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Washington State Liquor Control Board
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SENT VIA EMAIL
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Dear Board Members,

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Washington has been a pioneer of rational marijuana policy. It was among the first states to provide protection from criminal penalties to medical marijuana patients, and now it is leading the way in establishing a new approach that replaces counterproductive prohibition with a comprehensive system of responsible regulation of all marijuana production and distribution.

The ACLU-WA is submitting the following comments in relation to the Liquor Control Board's task of working with the Department of Health and the Department of Revenue to develop recommendations for the legislature regarding the interaction of medical marijuana regulations and the provisions of Initiative Measure No. 502 (as provided for in Section 141 of Third Engrossed Substitute Senate Bill 5034, the 2013-15 state operating budget).

As Washington law currently recognizes, marijuana provides invaluable medicinal assistance in alleviating the suffering from a range of medical conditions. In crafting policies for use of marijuana for medicinal purposes under Initiative 502 (I-502), the emphasis should be on accommodating needs of patients. We believe those needs can largely be accommodated within the framework of I-502.

The Board's recommendations to the legislature should focus on ensuring that patients retain rights currently granted by the medical marijuana law that the new regulatory system does not include, especially:

- the right to grow one's own medical supply; and
- the right to defend oneself against charges of possessing more marijuana than what most patients need to have.

Retain Personal Cultivation

The ACLU-WA strongly opposes elimination of patients' right to produce their own cannabis, a right they have enjoyed since the passage of Initiative 692 in

1998. And even before adoption of Washington's medical marijuana law, patients could avail themselves of the common law medical necessity defense if charged with marijuana manufacturing, a right recently reaffirmed by the Washington State Supreme Court.[1]

The availability of I-502 retail stores will accommodate the needs of most patients. However, due to federal obstruction of scientific research into the potential therapeutic uses of the cannabis plant, some patients have been forced to rely on trial and error to identify, and then reproduce, the specific strains of plants that possess the cannabinoid profiles most helpful for providing relief for their particular conditions. So, the option of personal cultivation needs to be retained. Moreover, the right to grow their own gardens ensures access to cannabis should a patient's city or county refuse to allow a state-licensed store within its boundaries and force protracted litigation. It is unnecessary, and would be unfair and harmful, to take away patients' right to produce their own cannabis when they have developed a strain of marijuana specially tailored to their personal medical needs.

Affirmative Defense

The right to defend oneself against charges of possessing more marijuana than what most patients need to have is an essential protection for fairness. The affirmative defense has been a core protection of Washington's medical marijuana law since its inception. And when the state Department of Health was tasked with developing a definition of a "sixty-day supply" of medical marijuana, the legislature made clear that the definition would be presumptive only; the right to prove need of a greater amount was reserved to the patients.

An affirmative defense is not a blank check to abuse the law. Patients who exceed presumptive limits can be charged and prosecuted if they are violating the law.

Medical Marijuana Endorsement?

The rules adopted by the board to implement Initiative 502 (I-502) provide at least the same level of regulatory oversight as other states' medical marijuana laws, if not more. Patients who choose to purchase, rather than produce, their medicine will have greater assurance of quality and safety than is available to them under the current unregulated patchwork of commercial collective gardens. Given these conditions, it makes little sense to create a parallel system of production and distribution and incur duplicative administrative and enforcement expenses. Nor would it be good policy to continue allowing collective gardens to engage in unregulated commercial activity.

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[1] *State v. Kurtz*, ___ Wn.2d ___, 309 P.3d 472 (2013).

The idea of a special "medical marijuana endorsement" for stores should be considered cautiously and carefully. If the new I-502 regulations exceed current standards for products sold to patients, it seems inadvisable to create additional requirements. If marijuana of high quality is made available, retailers may market it as such in their stores.

If, on the other hand, the state decides that medical marijuana products should be subject to higher quality and safety standards than those offered for general adult use, then the endorsement – or certification – should be for the product rather than the retail outlet.

History of Washington's Medical Use of Cannabis Act

We also would like to provide some necessary historical background on marijuana law in Washington state.

The Washington State Medical Use of Marijuana Act (Chapter 69.51A RCW) was adopted in 1998 via Initiative 692, passed with 59-41 percent voter approval. The measure identified three categories of individuals to receive protection from existing laws criminalizing the possession and use of marijuana: qualifying patients, primary caregivers, and physicians.[2] A "primary caregiver" was defined as a person who:

(a) Is eighteen years of age or older;
(b) Is responsible for the housing, health, or care of the patient;
(c) Has been designated in writing by a patient to perform the duties of primary caregiver under this chapter.[3]

Initiative 692 further required a primary caregiver to possess "no more marijuana than is necessary for the patient's personal, medical use, not exceeding the amount necessary for a sixty day supply," and to serve as a primary caregiver "to only one patient at any one time."[4]

Amendments to the Medical Use of Marijuana Act were made in 2007 that renamed primary caregivers "designated providers" and removed the requirement that they be "responsible for the housing, health, or care of the patient." The requirement that designated providers serve "only one patient at any one time" remained in place.

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[2] The full text of Initiative 692 is available online at http://www.sos.wa.gov/elections/initiatives/text/i692.pdf.
[3] Initiative 692, sec. 6(2), codified at former RCW 69.51A.010(2).
[4] Initiative 692, sec. 5(4)(b) and (e), codified at former RCW 69.51A.040(4)(b) and (e).

Two other substantive changes made required the state Department of Health, by July 1, 2008, to define "the quantity of marijuana that could reasonably be presumed to be a sixty-day supply for qualifying patients," and to:

> gather information from medical and scientific literature, consulting with experts and the public, and reviewing the best practices of other states regarding access to an adequate, safe, consistent, and secure source, including alternative distribution systems, of medical marijuana for qualifying patients.[5]

Eight years of experience with the medical marijuana law had established that "sixty-day supply" was too vague a standard to allow law enforcement officers to quickly determine whether a patient or provider was in compliance and thereby avoid unnecessarily intrusive investigations. It was also clear that the only-one-patient-per-provider system was impracticable; growing marijuana requires months before a first harvest can be made, and many patients need access to cannabis immediately after their diagnosis.

In 2011, the legislature passed a bill[6] that would have created a tightly regulated system of state-licensed producers and dispensaries that would finally provide patients with "access to an adequate, safe, consistent, and secure source" of medical marijuana that they would not have to grow themselves. Unfortunately, Gov. Chris Gregoire vetoed all of the provisions that would have established that system. Accordingly, no medical marijuana regulations whatsoever exist under Washington state law.[7]

Collective Gardens

One new provision survived Gov. Gregoire's veto: the "collective garden." The collective garden was intended to be an alternative source of cannabis for patients who had no reasonable access to a licensed dispensary or simply preferred to participate directly in the production of their medicine. It was not intended to operate as a commercial entity:

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[5] ESSB 6032 (2007), sec. 8(3), codified at former RCW 69.51A.080 (repealed by E2SSB 5073 in 2011).

[6] Engrossed Second Substitute Senate Bill 5073 (the legislation also changed the name of the law from "the Washington state medical use of *marijuana* act" to "the Washington state medical use of *cannabis* act."

[7] Pursuant to the mandate of ESSB 6032, the state Department of Health adopted a rule in 2008 providing a presumptive definition of a "sixty-day supply"– fifteen plants and twenty-four ounces of useable marijuana. WAC 246-75-010. DOH repealed this rule after the legislature codified the definition in E2SSB 5073. WSR 12-05-076 (2/16/12).

(1) Qualifying patients may create and participate in collective gardens for the purpose of producing, processing, transporting, and delivering cannabis for medical use subject to the following conditions:

(a) No more than ten qualifying patients may participate in a single collective garden at any time;

(b) A collective garden may contain no more than fifteen plants per patient up to a total of forty-five plants;

(c) A collective garden may contain no more than twenty-four ounces of useable cannabis per patient up to a total of seventy-two ounces of useable cannabis;

(d) A copy of each qualifying patient's valid documentation or proof of registration with the registry established in *section 901 of this act, including a copy of the patient's proof of identity, must be available at all times on the premises of the collective garden; and

(e) No useable cannabis from the collective garden is delivered to anyone other than one of the qualifying patients participating in the collective garden.

(2) For purposes of this section, the creation of a "collective garden" means qualifying patients sharing responsibility for acquiring and supplying the resources required to produce and process cannabis for medical use such as, for example, a location for a collective garden; equipment, supplies, and labor necessary to plant, grow, and harvest cannabis; cannabis plants, seeds, and cuttings; and equipment, supplies, and labor necessary for proper construction, plumbing, wiring, and ventilation of a garden of cannabis plants.

(3) A person who knowingly violates a provision of subsection (1) of this section is not entitled to the protections of this chapter.[8]

That the collective garden was intended to complement, not replace, the commercial dispensaries that had been included in E2SSB 5073 is supported by the fact that just eleven days after the veto, the prime sponsor of the legislation, Sen. Jeanne Kohl-Welles, introduced Senate Bill 5955. SB 5955 would have created "nonprofit patient cooperatives" that would have been allowed to sell cannabis to members, and also would have clarified that, on the other hand, contributions to a collective garden by members of that garden could not be "solely monetary."[9]

[8] E2SSB 5073, sec. 403, codified at RCW 69.51A.085 (the registry referenced in subparagraph (1)(d) was vetoed).

[9] SB 5955, sec. 6(1)(k) and Sec. 5(1)(c).

Only One Patient at Any One Time

On December 11, 2012, the language that had proven itself unworkable as a means of providing patients "access to an adequate, safe, consistent, and secure source" of cannabis became the legal loophole through which entrepreneurs would be able to leverage collective gardens to cycle hundreds and even thousands of patients through storefronts transacting commercial sales (referred to as "safe access points" rather than "dispensaries"). That was the day the Washington State Court of Appeals, Division III, reversed the conviction of Scott Shupe, who had operated the Change dispensary in Spokane.

In the years leading up to the *Shupe* decision, a few risk-tolerant individuals opened dispensaries under the theory that "only one patient at any one time" simply meant that the paperwork designating the provider to serve a particular patient had to be shredded between each transaction, and a new document executed by the next customer. In other words, the person behind the counter could serve as a designated provider to Patient A at 8:00, Patient B at 8:15, and so on, shredding each patient's designating paperwork between each sale.

Mr. Shupe's jury rejected this argument and convicted him on March 17, 2011, while the legislature was considering Senate Bill 5073. Nevertheless, E2SSB 5073 clarified the phrase "only one patient at any one time" by requiring *designated providers* to wait fifteen days after ending one care relationship before taking on a new patient.[10]

However, the new *collective garden* provision in E2SSB 5073 contained no such temporal restriction. RCW 69.51A.085(1)(a) simply states, "No more than ten qualifying patients may participate in a single collective garden *at any time*" (emphasis supplied). On December 11, 2012, the Court of Appeals announced that "the proper interpretation of 'to only one patient at any one time' is an interpretation that allows the greatest number of qualified patients to receive the medical marijuana treatment that they need. In other words, 'only one patient at any one time' means *one transaction after another so that each patient gets individual care*." *State v. Shupe*, 172 Wn. App. 341, 289 P.3d 741, 748 (2012) (emphasis supplied). Therefore, the identities of the ten members of a collective garden may change as soon as paperwork can be shredded and replaced, and one patient leaves the counter to make room for another.

Regulation of Commercial Transactions

Despite important legislative and agency advancements from 2007 through 2010, and a valiant effort by legislators and agency leadership in 2011, Washington's medical marijuana law was not allowed to evolve into a marketplace where

[10] E2SSB 5073, sec. 401(5), codified at RCW 69.51A.040(5).

patients with terminal and debilitating medical conditions had "access to an adequate, safe, consistent, and secure source" of cannabis that had been subject to regulatory oversight and thereby provided some assurance that quality and safety standards were being met. This is unfortunate, because regulatory oversight of commercial transactions is especially important for products intended for use by patients with terminal and debilitating medical conditions who may have compromised immune systems.

We thank the Liquor Control Board and agency staff for the tremendous work that has gone into development of rules to implement Initiative 502. You have been thorough, inclusive, and transparent. Your team has delivered admirable results that will provide a solid foundation for the launch of an unprecedented and historic shift in marijuana policy.

Sincerely,

Alison Holcomb
Criminal Justice Director