:
    - Actions by licensees that are permitted by both a state license and a local license or permit issued by the local jurisdiction and that are in accordance with local ordinances, are considered lawful and protected from arrest, prosecution, or other sanctions under state law
        - › AB-266, Section 19317

THE LOCAL APPROACH: Introduction

With the historic series of aforementioned legislative advancements came an unavoidable and unprecedented local policy quagmire: hundreds of counties, cities, towns, and communities closed their doors to the medical cannabis community. Within a few months, millions of patients, business hopefuls, and advocacy groups found themselves in hostile territory. While many policy experts predicted the general sequence of events as they unfurled, the message was clear: local policy will make or break the future of the cannabis industry in California.

In the wake of the confusion, scramble, and leadership void at the local and regional level, many different supporting entities began to emerge. While many local businesses found a voice

through these newly forming entities, ranging from trade associations to non-profit advocacy groups, most of these entities lacked the ability to fully cross-pollinate with state level resources and local level policy considerations to achieve the lasting success they desired.

In addition to this, many of the rules and restrictions that went into effect at the local level inadvertently codified the unfortunate social stigma and destructive misinformation that activists within the movement have been fighting to eliminate for nearly half a century. Among the greatest losses for the movement and the community was the loss of medical access for hundreds of thousands of medical cannabis patients, especially in the small towns and rural countryside, all across the state.

Through the unique nexus of industry and advocacy, the City of Davis has an opportunity to take a leading role in visibly demonstrating that constructive coexistence between each community is not only possible, but quite necessary. However, this is no simple task, as it requires a large-scale, coordinated operational strategy carried out by entities with fluidity in industry, advocacy, and local community spaces.

THE LOCAL APPROACH: Test Pilot Feasibility and Case Studies[70]

In an effort to advise the communities of Davis on how to proceed through the policy landscape of cannabis at the local level, the team at ICCP investigated several comparable localities to serve as informative case studies which detail both good and bad practices. We've identified one of these cities to be Santa Cruz. First, let's consider the primary statistical similarities between the cities of Davis and Santa Cruz. Out of the 34 key standardized metrics retrieved from U.S. Census Bureau records, 24 of Santa Cruz city's closely match their Davis counterparts, including total population, civilian labor force, and most economic figures. In addition, the following secondary statistical similarities exist between the two cities[71]:

- Similar land size (12.7 sq mi for Santa Cruz versus 9.887 sq mi for Davis)
- College town; Most populous city in county; Close proximity to metropolitan area; Rail access; Council-Manager government; Predominantly Democratic; Mediterranean (Csb) climate; Popular event destination; Strong bike culture

Santa Cruz has issued at least seven ordinances relating to changes in local marijuana and/or cannabis policy since the passing of the Compassionate Use Act of 1996. However, progress was slow and not altogether positive due to several ongoing regulatory issues. Before Emergency Ordinance No. 2000-12 went into effect, a handful of pioneering cannabis clubs set-up shop both inside and outside the city proper, the most notable of which was WAMM (Wo/Men's Alliance for Medical Marijuana). Once Chapter 6.90 of the Santa Cruz city Municipal Code was operationalized just four years after the passage of Prop 215, all medical (and commercial) operations involving cannabis within the city limits were made illegal, forcing some to move and others to close permanently (an example being Santa Cruz Cannabis Pharmaceuticals)[72]. The city implemented a strict two-dispensary limit with rigid regulatory

[70] Secured Pre-existing Proprietary IP of ICCP
[71] Cannabis Policy White Paper - Referenced and Supplemental Resources
[72] santacruz.indymedia.org/newswire/display/9816/index.php

controls, while the county of Santa Cruz proceeded with its own codes for unincorporated areas, creating a dissonant dual approach which favors outside cultivation and distribution.

An overview of City Council activity from 1996 to 2010 can be gathered from the preambulatory clauses listed in Ordinance Nos. 2009-17[73], 2009-21[74], and 2010-03[75] , which first introduced and then twice extended a “moratorium on the establishment of medical marijuana dispensaries and production houses within the city” until an updated ordinance could be introduced, discussed, and adopted:

- ...in 1996 the voters of the State of California approved Proposition 215, which was codified as Health and Safety Code Section 11362.5, et seq. and entitled the Compassionate Use Act of 1996 (“the Act”); and
- ...the intent of Proposition 215 was to enable persons who are in need of marijuana for medical purposes to obtain and use it under limited, specific circumstances; and
- ...the City Council, on April 11, 2000 adopted Ordinance No. 2000-06 pertaining to personal medical marijuana use in the City of Santa Cruz; and
- ...the City Council, on June 27, 2000 adopted Emergency Ordinance No. 2000-12 pertaining to the establishment of land use regulations for Medical Marijuana dispensaries and production within the City of Santa Cruz; and
- ...on January 1, 2004, Senate Bill 420 became effective to clarify the scope of the Act and to allow cities and counties to adopt and enforce rules and regulations consistent with SB 420 and the Act; and
- ...two Medical Marijuana dispensaries have been approved within the City of Santa Cruz in 2005 and 2006 respectively; and
- ...in February 2009 the U.S. Attorney General stated that federal law enforcement officials would ease enforcement at California medical marijuana facilities; and
- ...City staff received inquires nearly daily from members of the public in the first half of 2009 as to the possibility of establishing medical marijuana dispensaries and production houses throughout the City of Santa Cruz and had received two applications for medical marijuana dispensaries...; and
- ...the City of Santa Cruz is the only jurisdiction in the County of Santa Cruz that allows medical marijuana dispensaries and production houses; and
- ...concerns have been raised in the community regarding the inadequacy of the current regulations to address the increasing number of permit applications and the impact that a proliferation/overconcentration of medical marijuana dispensaries and production houses within the City may have on the community as a whole; and

As the records indicate, the first officially sanctioned medical dispensary (defined as a type of association by the city) was approved to operate in 2005 with the second approved in 2006. The former was co-owned and -operated by Lisa Molyneux and Syndy Reinecke until they were forced to close in November 2015 due to excessive operating costs within a restrictive

[73] www.cityofsantacruz.com/home/showdocument?id=9111
[74] www.cityofsantacruz.com/home/showdocument?id=9131
[75] www.cityofsantacruz.com/home/showdocument?id=12250

regulatory environment.[76] City officials tried to reap the rewards of their so-called legalization measures while enforcing prohibitively strict rules that effectively eliminated the ability of dispensaries to sustain their operations. This example shows the importance of fiscal responsibility and the balance of interests within a volatile market environment. Tax revenue cannot be justified and best practices cannot be developed if the system is essentially rigged to fail. Regulations must be crafted in an intelligent manner with the understanding that those costs tied to taxes, compliance, operations, and the like do not outweigh the incentives for operating in the first place.[77]

In 2010, just five years into the new regulatory system, city officials proved unable to agree on more effective and accommodating rules despite persistent public support for a more sensible approach and a growing number of examples to draw from, such as those of cities like Oakland and San Jose.[78] Santa Cruz instead moved to adopt even more restrictive measures like requiring license holders to start providing operating manuals and annual reports to ensure regulatory compliance. The following is an example of one of these controversial changes (instituted via City Ordinance No. 2010-10[79]):

> Section 6.90.085 of the Santa Cruz Municipal Code - ANNUAL REPORTS
>
> Report Requirements/Contents of Report. Each medical marijuana provider association dispensary operating in the City shall, on an annual basis, submit a report to the City Manager. Reports shall be on a calendar year basis and shall be submitted no later than May 31 following the calendar year to which the report pertains. (For example, a dispensary's 2010 annual report will be submitted to the City Manager no later than May 31, 2011). The report shall document the dispensary's compliance with the requirements of the Compassionate Use Act (California Health and Safety Code Section 11357 et seq.), the Medical Marijuana Practices Act (California Health and Safety Code Sections 11362.7 et seq.), California Attorney General Guidelines promulgated pursuant to California Health and Safety Code Section 11362.81(d), and this chapter as those statutes, guidelines and ordinances currently read or may hereafter be amended.
>
> In addition to verifying legal compliance, the annual reports shall be used by the City to periodically assess the adequacy and level of medical marijuana service available in the City for qualified patients who live in the City.
>
> At a minimum, the annual report shall provide the following information for the calendar year to which the report pertains:
>
> 1. SERVICE/PRODUCT STATISTICS:
>
> (a) The number of medical marijuana product sales transacted by the dispensary during the calendar year sorted by postal zip code, allowing for consolidation of zip codes outside Santa Cruz County.

[76] www.santacruzsentinel.com/article/NE/20151105/NEWS/151109816
[77] www.santacruzsentinel.com/article/NE/20160809/NEWS/160809574
[78] www.leafly.com/news/politics/cannabis-regulation-in-the-wild-west-the-san-jose-takeaway
[79] www.cityofsantacruz.com/home/showdocument?id=13636

(b) The number of medical marijuana product sales transactions in which the price of the product was discounted to account for the qualified patient's inability to pay the regular sales price, sorted by postal zip code, allowing for consolidation of zip codes outside Santa Cruz County.

(c) The number of medical marijuana product sale transactions that were conducted on a non-cash or non-credit/debit card basis and an explanation of the consideration provided by the qualified patient or primary caregiver in lieu of cash or credit/debit card.

(d) A listing of the medical marijuana products sold by the dispensary during the calendar year.

(e) The number of marijuana plants and clones cultivated by the dispensary during the calendar year, if any.

(f) A listing of the other (non-marijuana product) income-producing products and services offered by the dispensary during the calendar year.

2. Copies of the following State of California documents:

(a) Articles of Incorporation with seal from the Secretary of State's office

(b) Secretary of State Form SI 100 (Statement of Information) signed by the appropriate officer

(c) Seller's Permit

(d) The dispensary's California Corporation Franchise or Income Tax Return (Form 100) signed by the appropriate officer

3. Copies of the following organization governance documents

(a) By-laws of the nonprofit entity operating the dispensary specifying: its non-profit operation; criteria and procedures for election of board members and officers; terms of office for members and officers providing for a board of directors comprised of at least five board members; procedures for changes to by-laws; provisions for an annual membership meeting; and communication and participation by association members; and provisions requiring a majority of the board of directors to consist of individuals who are not compensated by the medical marijuana provider association and who are not family-members of compensated board members

(b) A list of current board members including each board member's name and address, date of election, length of term, and term limit if any.

(c) Mission statement adopted by the Board of Directors, if any.

4. A description of how the medical marijuana provider association provides members with access to information concerning its operations, and explaining the opportunities for association membership's evaluation and feedback on association policies and operations through a variety of means including, at a minimum, an annual report to association members and an annual meeting publicized in a timely

fashion to which all association members are invited. The annual report to association members shall notify association membership of the association's annual meeting and shall report pertinent service statistics, financial information and educational activities. At the annual meeting, association members shall be given the opportunity to discuss the full range of the association's services and practices.

5. A description of how the dispensary's revenues are used for the general welfare of association members and explaining how and why those revenues are allocated to the association's general operations budget, capital improvements budget, or reserve accounts; or, alternatively explaining how these revenues are to be equitably distributed to the dispensary's members in the form of cash, property, credit or services.

6. A description explaining how the dispensary ensures that it obtains its marijuana and marijuana products exclusively from dispensary members.

Despite the many challenges present, as demonstrated with Santa Cruz' seemingly unending regulatory struggles, there are still ample opportunities to approach the issue of medical (and later, adult-use) cannabis in a responsible and effective manner. Davis must succeed where Santa Cruz has failed, by addressing issues like the following[80]:

- How a growing amount of qualified medical patients can be guaranteed access to medicine at a more affordable rate, in more convenient locations, and in a dignified manner;
- How protecting patient privacy could be maintained with the growing financial burdens of maintaining more robust and open records; and
- How to gradually increase the number of dispensaries while maintaining control and ensuring that corruption and a market oligopoly doesn't occur.

Moving ahead, we have two more case study cities to consider. While these share less statistical similarities with Davis than Santa Cruz, they still offer handfuls of helpful information that could aid in the creation of smarter regulations.

The first of these is Denver, Colorado. A brief history of the state includes the passage of Amendment 20 in November 2000 that legalized the medical use of cannabis (then primarily referred to as marijuana), making it the fifth state to do so. Although other major changes didn't occur until November 2012 when Amendment 64 was passed (thereby legalizing recreational cannabis), several smaller developments did take place. The first was the 2005 Denver voter-approved measure that decriminalized the possession of small amounts of cannabis for recreational use. A similar though less-sweeping legislative measure (SB-1449) only passed in California in 2010. The second development, however, came about in 2009 when "Denver District Court Judge Naves threw out Colorado Department of Public Health and Environment's definition for caregivers and instructed CDPHE to hold an open meeting and revise the caregiver language. The department was unable to set a new definition, and so there was no regulatory language on how many medical marijuana patients a caregiver could supply until the

[80] www.indybay.org/newsitems/2010/03/09/18640441.php

General Assembly created new laws the following year."[81] This rather unusual judicial action lead to the start of the modern cannabis boom in the city of Denver and to an extent (with places like Boulder, and Colorado Springs), throughout the rest of the state.

Without going too deeply into the details, it must be noted that this strange and sudden policy void emboldened many medical cannabis proponents to oversee "a proliferation of medical marijuana centers throughout the state"[82] where "these centers grew large quantities of marijuana plants because they could claim to be the 'caregivers' for any registered medical marijuana patient."[83] According to Colorado's Marijuana Enforcement Division, itself a part of their Department of Revenue, "the number of marijuana dispensaries went from zero in 2008 to 900 by mid-2010."[84] Because of this exploitable loophole, the market was able to expand and be experimented with, with the various government and law enforcement agencies being forced to respond progressively, choosing to accept the Colorado Medical Marijuana Code with legislation passed in both 2010 and 2011 instead of instituting tougher crack-down measures. Although many detailed developments followed, the main takeaway was that local and state authorities were forced to allow a different breed of cannabis policy from that of Washington or California, where a matrix of four overlapping medical and adult-use cannabis laws (Medical Commercial, Caregiver/Patient, Recreational Commercial, and Recreational Home Grow) have yielded clear indicators of what has worked and what hasn't.

Some of these lessons, emanating from the central cannabis scene of Denver, have shown or hinted at the following:

- That broader tax rates hurt both emerging and existing cannabis entrepreneurs while lessening long-term tax revenue and increasing the likelihood of continued commercial activity in the gray and black markets[85];
- That more business-friendly policies and approaches (such as making allowances and preparations for profit-based medical dispensing) have shown to re-invigorate old or underdeveloped city spaces and offer many new jobs to a diverse workforce[86]; and
- That robust regional policy coordination is essential for ensuring consistency between medical and recreational cannabis standards and practices as well as for minimizing issues stemming from the patients/customers/tourists visiting from outside areas.

The third and last case study city is Seattle, Washington. On the state level, the first positive regulatory change regarding cannabis was the voter-approved Initiative 692 of November 1998, also known as the Washington State Medical Use of Marijuana Act. Like most measures of its kind and of its time, it was far from perfect, but it did "permit the medical use of marijuana by patients with certain terminal or debilitating conditions. Non-medical use of marijuana would still be prohibited. Physicians would be authorized to advise patients about the risks and benefits of the medical use of marijuana. Qualifying patients and their primary caregivers would be

[81] Police Foundation and the Colorado Association of Chiefs of Police - Report on Colorado's Legalization of Marijuana and the Impact on Public Safety (2015), PDF p15
[82] Ibid., PDF p15
[83] Ibid., PDF p15
[84] Ibid., PDF p14
[85] Police Foundation and the Colorado Association of Chiefs of Police - Report on Colorado's Legalization of Marijuana and the Impact on Public Safety (2015), PDF p29
[86] www.sacbee.com/news/state/california/california-weed/article2573389.html

protected from prosecution if they possess marijuana solely for medical use by the patient."[87] The next development took place in 2007, when Engrossed Substitute Senate Bill 6032 was passed to clarify the nearly decade-old law for patients, doctors, designated providers, and law enforcement officials. According to the ACLU, up until that point, the barriers to access for patients were still quite steep. Various researchers and stakeholders reasoned that "an adequate, safe, consistent, and secure source of medical marijuana must consider [certain] issues"[88], which included the following[89]:

- Risk of Arrest and Prosecution
    - Federal law, the lack of a legal source, and the ambiguous wording of many state laws leave patients and providers vulnerable to arrest and prosecution. The stress of arrest and prosecution can negatively affect patient well-being.
- Risk of Diversion
    - High demand for marijuana makes diversion to illegal users a concern for patients, the public, and law enforcement.
- Cost of Supply
    - Patients struggle to afford marijuana for medical use. Limited incomes and lack of insurance coverage make maintaining an adequate and consistent supply difficult.
- Physical Limitations
    - A source needs to take into account the physical abilities of patients and considerations of time, space, and location. Patients say these factors can sometimes prevent access.
- Supply Quality
    - Marijuana quality involves the consistency and safety of the product. Many patients desire variations in strain and potency. Marijuana can be unsafe if grown or handled improperly.
- Housing Issues
    - Renters risk eviction and property owners risk asset seizures for participating in the medical use of marijuana. These issues deter some patients from having marijuana.
- Child Safety Concerns
    - Patients with children at home receive no legal guidance on how to participate in the medical use of marijuana, keep their children safe, and retain custody.

The next step of this policy progression took place in November 2012 following some five years of local and state experimentation. The new voter-approved measure, Initiative 502, also known as the Washington Marijuana Legalization and Regulation Act, "legalized possession of marijuana among the general public, while also putting limitations on that by restricting the amount and the age (21 years of age or older) of those who may legally possess it. The law also

[87] www.sos.wa.gov/elections/initiatives/people.aspx?y=1998
[88] Washington State Department of Health - Report on Patient Access to Medical Marijuana in Washington State (2008), PDF p7
[89] Ibid., PDF p8

requires the substance to be heavily taxed and for the revenue generated from its sale to go to health care and substance abuse and prevention education. Growing or selling marijuana otherwise remains illegal under state law."[90] While this was generally well received by activists and legalization supporters across the state and country, in places like Seattle where robust local codes still hadn't set, issues regarding cultivation control and dispensary licensing remained common.

In this past year, however, things got even more scrambled for the medical cannabis sector. The Seattle City Council led by Mayor Ed Murray successfully codified a proposal that "[allowed] the City to follow state regulations more closely by granting a new regulatory license to existing Initiative 502 businesses. The proposal also [created] a path forward for medical marijuana dispensaries to follow enforcement guidelines and continue operations until they are able to receive state licenses in 2016."[91] In effect, this was a preemptive swing against dispensaries not formally nested under I-502 provisions. However, the real shakeup occurred when Senate Bill 5052 issued an ultimatum to medical dispensaries to either "close or incorporate themselves into another existing licensed retail cannabis shop."[92] This was a remarkable failure on both the city and state level to recognize the value of and need for a dual licensing scheme. But the Bill went even further by stipulating that "when a patient receives his or her medical recommendation, he or she will be entered into a new database for record-keeping, but [that] there will no longer be a patient registry (another source of contention among medical patients who were concerned about privacy). With a medical recommendation, patients will be exempt from sales tax but not from excise tax, which will be set around 30-37% for both medical and recreational customers."[93]

This cross-sectional regulatory culling shuttered hundreds of dispensaries, eliminating most of the original medical cannabis market (on July 1st, 2016). And while cities like Seattle continue to collect millions from taxes and fees, patients have once again been forced into an undesirable regulatory corner with high prices and few alternatives. These examples show that there is an abundance of failings and shortcomings within the emerging cannabis policy space with few shining examples of outright success. This is actually a good thing since the best lessons are learned by making many mistakes, thereby contributing to a growing wealth of knowledge of what not to do the next time around. Since Davis is entering these sorts of policy considerations somewhat late in the cycle, the city's chances to identify and adopt a better legal framework is quite high, especially with access to a whole network of allies such as student activists, educators, collective operators, and dedicated multi-faceted consulting companies.

As one of these organizations, ICCP has dedicated hundreds of hours to the research and development of qualified recommendations for how to proceed with these and other related reform efforts. We believe that community development programming is essential to the success of localized and regional policies. The damage dealt by the last century of prohibition cannot be repaired overnight, though the dialog has largely shifted from that of a criminal to a civil and health-centered (and soon, a commercial) nature. Furthermore, non-profit activism and popular

[90] wsma.org/wcm/Legal_Resource_Center/Medical_and_Recreational_Marijuana/wcm/Legal_Resource_Center/Marijuana/Medical_and_Recreational_Marijuana.aspx
[91] murray.seattle.gov/mayor-introduces-legislation-to-create-new-licenses-for-marijuana-businesses/
[92] www.leafly.com/news/politics/washington-governor-signs-senate-bill-5052-into-law
[93] www.leafly.com/news/politics/washington-governor-signs-senate-bill-5052-into-law

support for cannabis legalization and overall drug policy reform is at an all-time high, as evidenced by the momentum and work of groups like Students for Sensible Drug Policy. With special attention to issues like restorative justice and harm reduction, the City of Davis can become a model case study even beyond topics concerning cannabis.

THE LOCAL APPROACH: Medical Transition and Business Models[94]

Achieving a viable for-profit business model begins with the process of first becoming a non-profit/not-for-profit mutual benefit corporation. Although the language of the MCRSA implicitly extends the new licensing provisions to "individuals, partnerships, corporations, business trusts, etc. (under the definition of 'person' in [Section 19300.5(aj) of AB-266])"[95], thereby moving away from the older restrictions contained within SB-420, it is still strongly advisable to pursue a business structure in-line with the older standards until the various state bureaus involved in the regulatory framework can establish the proper mandated guidelines and assurances in 2017. Therefore, it is critical to take note of how new and existing local cannabis businesses can quickly and effectively secure compliance by temporarily transitioning all their operations into a non-profit/not-for-profit model:

- Mutual Benefit Corporations
    - Formed and operated solely for the benefit of its members, for a non-profit purpose other than charity. Collectives typically operate using this non-profit model but without the exemptions normally afforded to such entities. Any profits generated would therefore be taxed and in most cases, federal tax exemptions would be denied on account of Section 280E[96] of the Internal Revenue Code. However, registration with and payment to state agencies like the Franchise Tax Board, the Board of Equalization, and the Employment Development Department is still required.
- Legal Differences between Collectives, Cooperatives, and Dispensaries[97] [98]
    - Collectives, in their simplest form, are places where those who provide medical cannabis can help those who currently do not grow or have their own. Collectives allow patients the ability to participate as long as they both have valid medical authorization and membership in the collectives themselves.
    - The term "collective" actually comes from the MMP provision under California Health and Safety Code Section 11362.775 which is what allows patients and caregivers the legal ability to "collectively or cooperatively" cultivate medical marijuana. While the term "cooperatively" referred to the "cooperative corporation", the term "collectively" has remained undefined in California law.
    - According to the California Attorney General, a collective should be "an organization that merely facilitates the collaborative efforts of patient and caregiver members – including the allocation of costs and revenues. As such, a collective is not a statutory

[94] Secured Pre-existing Proprietary IP of ICCP
[95] www.canorml.org/news/A_SUMMARY_OF_THE_MEDICAL_MARIJUANA_REGULATION_AND_SAFETY_ACT
[96] www.law.cornell.edu/uscode/text/26/280E
[97] theweedbusiness.com/what-is-a-medical-marijuana-collective/
[98] www.ftb.ca.gov/businesses/Medical_Marijuana/Income_Tax_Law.shtml

entity, but as a practical matter it might have to be organized as some form of business to carry out its activities."

- No business may call itself a "cooperative" (or "coop") unless it is properly organized and registered as such a non-profit corporation under the Corporations or Food and Agricultural Code. Cooperative corporations are "democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons." The earnings and savings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash, property, credits, or services. Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year.
- The guidelines also outline that both collectives and cooperatives "should not purchase marijuana from, or sell to, non-members; instead, they should only provide a means for facilitating or coordinating transactions between members."
- Originally, most dispensaries operated using for-profit business models, preferring to sell cannabis to any and all qualified patients versus the "members only" option that collectives and co-ops operate on. Due to the illegality of their operations and the frequency of the resulting raids and arrests, most were forced to switch to a collective non-profit business model.

The following lists the general steps involved in transitioning a new entity into a compliant non-profit/not-for-profit model geared towards the medicinal cannabis market[99]:

1. Develop a general operations/business plan.
2. Obtain preliminary approval from local authorities to ensure compliance.
3. Search for and reserve your desired entity name with the SoS.
4. Gather an initial group of capable individuals willing and able to serve as the first Officers and staff for your organization.
5. Secure the membership of at least three (3) but preferably five (5) or more individuals to serve as the first members of the Board of Directors including, if possible, a "permanent" physician.
6. Hire or certify a Registered Agent for service of process requirements.
7. File the Articles of Incorporation (AoI) for your organization with the SoS.
    - The ARTS-MU form is the most recommended choice.
8. File a Fictitious Business Name Statement (Doing Business As) with the Yolo County Clerk-Recorder and publish the info in a local paper.
9. Apply and obtain an Employer Identification Number (EIN) from the IRS.
10. Draft and have all founding Officers and Directors sign Confidentiality and Invention Assignment Agreements.
11. Draft the Corporate Bylaws.

[99] Partially Secured Proprietary IP of ICCP

12. Draft the Conflict of Interest Policy.
    - While not formally required, it is a strongly recommended best practice.
13. Draft the Membership Rules and Guidelines for Patients.
    - Establish authorizations for cultivation, transportation, and HIPAA/CMIA.
14. Draft other resolutions as needed including one to open an official bank account.
15. Set up a corporate records book and purchase a specialized corporate kit.
16. Follow the Bylaws preemptively to properly schedule the first organizational meeting, usually of the Incorporators or the Board of Directors (which may include the Incorporators/Founders).
17. Hold the first organizational meeting and complete the First Organizational Action.
    - Elect the Officers, adopt the Bylaws, the Conflict of Interest Policy, and the Membership Rules and Guidelines for Patients, establish the tax year, approve the resolution to open a bank account, and take other appropriate actions (retroactive, concurrent, or preemptive).
18. File the Statement of Information (SoI) with the SoS.
19. Apply and obtain a California seller's permit from the BoE.
20. Apply and obtain a California sales tax number from the BoE.
21. Establish procedures to make required periodic filings with the IRS, the FTB, and the SoS.
22. Secure a storefront property that is in compliance with all local and state laws.
23. Register online with the Employment Development Department (EDD) in order to receive an Employer Payroll Tax Account Number also known as a State Employer Identification Number (SEIN).
24. Begin operating openly once sufficient funds have been obtained from both the dues of the initial membership and authorized investment avenues.
25. Establish best practices and maintain strict and thorough record-keeping.
26. Continue cultivating community support and maintaining regulatory compliance.

Once the regulatory space matures, primarily throughout 2017, then the transition into a full-fledged for-profit model can be pursued without reservation. The following will attempt to briefly outline such a process based off of the information accessible online at this point in time:

1. Initiate the process once state and local authorities have begun to issue MCRSA-specific licenses.
    - The protective legal provision in SB-420 regarding patient collectives and cooperatives (HSC 11362.775) shall sunset one year after the BMCR posts a notice on its website that licenses have commenced being issued. After that date, all

cannabis collectives will have to be licensed, except for individual patient and caregiver gardens serving no more than five patients.[100]

2. Decide on whether to create a separate for-profit corporation which your existing non-profit corporation can merge with or to directly convert into a for-profit entity.
3. Both the Board of Directors and the Membership of Patients must decide how to proceed.
4. If going the conversion route, then an official Amendment to the AoI must be filed with the SoS. If the state approves the Amendment, then additional requirements for the revision of other documents will more than likely follow.
5. In any situation, it is important to understand that definitive rules have not been established yet and that any unwarranted operational changes may incur legal troubles.

CONCLUSION

The decades-long War on Drugs has shown us what life can look like when our societal norms and policies are fueled by fear and misdirection instead of compassion and honesty. So much unnecessary harm has been inflicted, whether directly or indirectly, to non-violent individuals and those unfortunate to suffer from sickness and pain, when so much could have been done had medicine like cannabis been readily and openly available. Thankfully, most places in the United States are recognizing the mistakes of the past and are actively fighting to rectify many of those issues, such as with drug policy reform and restorative justice.

Since the passing of the Compassionate Use Act (Prop 215) all the way back in 1996, lessons were being learned all across the country while new attitudes and best practices were being developed for an even better system down-the-road. All of this culminated in the Medical Cannabis Regulation and Safety Act with the AUMA likely to follow soon, both of which will define a generation of politics in the great state of California. Within these last twenty years of gradual progressive reforms, one of the most important take-aways has been how properly regulated medical cannabis dispensaries have proven to be absolutely essential to the success of any well-written medical cannabis program.

So the answer seems to reside in how best to implement these evolving businesses instead of if they should be allowed to operate in communities. Towards that end, a particular quote from Americans for Safe Access offers some sound advice:

> “Community zoning determines how (and if) residents will be able to benefit from these laws. Experience shows that well-regulated dispensaries are responsible neighbors and valued members of the community. They bring jobs and increased economic activity while providing patients suffering from serious illnesses with an essential physician-recommended medicine.
>
> In deciding where and how these businesses are allowed to operate, policymakers can look to the experience of other local governments to devise workable strategies. Decades of experience show the needs of legal patients and

[100] www.canorml.org/news/A_SUMMARY_OF_THE_MEDICAL_MARIJUANA_REGULATION_AND_SAFETY_ACT

> the community at large can be balanced. Cities and counties can zone and regulate access points in a win-win scenario. To do this, policymakers must be responsive [to] all of the stakeholders and avoid making decisions based on bias and misinformation."[101]

RECOMMENDATIONS

It is the professional opinion of ICCP that an ideal arrangement for the City of Davis, as it pertains to the establishment and operation of medical cannabis dispensaries, is to first pursue a twelve month pilot program restricted to only two or three dispensaries. Accounting for the various successes and failures in other local policy plans as discussed in the previous Section allows for the development of a progressive yet prudent framework that balances the interests of community stakeholders while providing Davis a way forward in this exciting policy space. Ultimately, emerging businesses in this developing industry must remain mindful of and connected to the advocacy movement that preceded it. Failure to do so has shown to result in short-sighted policy with limited durability for change, and it limits our local communities from the full potential of a post-prohibition world.

The rest of this Section presents three key resources for local policy considerations, with the last showcasing the tailored recommendations prepared by ICCP in coordination with the Client:

ASA's Quick Guide for Evaluating Proposed Medical [Cannabis] Dispensary Ordinances in California[102]***:***

What the ordinance MUST include:

- Allowance for over-the-counter/storefront sales (sometimes called reimbursements, contributions, or not-for-profit sales)
- Allowance for patients to medicate on-site
- Allowance for sale of cannabis edibles and concentrated extracts
- Distinction between Medical Cannabis Dispensing Collectives (MCDCs) and private patient collectives or cooperatives

What to look out for in proposed ordinances:

- Is the general language and focus framed as a medical or healthcare issue, rather than a criminal justice or law enforcement problem?
- Does the ordinance affirm that MCDCs should be organized to serve patients and have a "not-for-profit" business model?
- Is there a cap on the number of MCDCs allowed to operate that could negatively impact accessibility, affordability and quality?

[101] Americans for Safe Access - White Paper on Medical Cannabis Dispensaries (2015), PDF p12

[102] Americans for Safe Access - Report on Medical Cannabis Dispensing Collectives and Local Regulation (2011), PDF p20

- How was the MCDC cap number determined (per capita, per pharmacy)?
- What criteria will be used to approve and license MCDCs?
- Will quality through competition be supported?

Zoning considerations:

- Will each MCDC be required to apply for a conditional use permit, or does the ordinance specify MCDCs as an enumerated business?
- Are there proximity restrictions or "buffer zones" from so-called "sensitive uses" which will make locating a dispensary onerous?
- Has a map been prepared that shows where the ordinance will require MCDCs to locate?

Does the ordinance provide for a community oversight committee tasked with any licensing or appeals processes?

- Will the oversight committee include patients, activists, MCDC operators, and members of the local community?

What are the MCDC requirements for bookkeeping and records disclosure?

- Does the ordinance allow MCDCs to keep identifying information about its members off-site, to protect patient identities?
- Does law enforcement have unfettered access to patient records or is a subpoena required?

Are there caps on the number of patient-members an MCDC can serve?

Is on-site cultivation prohibited for MCDCs?

ASA's Generic Model Ordinance for Medical Cannabis Dispensaries[103]*:*

I. PURPOSE AND INTENT

(1) To implement the provisions of the Medical Cannabis Regulation and Safety Act (the "MCRSA") with respect to local zoning and land use.

(2) To help ensure that seriously ill residents can obtain and use cannabis for medical purposes where that medical use has been deemed appropriate by a physician in accordance with California law.

(3) To establish a new section in the city code pertaining to the permitted distribution of medical cannabis consistent with state law. Nothing in this Chapter purports to permit activities that are otherwise illegal under state or local law.

(4) Nothing in this Chapter is intended to reduce the rights of a Qualified Patient or Primary Caregiver otherwise authorized by the MCRSA.

[103] Americans for Safe Access - White Paper on Medical Cannabis Dispensaries (2015), PDF pp13-16

(5) To help ensure that the Qualified Patients and their Primary Caregivers who obtain or cultivate cannabis solely for the Qualified Patient's medical treatment are not subject to arrest, criminal prosecution, or sanction.

(6) To prevent the diversion of medical cannabis for unlawful use and protect the safety and welfare of the community.

II. DEFINITIONS

The following phrases, when used in this Chapter, shall be construed as defined in California state law:

"Medical Cannabis Dispensary;"

"Primary Caregiver;" and

"Qualified Patient."

III. LOCATION

The location at which a Medical Cannabis Dispensary distributes medical cannabis must meet the following requirements:

(1) The location must be in a Nonresidential Zone appropriate for Commercial, Manufacturing, or Retail uses, including health care use;

(2) The location:

(a) must not be within a 500-foot radius of a school, as measured from edge of the parameter, and

(b) a school that opens after the date that a dispensary applies for licensure from the state, or a school that is permanently closed on the date the dispensary application to the state is submitted shall not be considered for the purposes of subsection (2)(a) of this section; and

(3) The location must not be within 1,000 feet of another Medical Cannabis Dispensary.

IV. POLICE DEPARTMENT PROCEDURES AND TRAINING

Within six months of the date that this Chapter becomes effective, training materials, handbooks, and printed procedures of the Police Department shall be updated to reflect its provisions. These updated materials shall be made available to police officers in the regular course of their training and service.

(1) Qualified Patients and their Primary Caregivers who come into contact with law enforcement shall not be cited or arrested and dried cannabis or cannabis plants in their possession shall not be seized if they are in compliance with the provisions of this Chapter.

(2) Qualified Patients and their Primary Caregivers who come into contact with law enforcement and cannot establish or demonstrate their status as a Qualified Patient or Primary Caregiver, but

are otherwise in compliance with the provisions of this Chapter, shall not be cited or arrested and dried cannabis or cannabis plants in their possession shall not be seized if:

(a) based on the activity and circumstances, the officer determines that there is no evidence of criminal activity;

(b) the claim by a Qualified Patient or a Primary Caregiver is credible; or

(c) proof of status as a Qualified Patient or Primary Caregiver can be provided to the Police Department within three (3) business days of the date of contact with law enforcement.

(3) The Police Department and any agent or contractor acting on behalf of the city shall enforce all civil and criminal ordinances related to Medical Cannabis Dispensaries, employees, and clients in a manner that is consistent with other legally licensed businesses in the city. No additional restrictions other than defined in this Chapter shall be applied or enforced.

(4) Medical cannabis-related activities shall be the lowest possible priority of the Police Department.

V. MEDICAL CANNABIS DISPENSARY OPERATIONAL STANDARDS

(1) Medical Cannabis Dispensaries must obtain all necessary state and local licenses before commencing operations and shall maintain a valid license/permit during any period of operation;

(2) No Medical Cannabis Dispensary may provide medical cannabis to any persons other than Qualified Patients and Primary Caregivers whose status to possess cannabis pursuant to state law has been verified. No medical cannabis provided to a Primary Caregiver may be supplied to any person(s) other than the Qualified Patient(s) who designated the Primary Caregiver. No Medical Cannabis Dispensary shall provide medical cannabis to any Qualified Patient or Primary Caregiver if it is known that the Qualified Patient or Primary Caregiver is diverting medical cannabis for unlawful use;

(3) Medical Cannabis Dispensaries must demonstrate compliance with state in law in the areas of security plans, inventory records, patient records, product safety, product labeling, disposal protocols and recall strategies;

(4) Medical Cannabis Dispensaries must establish “good-neighbor” policies for patients and Primary Caregivers visiting the location that includes at a minimum parking instructions and prohibition of using medicine on and around location. A copy of the policies must be posted in a conspicuous location inside the facility;

(5) A Medical Cannabis Dispensary shall provide a neighborhood security guard patrol for a two-block radius surrounding the collective during all hours of operation;

(6) Interior building lighting, exterior building lighting and parking area lighting must be in compliance with applicable regulations, and must be of sufficient brightness and color rendition so as to allow the ready identification of any individual committing a crime on site at a distance of

no less than 40 feet (a distance that should allow a person reasonable reaction time upon recognition of a viable threat);

(7) Absolutely no cannabis products may be visible from the building exterior;

(8) No persons under the age of 18 shall be allowed on site, unless the individual is a Qualified Patient and accompanied by his or her parent or documented legal guardian;

(9) No outdoor cultivation shall occur at a Medical Cannabis Dispensary location unless it is:

(a) not visible from anywhere outside of the Medical Cannabis Dispensary property, and

(b) secured from public access by means of a locked gate and any other security measures necessary to prevent unauthorized entry;

(10) No Medical Cannabis Dispensary shall permit the sale or dispensing of alcoholic beverages for consumption on the premises or offsite of the premises;

(11) No dried medical cannabis shall be stored in structures without at least four walls and a roof, or stored in an unlocked vault or safe, or other unsecured storage structure; nor shall any dried medical cannabis be stored in a safe or vault that is not bolted to the floor or structure of the facility;

(12) Operating hours for Medical Cannabis Dispensaries shall not exceed the hours between 6:00 AM and 10:00 PM daily; and

(13) Signs displayed on the exterior and interior of the property shall conform to state and city regulations.

VI. SEVERABILITY

If any section, subsection, paragraph, sentence, or word of this Chapter is deemed to be invalid, the invalidity of such provision shall not affect the validity of any other sections, subsections, paragraphs, sentences, or words of this Chapter, or the application thereof; and to that end, the sections, subsections, paragraphs, sentences, and words of this Chapter shall be deemed severable.

ICCP - Foundational Ordinance Recommendations for The City of Davis[104]*:*

Key Considerations:

I. Early 2017 - Create a community oversight sub-committee or task force in charge of reviewing community impact potential with licensing and permitting inquiries, composed of local community members from a diverse array of current and potential stakeholder groups

II. Mid 2017 - Allow the conditional licensure of two or three medical cannabis nonprofits for exploratory dispensary operations during an initial twelve month pilot period

[104] Secured Pre-existing Proprietary IP of ICCP

III. Mid 2017 - Establish a framework and action plan for future cannabis organizations in Davis based off of the community collaboration model of the pilot program (which will likely be partnered with the Yolo Conflict Resolution Center and Restorative Justice Programming)

IV. Late 2017 - Allow the conditional licensure of outdoor cultivation, manufacturing, and scientific research operations that can accommodate rising academic and market demands

V. Structure the ordinances and legislative timetables to allow for easy transitional actions and scaling efforts, congruent with Prop 64 and in coordination with Yolo County Policy

Key Qualifiers:

I. The content provided below is hand-selected language with some paraphrasing, gathered from other city ordinances such as those of Berkeley, San Jose, San Leandro, and Watsonville

II. The content provided below is limited in scope as to more effectively portray the most pertinent information discovered in regards to successful medical cannabis dispensary regulations

III. The content provided below is offered only as an informative service to qualified readers and does not constitute solicitation or provision of actual legal advice

Key Clauses:

I. DEFINITIONS

(1) Unless noted otherwise, all definitions shall mirror those provided in the MCRSA and the California Health and Safety Code.

II. ZONING

(1) Outdoor cultivation shall be restricted to agricultural districts.

(2) Indoor cultivation shall be restricted to agricultural, industrial, and residential districts.

(3) Dispensing shall be restricted to commercial districts.

(4) All other limitations shall mirror those provided in the MCRSA and Prop 64.

III. COMPLIANCE

(1) All medical cannabis facilities shall pay any applicable sales, use, business or other tax, and all license, registration, or other fees pursuant to Federal, State, and local law.

(2) All medical cannabis facilities and their related licensees or cooperatives shall fully comply with all the provisions of the Compassionate Use Act of 1996, the Medical Cannabis Program Act, the 2008 Attorney General Guidelines, any subsequently enacted State law or regulatory, licensing, or certification requirement, all applicable provisions of this code, and any specific, additional operating procedures and measures as may be imposed as conditions of approval of the regulatory permit.

(3) Nothing in this chapter shall be construed as authorizing any actions which violate State or local law with regard to the cultivation, transportation, manufacture, provision, sale, transfer, or disposition of medical cannabis.

IV. OPERATIONS

(1) Recordkeeping

(a) Dispensaries shall maintain records of their members using only the State of California Medical Marijuana Identification Card number issued by the County or the County's designee, pursuant to California Health and Safety Code Section 11362.7 et seq., or a copy of a written doctor's prescription or recommendation, as a protection for the confidentiality of the cardholders.

(b) Dispensaries shall track when members' medical marijuana recommendations and/or identification cards expire and enforce conditions of membership by excluding members whose identification cards or recommendations are invalid or expired.

(c) Dispensaries shall maintain member records in a manner to protect confidential information in the records if the records contain information protected by applicable law, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Public Law 104-191.

(d) Dispensaries shall make their financial records available to the City on an annual basis. Such audited records shall be limited to information necessary for the City to determine the not-for-profit status of the organization and shall include information on staff/principal compensation.

(2) Non-Diversion

(a) Dispensaries shall take all practicable steps necessary to prevent and deter diversion of medical cannabis to non-members. Dispensaries must limit access to medical cannabis, medical cannabis products and edibles to authorized personnel only, and must maintain an inventory management system that:

(i) accounts for all medical cannabis, medical cannabis products and edibles;

(ii) tracks each batch of medical cannabis, medical cannabis products and edibles received from its source, including each batch’s approximate content of active ingredients and cannabis by-products as a percentage of weight;

(iii) retains all information listed in paragraphs i and ii above for a period of at least 120 days from receipt of the batch; and

(iv) is capable of producing a summary showing the information necessary to verify non-diversion.

(3) Dispensing

(a) Dispensaries may not dispense to any person who is not a member, and may not dispense without first verifying membership.

(b) Dispensaries may not provide more medical cannabis to an individual than is necessary for that person's personal medical use, and may not dispense more than one ounce of dried cannabis per day per qualified patient as defined in state law, provided that:

(i) if a qualified patient has a physician's recommendation that this quantity does not meet his or her medical needs, the qualified patient or his or her primary caregiver may possess, then the dispensaries may dispense to him or her an amount of medical cannabis consistent with those needs;

(ii) a qualified patient needs a greater quantity due to a planned absence from the area.

(c) Dispensaries may not distribute free samples for promotional purposes outside of dispensary premises.

(4) Security

(a) Dispensaries shall provide adequate security and lighting on-site to ensure the safety of persons and protect the premises from theft at all times. Lighting shall be of sufficient intensity to illuminate all areas of the lot.

(b) Dispensaries must maintain security guards and camera coverage of their entire grounds to an extent sufficient to ensure the safety of persons and deter crime. Cameras must be maintained in good condition, and use a high definition format which is of adequate quality, color rendition and resolution to allow the ready identification of any individual committing a crime. The cameras shall be in use 24 hours per day, seven (7) days per week. Surveillance footage must be retained for a period of 90 days and made available to the Davis Police Department for purposes of investigation of alleged crimes, promptly upon request.

(c) Dispensaries must be equipped with an alarm system that is operated and monitored by a security company licensed by and in good standing with the California Department of Consumer Affairs. Alarms shall be maintained and in good working condition at all times.

(d) In order to prevent unauthorized entry during non-business hours, dispensaries shall either secure all exterior windows and roof hatches from the inside with bars, retractable, folding or sliding metal gates, or metal rollup or accordion doors, or provide at least one security guard during those hours.

(e) Any security guards employed by dispensaries shall be licensed and possess a valid Department of Consumer Affairs "Security Guard Card" at all times. Security personnel may not be armed.

(f) All medical cannabis, medical cannabis products and edibles, except for limited amounts used for display purposes, samples or immediate sale, shall be securely stored at all times, and the entrance to all storage areas shall be locked and under the control of staff.

V. MISCELLANEOUS

(1) Authority

(a) The City Manager is authorized to promulgate all regulations necessary to implement the requirements and fulfill the policies of this Ordinance relating to medical cannabis until a proper oversight sub-committee can be established.

(2) Policing

(a) All issues arising from lawful medical cannabis operations within the City of Davis shall be immediately accessed at the lowest level of priority for policing.

(3) Liability

(a) To the fullest extent permitted by law, any actions taken by a public officer or employee under the provisions of this chapter shall not become a personal liability of any public officer or employee of the City of Davis.

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