Marijuana Policy Project
P.O. Box 21824 • Washington, DC 20009
202-462-5747 • www.mpp.org

October 28, 2024 **Kansas Special Committee on Medical Marijuana**

Testimony from Kevin Caldwell, Southeast legislative manager, Marijuana Policy Project, on the Public Policy Implications Concerning the Legalization and Regulation of Medical Marijuana — Comments in Favor of Action

Dear Senator Fagg and members of the committee:

Thank you for the opportunity to testify in support of establishing a well-regulated, compassionate medical cannabis program in Kansas. My name is Kevin Caldwell, and I am the Southeast legislative manager at the Marijuana Policy Project (MPP), the nation's largest organization working to reform cannabis laws. MPP has played a leading role in crafting and enacting most of the effective medical cannabis laws since 2000.

Medical cannabis has been shown to be a safe and effective treatment for a variety of medical conditions.[1] Support from the medical community, state and federal lawmakers, and the public — combined with a large and growing body of scientific research — has led to 38 states and the District of Columbia enacting effective medical marijuana programs since 1996. These laws are generally working well and protecting patients.

Kansas is now surrounded on three sides by states that have legalized medical cannabis (two of which also have legalized cannabis for adults 21 and older). Meanwhile, 73 percent of Kansans support the legalization of medical cannabis.[2] In November, the citizens of Nebraska will vote on establishing a medical cannabis program. If that initiative passes, Kansas will be surrounded by states with compassionate use programs.

Kansas should join the vast majority of states and establish a well-regulated, compassionate medical cannabis program. People who could benefit from medical cannabis should not have to wait — and in some cases cannot wait — for the right to use it legally. If medical cannabis can provide relief to those suffering from terrible illnesses like cancer and multiple sclerosis, it is unconscionable to criminalize them for using it. Regulating the cultivation and sale of medical cannabis would ensure patients have the legal, safe, and reliable access to medical cannabis they deserve.

---

[1] *See* MPP's summary of medical marijuana research at www.mpp.org/assets/pdfs/library/MedConditionsHandout.pdf and the Center for Medicinal Cannabis Research's completed studies at http://www.cmcr.ucsd.edu/index.php?Itemid=135

[2] *See* Emerson College Poll, October 2024, at https://drive.google.com/file/d/1jySvitJYMHZnf21NG3Ri9Zv6r5vPvf4J/view

The reality is that many seriously ill Kansans are already using cannabis. They can buy it on the robust illicit market, or they can cross the border to Colorado or Missouri and purchase cannabis from adult-use stores there. Enacting a state medical cannabis law brings medical professionals into the decision-making process, enabling healthcare providers to evaluate cannabis' risks and benefits as part of the patients' comprehensive treatment plan. It also ensures that patients have a product that has been produced and sold according to Kansas regulations, to ensure packaging and products do not appeal to minors, and that cannabis is lab-tested and free of contaminants.

The Marijuana Policy Project defines a state as having a workable medical marijuana law if the state has enacted a law that meets the following three criteria: 1) qualifying patients are allowed to possess and use cannabis without breaking state or local law; 2) there is some realistic means for patients to access cannabis in-state that does not rely on federal cooperation (typically through private, state-regulated dispensaries and/or home cultivation); and 3) patients may use a variety of strains of marijuana, or marijuana extracts, including both strains with higher and lower amounts of THC.

On behalf of the Marijuana Policy Project, I would like to outline the key policy points our organization defines as critical to a compassionate, patient-focused medical cannabis program. We submitted an updated model medical cannabis bill for your review.[3]

I. Immediate and explicit patient protections from arrest, detention, and prosecution

A core feature of effective medical cannabis laws is protecting patients from state and local criminal and civil penalties. Patients with serious conditions and a doctor's recommendation must be explicitly protected from both arrest and conviction. As soon as a patient receives a doctor's certification, they should receive immediate legal protections. This includes until any registry is up and running and while they wait for any ID card application to be processed. In states that remove criminal penalties but do not provide explicit prohibitions against arresting patients, patients sometimes are arrested, and it is left to the courts to acquit them.

Patients are already getting cannabis from neighboring Missouri and Colorado. They should not continue to face arrests and possible convictions while they wait for full implementation.

Ongoing arrests and prosecutions are traumatic, bad for patients' health, and a waste of law enforcement resources.

---

[3] See https://www.mpp.org/issues/medical-marijuana/model-state-medical-marijuana-bill/

Legal protections must also cover caregivers, physicians, medical cannabis businesses, attorneys who advise businesses, and staff at medical cannabis businesses. For a medical program to be fully functional, all professionals and loved ones must be able to perform their responsibilities without fear of state legal penalties.

II. Ensuring easy, ready access to medical cannabis

Provisions should be included to ensure patients have easy, ready access to the medicine they need. This involves allowing separate growers, infused product makers, retailers, and home delivery. It also includes ensuring there are enough retailers located throughout the state. Unnecessarily limiting the number of medical cannabis dispensaries burdens patients to access medical cannabis, resulting in patients or their loved ones driving hours just to get their medicine. States that do cap the number of dispensaries typically include some kind of provision in the state law or in regulations to ensure equitable distribution of dispensaries throughout the state. Localities should also be prohibited from banning home delivery to ensure statewide access.

Ideally, home cultivation would also be allowed to ensure access. For many people with serious medical conditions, medical expenses and a reduced ability to work make the price of store-bought cannabis out of reach. Securely cultivating cannabis at home is the only way for some people who can benefit from cannabis to access it.

The bill should also be written in a way that ensures patients have access to various forms of cannabis and modes of administration. The vast majority of medical cannabis laws allow patients to administer medical cannabis through whatever method works best for them — be it whole plant cannabis, tinctures, ointments, oils, or edibles. Like any medication, doctors and patients should have access to all safe and effective options that exist. Smoking and vaporizing cannabis are much more effective delivery methods than pills for many patients, because they take effect almost immediately. Inhalation allows patients to use the exact dosage that works for them, by increasing dosage in small increments. Manufactured edibles are another important option, because they are easier for some patients to ingest, and they have a longer-lasting effect, which is helpful to many patients with pain and multiple sclerosis. Some patients respond best to tinctures (oils used under the tongue), topical medications, and suppositories.

Allowing varying amounts of THC is also vital, as patients with some symptoms — such as wasting, appetite loss, inflammatory bowel disease, and pain from end-stage cancer — often respond best to cannabis with a significant portion of THC.

III. Allowing enough qualifying conditions

The majority of medical cannabis laws explicitly list serious medical conditions that qualify for the state's medical cannabis program. At least seven states — California,

Louisiana, Maine, Massachusetts, Maryland, New Hampshire, and Oklahoma — and Washington D.C., allow doctors broad latitude to recommend cannabis for any serious medical condition (or in some cases, any condition at all). MPP believes the following medical conditions should be included at a minimum: cancer, glaucoma, HIV/AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, ulcerative colitis, Alzheimer's disease, PTSD, chronic pain, autism with aggressive or self-injurious behavior, or the treatment of these conditions, or a chronic or debilitating condition that produces wasting syndrome, severe nausea, seizures, or severe and persistent muscle spasms. The health department should also accept petitions to consider adding conditions.

IV. Health and safety protections

Regulations should be crafted to ensure medical cannabis is free of pesticides, molds, and other impurities, and that patients will know exactly what they are getting. In an effective medical marijuana program, medical cannabis is lab-tested and accurately labeled, and regulations include bans on harmful pesticides and additives.

Regulators should develop labeling requirements for medical cannabis and cannabis products that include: the length of time the product takes to take effect, disclosure of ingredients and possible allergens, a nutritional fact panel, and requiring that edible cannabis products be clearly identifiable and include a standard symbol indicating that the product contains cannabis. Packaging and labeling requirements should prohibit the use of any images designed or likely to appeal to minors. Regulations should also include reasonable security requirements to prevent diversion and theft (i.e., lighting, physical security, and alarm requirements), but that are not so excessive that they unnecessarily drive up costs and thus prices.

V. Anti-discrimination protections for patients

MPP urges the inclusion of anti-discrimination provisions, so that patients do not lose employment, housing, child custody, or medical care based on their responsible use of medical cannabis. Because the Americans with Disabilities Act (ADA) does not extend to medical cannabis, which is illegal under federal law, many newer medical cannabis laws include similar legal protections. These provisions extend protections from discrimination to seriously ill patients who use cannabis, as they would if they use pharmaceuticals, such as ensuring they do not lose their jobs, be denied employment (unless there is a federal law requiring that to happen), or be denied organ transplants. We have provided a state-by-state breakdown of protections for medical cannabis patients.[4]

VI. Confidentiality protections

[4] See https://www.mpp.org/issues/medical-marijuana/medical-marijuana-protections-in-the-50-states/

Provisions should be included to protect the confidentiality of patients. Any information kept or maintained by medical cannabis establishments should identify cardholders by their registry ID number, not by their name or other personally identifying information. In addition, the state's registry database must be confidential and not allow law enforcement to engage in fishing expeditions. Law enforcement and dispensary staff should be able to submit an ID number to verify it is associated with a card, but should not be able to search patients by name.

Closing Comments

In closing, I would also like to address the concerns voiced by some law enforcement representatives. These same concerns have been voiced in every state that has implemented medical cannabis laws, whether the programs were approved legislatively or via ballot initiative. These concerns have not materialized in the states that have implemented well-regulated programs.[5] While it is always important to get feedback from law enforcement, in this case their compatriots in other states have been able to continue to effectively protect and serve their communities while at the same time permitting patients with debilitating conditions access to safe, laboratory-tested cannabis products.[6]

Thank you for your time and consideration of this issue, which is so important to the health and quality of life of thousands of Kansans. I would be happy to answer any questions you may have and can be reached at the number or email below.

Sincerely,
Kevin Caldwell
Southeast Legislative Manager, Marijuana Policy Project
202-462-5747 ext.2040
504-914-1406
kcaldwell@mpp.org

[5] See https://www.mpp.org/issues/medical-marijuana/medical-marijuana-laws-and-public-safety-problems/
[6] See https://www.mpp.org/issues/medical-marijuana/law-enforcement-quotes-well-regulated-medical-cannabis-laws-arent-causing-problems/

Medical Cannabis Briefing Paper

For thousands of years, cannabis has been used to treat a wide variety of ailments. Until 1937, cannabis (Cannabis sativa L.) was legal in the United States for all purposes. Presently, federal law allows **only one American** to use cannabis as a medicine.

On March 17, 1999, the National Academy of Sciences' Institute of Medicine (IOM) concluded, "[T]here are some limited circumstances in which we recommend smoking cannabis for medical uses." The IOM report, the result of two years of research that was funded by the White House drug policy office, analyzed all existing data on cannabis's therapeutic uses. A subsequent, 2017 review by the now-renamed National Academy of Sciences, Engineering, and Medicine also supported cannabis' medical benefits.

MEDICAL VALUE

Cannabis is one of the safest therapeutically active substances known. No one has ever died from an overdose, and it has a wide variety of therapeutic applications, including:

- Relief from pain
- Relief from nausea and appetite loss; and
- Reduction of muscle spasms.

Cannabis has been beneficial in the treatment of the following conditions:

AIDS. Cannabis can reduce the nausea, vomiting, and loss of appetite caused by the ailment itself and by various AIDS medications. Observational research has found that by relieving these side effects, medical cannabis increases the ability of patients to stay on life-extending treatment. (See also CHRONIC PAIN below.)

AUTISM. Research has shown cannabis and its components can alleviate symptoms of autism including self-injury, anger, aggression, agitation, and depression, along with improvements in cognition, sensory sensitivity, attention, social interaction, and language.

CANCER. Cannabis can stimulate the appetite and alleviate nausea and vomiting, which are common side effects of chemotherapy treatment.

CROHN'S DISEASE. A placebo-controlled clinical trial that was published in 2013 found that complete remission was achieved in five out of 11 subjects who were administered cannabis, compared to one of the 10 who received a placebo.

MULTIPLE SCLEROSIS. Cannabis can limit the muscle pain and spasticity caused by the disease, as well as relieve tremors and unsteadiness of gait. (Multiple sclerosis is the leading cause of

neurological disability among young and middle-aged adults in the United States.)

EPILEPSY. Cannabis can prevent epileptic seizures in some patients.

CHRONIC PAIN. Cannabis can alleviate chronic, often debilitating pain caused by myriad disorders and injuries. Several published clinical trials have found that cannabis effectively relieves neuropathic pain (pain caused by nerve injury), a particularly hard-to-treat type of pain that afflicts millions suffering from diabetes, HIV/AIDS, multiple sclerosis, and other illnesses. In addition, a 2017 review by the National Academies of Sciences, Engineering and Medicine concluded there is conclusive or substantial evidence that cannabis alleviates chronic pain.

Each of these applications has been deemed legitimate by at least one court, legislature, and/or government agency in the United States.

Many patients and loved ones also report that cannabis is useful for treating migraines, menstrual cramps, alcohol and opiate addiction, post-traumatic stress disorder (PTSD), depression, and other debilitating mood disorders.

Cannabis is being recommended to millions of patients under state laws in the United States. Nevertheless, other than a single person with special permission from the federal government, medical cannabis remains illegal under federal law!

People currently suffering from any of the conditions mentioned above, for whom legal medical options have proven unsafe or ineffective, have two options:

1. Continue to suffer without effective treatment; or
2. Illegally obtain cannabis — and risk suffering consequences directly related to its illegality, such as:

- An insufficient supply due to the prohibition-inflated price or scarcity;
- Impure, contaminated, or chemically adulterated cannabis; and
- Arrests, fines, court costs, property forfeiture, incarceration, probation, and criminal records.

BACKGROUND

Prior to 1937, at least 27 medicines containing cannabis were legally available in the United States. Many were made by well-known pharmaceutical firms that still exist today, such as Squibb (now Bristol-Myers Squibb) and Eli Lilly. The Marijuana Tax Act of 1937 federally prohibited cannabis. Dr. William C. Woodward of the American Medical Association opposed the Act, testifying that prohibition would ultimately prevent the medical uses of cannabis.

The Controlled Substances Act of 1970 placed all illicit and prescription drugs into five "schedules" (categories). Cannabis was placed in Schedule I, defining it as having a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.

This definition simply does not apply to cannabis. Of course, at the time of the Controlled Substances Act, cannabis had been prohibited for more than three decades. Its medical uses forgotten, cannabis

was considered a dangerous and addictive narcotic.

A substantial increase in the number of recreational users in the 1970s contributed to the rediscovery of cannabis's medical uses:

- Many scientists studied the health effects of cannabis and inadvertently discovered cannabis's medical uses in the process.
- Many who used cannabis recreationally also suffered from diseases for which cannabis is beneficial. By accident, they discovered its therapeutic value.

As the word spread, more and more patients started self-medicating with cannabis and dozens of states changed their laws to authorize it. However, cannabis's federal policy continues to bar doctors from prescribing it and severely curtails research. With cannabis federally illegal, patients in many states can still lose their jobs or housing for cannabis, insurance does not cover it, and non-U.S. citizens can face devastating consequences for using cannabis or working in the industry.

THE RESCHEDULING BATTLE

In 1972, a petition was submitted to the Bureau of Narcotics and Dangerous Drugs — now the Drug Enforcement Administration (DEA) — to reschedule cannabis to pave the way for it to eventually be available by prescription. After 16 years of court battles, the DEA's chief administrative law judge, Francis L. Young, ruled on September 6, 1988:

"Marijuana, in its natural form, is one of the safest therapeutically active substances known. ..."

"... [T]he provisions of the [Controlled Substances] Act permit and require the transfer of marijuana from Schedule I to Schedule II."

"It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance. ... "

Marijuana's placement in a lower schedule could eventually enable doctors to prescribe it to their patients. But top DEA bureaucrats rejected Judge Young's ruling and refused to reschedule cannabis. Two appeals later, petitioners experienced their first defeat in the 22-year-old lawsuit. On February 18, 1994, the U.S. Court of Appeals (D.C. Circuit) ruled that the DEA is allowed to reject its judge's ruling and set its own criteria — enabling the DEA to keep cannabis in Schedule I.

In August 2023, the U.S. Department of Health and Human Services (HHS) recommended reclassifying cannabis as a Schedule III drug. The DEA is expected to make the final decision sometime in 2024, on if federal law will finally acknowledge the reality that cannabis has medical value.

While rescheduling would have several benefits, including facilitating research, it would not change the status of state-legal dispensaries or a myriad of cannabis-based products that patients are using to treat their ailments. If the only thing the federal government does is reschedule cannabis, in a best-case scenario, each individual product could take millions in research and years in approval from the FDA. This is financially untenable. To harmonize state and federal law, and to make medical cannabis patients and providers conduct legal, Congress will need to act.

TEMPORARY COMPASSION

In 1975, Robert Randall, who suffered from glaucoma, was arrested for cultivating his own cannabis. He won his case by using the "medical necessity defense," forcing the government to find a way to provide him with his medicine. As a result, the Investigational New Drug (IND) compassionate access program was established, enabling some patients to receive cannabis from the government.

The program was grossly inadequate at helping the potentially millions of people who need medical cannabis. Many patients would never consider the idea that an illegal drug might be their best medicine, and most who were fortunate enough to discover cannabis's medical value did not discover the IND program. Those who did often could not find doctors willing to take on the program's arduous, bureaucratic requirements.

In 1992, in response to a flood of new applications from AIDS patients, the George H.W. Bush administration closed the program to new applicants, and pleas to reopen it were ignored by subsequent administrations. Over the decades, the small number of enrolled patients passed away. As of 2023, the IND program remains in operation only for one previously approved patient.

PUBLIC AND PROFESSIONAL OPINION

There is wide support for ending the prohibition of medical cannabis among both the public and the medical community:

- Since 1996, 38 blue, red, and purple states have passed comprehensive medical cannabis laws, both by citizen initiative and legislative action.
- An April 2021 Quinnipiac University poll found that 93% of Americans believe medical cannabis should be allowed.
- Organizations supporting some form of physician-supervised access to medical cannabis include the American Academy of Family Physicians, American Nurses Association, American Public Health Association, American Academy of HIV Medicine, Epilepsy Foundation, and many others.
- A 2013 scientific survey of physicians conducted by the *New England Journal of Medicine* found that 76% of doctors supported the use of cannabis for medical purposes. [J. Adler & J. Colbert, "Medicinal Use of Marijuana — Polling Results," *New England Journal of Medicine* 368 (2013): 30.]

CHANGING STATE LAWS

The federal government has no legal authority to prevent state governments from changing their laws to remove state-level penalties for medical cannabis use. Thirty-eight states (20 through their legislatures and 18 by ballot initiatives), four U.S. territories, and the District of Columbia have already done so. State legislatures have the authority and moral responsibility to change state law to:

- Exempt seriously ill patients from state-level prosecution for medical cannabis possession;

- Allow seriously ill patients safe access to medical cannabis from regulated dispensaries, and — ideally — also via home cultivation; and
- Exempt doctors who recommend medical cannabis from prosecution or the denial of any right or privilege.

Even within the confines of federal law, states can enact reforms that have the practical effect of removing the fear of patients being arrested and prosecuted under state law — as well as the symbolic effect of pushing the federal government to allow doctors to prescribe cannabis.

U.S. CONGRESS: THE FINAL BATTLEGROUND

State governments that want to allow cannabis to be sold in pharmacies or other regulated entities have been stymied by the federal government's overriding prohibition of cannabis.

The U.S. Supreme Court's June 2005 decision in *Gonzales v. Raich* preserved state medical cannabis laws but allowed continued federal attacks on patients, even in states with such laws. The Department of Justice indicated in 2009 and in 2013 that it would refrain from raids where activity is clearly legal under state law, but then-U.S. Attorney General Jeff Sessions rescinded those memos. But amendments to government funding bills passed since 2014 have prevented the Department of Justice from using funds to interfere with state medical cannabis laws. However, these amendments may be revisited in future budgets, and medical cannabis remains illegal under federal law, creating numerous complications — including many banks being unwilling to do business with dispensaries.

Efforts to obtain FDA approval of cannabis also remain stalled. Though some small studies of cannabis have been published or are underway, the National Institute on Drug Abuse has consistently made it difficult (and often nearly impossible) for researchers to obtain cannabis for their studies. At present, it is effectively impossible to do the sort of large-scale, extremely costly trials required for FDA approval — which would be required for each individual product or preparation.

In the meantime, patients continue to suffer. Congress has the power and the responsibility to change federal law so that seriously ill people nationwide can use and safely access medical cannabis without fear of arrest and imprisonment.

Medical Cannabis Protections in the 50 States

Since the 1970s, 49 states, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands, and the Northern Mariana Islands have recognized the medical value of at least some cannabis preparations. These laws are intended to protect patients who need this medicine to treat their conditions (such as seizures or chronic pain) and improve their quality of life. However, there is a vast difference in the scope and effectiveness of the laws. Some are well-constructed and allow those diagnosed with approved conditions access to the medication they need without imposing onerous hurdles, while others are far more restrictive and drive patients to more dangerous medicines, such as opiates. Some are rendered ineffective due to their failure to account for federal drug laws. These laws can be placed into four categories:

I: Workable Medical Cannabis Laws

Currently, 38 states, the District of Columbia, and three U.S. territories, have enacted workable medical cannabis laws that provide, or will provide, meaningful access to medical cannabis for qualifying patients. In order for a state to have a workable medical cannabis law, it must meet the following criteria:

1. Patients are provided legal protections for the medical use and possession of cannabis;
2. There is some realistic means of patients obtaining in-state access to cannabis that does not rely on federal cooperation, typically through private, state-regulated dispensaries, home cultivation, or both; and
3. The law allows for a variety of strains of cannabis, or extracts of cannabis, including both products with higher and lower amounts of THC — in amounts sufficient to meet most patients' medical needs.

Doctors or other practitioners typically must either certify that the patient has a qualifying condition, recommend medical cannabis, or both.

Within this category, there is a great deal of variation as to how comprehensive and effective the laws are, including if they allow home cultivation; if they provide for adequate, statewide access via dispensaries and delivery; how broad the list of qualifying conditions is; and what forms of cannabis are allowed.

II: Low-THC Laws With In-State Access

Low-THC medical cannabis laws allow certain preparations of cannabis to be administered to certain patients. They generally require a physician's certification. These laws generally include a maximum THC content and a minimum CBD (cannabidiol) content, and they are often limited to extracts (not whole-plant flower). Unlike effective medical cannabis laws, these laws leave behind patients who need more than a modest amount of THC.

In a sense, the entire country could be considered to have a low-THC law. Nationwide, the 2018 FARM

bill opened the door for the sale of very low THC preparations (0.3% THC), without requiring a doctor's certification. The three states MPP categorizes as having low-THC Medical Cannabis Laws With In-State Access all license intrastate businesses to sell qualifying patients cannabis preparations in excess of what is allowed by the FARM Act. All are limited to extracts (not whole plant, botanical cannabis).

III: CBD Laws Without Access

Most low-THC, high CBD laws fall under this category. These states failed to create systems for lab-tested, regulated access. Many of these laws also only provide an affirmative defense for those permitted to possess CBD oil — which can be raised at a trial to prevent a conviction — rather than protection from arrest. Others rely on risk-averse institutions such as universities or pharmacies being willing to break federal law by growing and dispensing cannabis, or they require federal permission for the program to become operational.

While many of these laws themselves do not provide access, the 2018 FARM Act opened the door to a nationwide market of low-THC, high-CBD products, which do not require a doctor's authorization. Also, many states now allow for the cultivation and production of hemp, which can be a source of CBD products with no more than 0.3% THC. However, most of those laws do not provide for testing to ensure the consistency or safety of the products.

IV: Ineffective Medical Cannabis Laws

These are laws that do not limit THC quantity, but they lack realistic provisions for access and are therefore rendered symbolic or otherwise ineffective. For example, they may use the word "prescribe" instead of "recommend" or limit access to clinical trials — which are rare, extremely expensive, almost exclusively short-term, and require federal approval. Thirty-four states and the District of Columbia enacted laws of this nature between 1978 and 1996. There is no column currently listed for this category because each state with a flawed medical cannabis law also has another type of law — either a CBD law or a workable medical cannabis law.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Alabama	X			Alabama patients with a qualifying condition — such as autism, depression, PTSD, panic disorder, or a condition causing intractable or chronic pain "in which conventional therapeutic intervention and opiate therapy is contraindicated or has proved ineffective" — may register for a medical cannabis card if they have a certification from a physician who has taken a training course, registered, and paid a fee. Raw plant, smoking, and vaporization are not allowed. Pills, gelatin cubes, lozenges, oils, suppositories, nebulizers, and patches are permitted. The Alabama Medical Cannabis Commission will license medical cannabis businesses, including dispensaries. Home cultivation is not allowed. The law passed in 2021.
Alaska	X			The Alaska Department of Health and Social Services issues medical cannabis cards to anyone diagnosed with cancer, HIV/AIDS, cachexia, severe pain, severe nausea, seizures, persistent muscle spasms, and any additional conditions at its discretion. The state does not allow medical cannabis dispensaries, but does permit home cultivation, and patients may possess one ounce of cannabis and up to six plants. After the passage of Ballot Measure 2 in 2014, anyone over 21 may possess the same quantities of cannabis as permitted under medical cannabis regulations. In addition, regulated stores opened in 2016 for adults who are 21 or older.
Arizona	X			Arizona patients with cancer, HIV/AIDS, hepatitis C, ALS, Crohn's disease, glaucoma, Alzheimer's disease, PTSD, severe and chronic pain, cachexia, severe nausea, seizures, or persistent muscle spasms can be issued a medical cannabis card from the Department of Health Services with a recommendation from a physician. As of March 2023, 131 dispensaries were open in Arizona; one is allowed for every 10 pharmacies. Patients can possess up to two-and-a-half ounces of cannabis, and home cultivation is restricted to 12 plants kept in a locked facility for those who live further than 25 miles away from the nearest dispensary. In 2020, voters approved an initiative to allow adults 21 and older to use, grow, and buy cannabis.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Arkansas	X			Arkansas patients with cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, Tourette's, Crohn's disease, ulcerative colitis, PTSD, severe arthritis, fibromyalgia, Alzheimer's, cachexia, peripheral neuropathy, intractable pain, severe nausea, seizures, and severe or persistent muscle spasms qualify for a medical cannabis card with a physician's recommendation. The state has licensed eight cultivation facilities and 38 dispensaries, the first of which opened in May 2019. Patients may possess up to two-and-a-half ounces of cannabis. Home cultivation is not allowed.
California	X			Patients with any ailment qualify for medical cannabis with a doctor's recommendation. Health Department-issued ID cards are voluntary. Home cultivation is allowed, and medical cannabis patients are allowed to possess at least eight ounces of cannabis and six mature or 12 immature plants. Since early 2018, the state has regulated and licensed a variety of types of medical cannabis businesses. In 2016, voters approved an initiative to allow adults 21 and older to use, grow, and buy cannabis.
Colorado	X			Medical cannabis cards are issued by the Colorado Department of Public Health and Environment for qualified patients diagnosed with cancer, HIV/AIDS, glaucoma, severe pain, cachexia, severe nausea, seizures, and persistent muscle spasms. There are more than 350 licensed medical cannabis centers in the state, each regulated by the Department of Revenue and local governments. Growers and infused-product manufacturers are also licensed. Patients may possess up to two ounces of cannabis and six plants for home cultivation. Also, in 2012, voters approved an initiative to allow adults 21 and older to use, grow, and buy cannabis.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Conn.	X			To qualify, adult patients must have one of about 30 conditions, including cancer, chronic pain (narrowly defined), PTSD, cerebral palsy, or any other condition added by the Department of Consumer Protection. Fewer conditions qualify for minors. The department issues medical cannabis cards and licenses producers and dispensaries. As of June 2023, there were 18 dispensaries and four growers licensed. Patients are limited to a “one-month supply” determined by the department (currently five ounces). In 2021, lawmakers and the governor approved legalization for adults 21 and older.
Delaware	X			The Delaware Department of Health and Social Services issues medical cannabis cards to adult patients diagnosed with cancer, HIV/AIDS, ALS, decompensated cirrhosis, Alzheimer’s, PTSD, debilitating pain that has either not responded to or produced serious side effects with traditional medication, terminal illness, glaucoma, autism with aggressive behavior, intractable nausea, seizures, persistent muscle spasms, daily persistent headache, and any condition added by the department of health. Fewer conditions qualify for minors. Twelve compassion centers were open as of June 2023. Home cultivation is not allowed.
Florida	X			Florida patients with cancer, epilepsy, glaucoma, HIV/AIDS), PTSD, ALS, Crohn's disease, Parkinson's disease, multiple sclerosis, chronic nonmalignant pain, “or other debilitating medical conditions of the same kind or class as or comparable to those enumerated,” can be issued a medical cannabis card from the Department of Health with a recommendation from a physician. The department licenses medical cannabis treatment centers, which may have both a cultivation location and multiple dispensing locations. As of July 2023, there are 295 dispensing locations. Home cultivation is not allowed.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Georgia		X		Georgia allows patients diagnosed with seizure disorders, cancer, ALS, multiple sclerosis, Crohn’s disease, intractable pain, PTSD (for adults only), mitochondrial disease, autism, Tourette’s syndrome, epidermolysis bullosa, Alzheimer's disease, AIDS, peripheral neuropathy, Parkinson’s disease, or sickle cell disease to qualify for low-THC medical cannabis. Cannabis extracts are restricted to 5% THC and must contain at least as much CBD. Flower and edibles are not available. In 2019, the legislature added provisions for in-state production and distribution of low-THC medical cannabis oils. The first sales began in April 2023.
Hawaii	X			The Hawaii Department of Public Health issues medical cannabis cards to qualifying patients diagnosed with severe pain, cachexia or wasting syndrome, severe nausea, seizures, severe and persistent muscle spasms, HIV/AIDS, ALS, glaucoma, PTSD, rheumatoid arthritis, lupus, or any additional conditions approved by the department. A patient and caregiver can collectively possess 10 tagged plants and four ounces of usable cannabis. In 2016, the state licensed eight dispensaries, which are allowed up to two production and three retail locations each.
Idaho				Idaho is the only state with no laws recognizing medical cannabis or cannabinoids. In 2015, the governor vetoed a bill that would have provided an affirmative defense for the possession of cannabidiol oil for patients suffering from cancer, ALS, seizure disorders, multiple sclerosis, Crohn’s disease, mitochondrial disease, fibromyalgia, Parkinson’s disease, or sickle cell disease.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Illinois	X			The Illinois Department of Public Health issues medical cannabis cards to qualified patients with any of around 40 medical conditions, including chronic pain, PTSD, HIV/AIDS, autism, cancer, spinal cord injury or disease, multiple sclerosis, Crohn's disease, seizures, irritable bowel syndrome, migraines, and any other condition added by the Department of Public Health. In addition, medical cannabis is allowed for any patient who is or could be prescribed opiates. Sixty dispensaries and 22 cultivation facilities are allowed. In 2019, the state legalized cannabis for adults 21 and older. Home cultivation is allowed for registered patients.
Indiana			X	Any person may buy, sell, and possess CBD oil, as long as it meets certain labeling requirements and contains no more than 0.3 percent THC.
Iowa		X		Patients diagnosed with chronic pain, terminal illness, multiple sclerosis, seizures, AIDS or HIV, Crohn's disease, amyotrophic lateral sclerosis, Parkinson's disease, cancer (in some cases), PTSD, or autism with self-harm may possess and use medical cannabis extracts with their medical practitioners' approval. They are limited to 4.5 grams of cannabis every 90 days, unless their practitioner affirms they need a different amount. The Department of Public Health has approved two manufacturing facilities and five dispensaries as of June 2021.
Kansas			X	Kansas' law provides an affirmative defense for possession of CBD oil with up to five percent THC.
Kentucky	X			Pursuant to a 2023 law, the Cabinet for Health and Family Services will issue medical cannabis cards to qualifying patients diagnosed with cancer; chronic, severe, intractable, or debilitating pain; epilepsy/seizure disorder; multiple sclerosis, muscle spasms; chronic nausea or cyclical vomiting; PTSD; and any other condition the Kentucky Center for Cannabis approves. Default 10- and 30-day supplies will be set by regulators, who will also license dispensaries and other cannabis businesses. Home cultivation is not allowed.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Louisiana	X			Doctors may recommend cannabis to patients for any condition that is debilitating for that patient. Patients also qualify if they have a listed condition, which include chemotherapy-related symptoms, spastic quadriplegia, cachexia, seizures, Crohn's disease, glaucoma, severe spasms, intractable pain, PTSD, Alzheimer's disease, traumatic brain injury, ALS, chronic pain related to fibromyalgia or sickle cell anemia, or, in some cases, autism. The Board of Pharmacy licensed 10 pharmacies (without DEA licenses) to dispense cannabis, and the Department of Agriculture licensed two cultivators. As patient numbers increase, dispensaries may open satellite locations.
Maine	X			Medical cannabis cards are optional for patients and some caregivers in Maine. Doctors can certify any patients they believe cannabis may help. Patients may possess up to eight pounds of cannabis and may grow up to six mature plants. Caregivers may also grow for patients. The health department regulates dispensaries, and caregiver storefronts are allowed. Also, in November 2016, voters approved an initiative to allow adults 21 and older to use, grow, and buy cannabis.
Maryland	X			Doctors can register patients with any severe condition "for which other medical treatments have been ineffective if the symptoms reasonably can be expected to be relieved by" cannabis. Physical ID cards are optional. Regulators have approved more than 100 dispensaries along with growers and processors. In July 2023, it became legal for all adults 21 and older to possess, grow, and buy cannabis. All dispensaries are now dual-use: medical and adult-use.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Massachusetts	X			The Massachusetts Cannabis Control Commission issues medical cannabis cards for patients diagnosed with cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, Crohn's disease, Parkinson's disease, multiple sclerosis, or any other condition that substantially limits life activities as approved by a patient's physician. As of July 2023, 93 medical cannabis dispensaries are licensed. Patients are limited to a 60-day, 10-ounce supply, with exceptions to be specified by a physician. Additionally, for patients facing financial hardship or those who live far away from a dispensary, permission to grow at home in an enclosed, locked location is granted. Also, in November 2016, voters approved an initiative to allow adults 21 and older to use, grow, and buy cannabis.
Michigan	X			Medical cannabis cards are managed by the Cannabis Regulatory Agency, and are issued to patients diagnosed with cancer, HIV/AIDS, hepatitis C, ALS, Crohn's disease, nail patella, glaucoma, Alzheimer's, PTSD, severe and chronic pain, cachexia, severe nausea, seizures, severe and persistent muscle spasms, or any other conditions added by the department. Patients or caregivers are allowed to grow up to 12 plants in an enclosed, locked location. Possession for medical purposes is limited to two and a half ounces. Also, in November 2018, voters approved an initiative to allow adults 21 and older to use, grow, and buy cannabis.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Minnesota	X			Minnesota’s Department of Health issues medical cannabis cards for patients diagnosed with cancer, chronic pain, HIV/AIDS, Tourette’s, ALS, seizures, severe spasms, Crohn’s, terminal illnesses, PTSD, autism, obstructive sleep apnea, irritable bowel syndrome, obsessive-compulsive disorder, tic disorders, and other conditions added by the department. Minnesota licensed two manufacturers, which may have up to four dispensaries each. Patients are limited to a 30-day supply as determined by a pharmacist. Also, in 2023, the legislature made it legal for all adults 21 and older to possess, cultivate, and buy cannabis. Adults may possess up to two pounds at home and grow up to eight plants (four mature) securely at home. Adult-use stores may not open until 2025, other than on Tribal lands within the state.
Mississippi	X			Mississippi's Department of Health issues medical cannabis cards for patients diagnosed with qualifying conditions including chronic pain (which is narrowly defined), cancer, Parkinson's, Huntington's, muscular dystrophy, glaucoma, spastic quadriplegia, HIV, AIDS, hepatitis, ALS, Crohn's, ulcerative colitis, sickle cell anemia, Alzheimer's, agitation of dementia, PTSD, autism, spinal cord disease, or severe injury. They must also have a doctor’s certification. As of May 2023, over 175 dispensaries and 90 cultivators are licensed. Possession and purchase limits are calculated based on "Medical Cannabis Equivalency Units" of 3.5 grams of flower, up to 100 mg of THC in infused products, and up to one gram of concentrate.
Missouri	X			The Department of Health and Senior Services issues ID cards to patients with a wide range of qualifying conditions, including cancer, HIV, glaucoma, and severe pain – provided the patient’s health care provider approves of the treatment. With a cultivation registration card, patients and caregivers may cultivate up to six plants in their homes. In 2022, voters legalized cannabis possession, use, and cultivation for all adults 21 and older. As of July 2023, there are 213 licensed dispensaries.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Montana	X			Montana's Department of Health and Human Services issues medical cannabis cards to patients suffering from cancer, HIV/AIDS, glaucoma, cachexia, intractable nausea or vomiting, seizure disorder, Crohn's disease, painful peripheral neuropathy, PTSD, admittance to hospice care, and in some cases, severe pain or spasms. Patients or their providers can possess up to four mature plants, 12 seedlings, and one ounce of usable cannabis. A 2016 voter initiative created protections for dispensaries. Also, in November 2020, voters approved an initiative to allow adults 21 and older to use, grow, and buy cannabis.
Nebraska			X	In 2014, lawmakers approved a law intended to allow the University of Nebraska Medical Center to conduct a pilot study on low-THC, high-CBD cannabis oils for patients with intractable seizures.
Nevada	X			Patients suffering from cancer, HIV/AIDS, glaucoma, PTSD, severe pain, cachexia, severe nausea, seizures, persistent muscle spasms, autism, anxiety disorder, autoimmune disease, anorexia nervosa, opioid dependence, neuropathic condition, or any other condition approved by the Nevada Department of Health and Human Services are eligible to receive medical cannabis cards. Up to 66 dispensaries are allowed, as are growers, labs, and infused product manufacturers. Patients are allowed to possess up to two and a half ounces every 14 days and a set quantity of cannabis-infused products. Patients or caregivers authorized to grow cannabis may possess up to 12 plants. Also, in 2016, voters approved an initiative to allow adults 21 and older to use, buy, and, in some cases grow, cannabis.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
New Hampshire	X			The qualifying conditions are PTSD, moderate to severe chronic pain, or any injury or condition that produces one of the following: elevated intraocular pressure, cachexia, chemotherapy-induced anorexia, wasting syndrome, seizures, agitation of Alzheimer's disease, autism spectrum disorder, moderate to severe insomnia, constant or severe nausea, moderate to severe vomiting, or severe, persistent spasms. Patients may possess no more than two ounces of cannabis. There are four nonprofit alternative treatment centers (ATCs), which operate a total of seven dispensary locations.
New Jersey	X			The New Jersey Cannabis Regulatory Commission issues medical cannabis cards to patients with chronic pain, PTSD, ALS, multiple sclerosis, muscular dystrophy, inflammatory bowel disease, cancer, HIV/AIDS, terminal illness, seizure disorders, intractable skeletal muscular spasticity, glaucoma, anxiety, migraine, muscular dystrophy, Tourette's Syndrome, and other conditions added by the department. The program establishes three license types: cultivators, manufacturers, and dispensaries. The Cannabis Regulatory Commission sets the number of retail and manufacturing licenses. In 2021, the legislature enacted implementing legislation for a 2020 voter referendum to legalize cannabis for adults 21 and older. Home cultivation is not allowed.
New Mexico	X			The Department of Health issues medical cannabis cards to hospice patients and to patients suffering from any of nearly 30 conditions including chronic pain, PTSD, opiate use disorder, autism, epilepsy, cancer, Crohn’s, HIV/AIDS, glaucoma, intractable nausea or vomiting, or any other conditions added by the health department. As of July 2023, there were over 1,047 dispensaries. In 2021, the legislature legalized the possession, cultivation, and purchase of cannabis for adults 21 and older. Patients can purchase about 15 ounces every 90 days. There is no possession limit at home. All adults can grow six mature plants and six seedlings.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
New York	X			The Office of Cannabis Management issues ID cards to patients who have any condition deemed clinically appropriate by their health care provider. Ten manufacturers — with four locations each — have been approved to dispense medical cannabis. Patients may possess a 30-day supply. Smoking is not permitted. In 2021, the legislature legalized the possession and purchase of cannabis for adults 21 and older. Home cultivation of up to six plants (three mature) is now allowed for patients. Home cultivation will be allowed by adults by mid-2024.
North Carolina			X	North Carolina authorizes the use of hemp extracts with at least 5% CBD and no more than 0.9% THC for patients with intractable epilepsy. In 2016, the state began allowing industrial hemp cultivation, as long as it has no more than 0.3% THC.
North Dakota	X			The North Dakota Department of Health issues ID cards to patients with conditions including a terminal illness, cancer, HIV/AIDS, hepatitis C, ALS, PTSD, Alzheimer's, dementia, Crohn's disease, fibromyalgia, spinal stenosis, glaucoma, epilepsy, a medical condition that produces cachexia or wasting, autism, anxiety disorder, intractable nausea, or, in some cases, severe and debilitating pain. Patients are allowed to obtain up to a 30-day supply from regulated dispensaries. The department licensed eight compassionate care centers and two manufacturers. Home cultivation is not allowed. The first dispensary opened in March 2019.
Okla.	X			The Oklahoma Department of Health issues medical cannabis licenses for patients with a doctor's recommendation. There is no list of qualifying conditions. Medical cannabis dispensaries may sell to patients. Patients are limited to possessing three ounces of cannabis (or eight at home), six mature plants, and six seedlings. They may possess up to an ounce of concentrates and 72 ounces of edible cannabis products. As of July 2023, 2,821 dispensaries and 6,378 growers were licensed in Oklahoma.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Oregon	X			The Oregon Department of Human Services issues medical cannabis cards for patients diagnosed with cancer, HIV/AIDS, glaucoma, a degenerative or pervasive neurological condition, cachexia, severe pain, severe nausea, seizures, PTSD, persistent muscle spasms, and any other condition added by the health department. Medical cannabis dispensaries may sell to patients and receive cannabis from patients, caregivers, and registered grow sites. Patients are limited to possessing 24 ounces of cannabis, six mature plants, and 18 immature plants. Also, in 2014, voters approved an initiative to allow adults 21 and older to use, grow, and buy cannabis.
Penn.	X			Pennsylvania's health department issues ID cards to qualifying patients with conditions including cancer, ALS, HIV/AIDS, Parkinson's, IBD, neurodegenerative diseases, Huntington's, Crohn's, PTSD, seizures, autism, sickle cell anemia, anxiety disorders, Tourette's syndrome, substitute therapy for opiate addiction, and severe chronic or intractable pain. State law allows up to 50 dispensaries with up to three locations each and up to 25 separate growers/ processors. The first dispensaries opened in February 2018. Home cultivation is not allowed.
Rhode Island	X			Rhode Island's Department of Public Health issues medical cannabis cards for patients suffering from cancer, HIV/AIDS, PTSD, hepatitis C, glaucoma, Alzheimer's, severe debilitating pain, cachexia, severe nausea, seizures, persistent muscle spasms, autism, and any other conditions added by the health department. In 2022, the legislature and governor legalized cannabis for adults 21 and older. Home cultivation is allowed for both patients and adults 21 and older.
South Carolina			X	Qualifying patients with severe forms of epilepsy that are not "adequately treated by traditional medical therapies" may be given cannabidiol or any preparation of cannabis with no more than 0.9% THC content and no less than 15% CBD. Although the CBD law itself does not include access, the state also has an industrial hemp law, defined as less than 0.3% THC.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
South Dakota	X			The Department of Health issues registry cards to patients with a practitioner's certification and a qualifying medical condition: HIV/AIDS, multiple sclerosis, ALS, cancer or its treatment (in some cases), Crohn's, epilepsy, PTSD, or a medical condition that produces: wasting syndrome; severe, debilitating pain; severe nausea (not associated with pregnancy); seizures; or severe and persistent muscle spasms. Patients may possess up to three ounces of cannabis and cultivate two mature and two immature plants. As of July 2023, there are 77 licensed dispensaries, 17 manufacturers, and 41 cultivators.
Tenn.			X	Patients with a doctor’s certification and a qualifying condition may possess cannabis oils with less than 0.9% THC. There is no provision for in-state access, though an industrial hemp law and the FARM Act provides a source. The conditions are: Alzheimer's disease; ALS; end-stage cancer; inflammatory bowel disease, including Crohn's disease and ulcerative colitis; epilepsy or seizures; multiple sclerosis; Parkinson's disease; HIV or AIDS; and sickle cell disease.
Texas		X		Texas allows certain patients to be prescribed cannabis with at least 10% CBD but no more than 1% THC. The qualifying conditions are epilepsy, multiple sclerosis, spasticity, ALS, autism, terminal illness, PTSD and neurodegenerative diseases. Medical cannabis may be cultivated, processed, and dispensed by a handful of organizations regulated by the Texas Department of Public Safety. Because the CBD oil must be prescribed under the law, participating doctors seem to be at risk under federal law. However, some doctors are participating, and dispensaries are operational in the state.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Utah	X			Utah’s qualifying conditions include: HIV, Alzheimer's disease, ALS, cancer, cachexia, persistent nausea that is not significantly responsive to traditional treatment (with exceptions), Crohn's disease, ulcerative colitis, epilepsy, debilitating seizures, multiple sclerosis, debilitating muscle spasms, PTSD (provided certain conditions are met), autism, a terminal illness (with six months or fewer remaining), hospice care, or acute or chronic pain (provided that certain conditions are met). Patients may also petition the "compassionate use board" to become a qualifying patient for other conditions. The health department licenses and regulates growers and dispensaries. Home cultivation is not allowed.
Vermont	X			The Cannabis Control Board issues medical cannabis cards to patients suffering from cancer, multiple sclerosis, HIV/AIDS, PTSD, Crohn’s, Parkinson’s, glaucoma, chronic pain, cachexia, severe nausea, or seizures. Patients may possess up to two ounces and may grow up to six mature plants and 12 immature plants in an enclosed, locked facility. Five dispensaries were open as of July 2023. In addition, adults 21 and older may possess, cultivate, and buy limited amounts of cannabis.
Virginia	X			Patients qualify with a written certification from a physician, physician’s assistant, or nurse practitioner. There is no list of qualifying conditions. The state has approved five “pharmaceutical processors” and up to 25 dispensing locations will be approved. Twenty-one dispensaries are open as of July 2023. In 2021, the legislature legalized cultivation, use, and purchase of cannabis for adults 21 and older. However, many of the provisions for regulated, licensed sales required re-authorization by the legislature, which has not happened due to a change in control.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Wash.	X			Qualifying conditions include cancer, HIV/AIDS, multiple sclerosis, seizure and spasm disorders, intractable pain, glaucoma, Crohn's disease, hepatitis C, PTSD, and diseases causing nausea, vomiting, or appetite loss. Registered patients may grow six plants, while unregistered may grow four. Also, in 2012, voters approved an initiative to allow adults 21 and older to use, possess, and buy cannabis.
West Virginia	X			The Bureau of Health issues identification cards to qualifying patients with a terminal illness, cancer, HIV/AIDS, ALS, Parkinson's disease, multiple sclerosis, spinal cord damage, epilepsy, neuropathies, Huntington's disease, Crohn's disease, PTSD, intractable seizures, sickle cell anemia, or — in some cases — intractable pain. As of April 2023, there were 48 dispensaries open in the state, along with growers, processors, and testing labs. Home cultivation is not allowed.
Wisconsin			X	Wisconsin allows anyone diagnosed with seizure disorders to possess "cannabidiol in a form without a psychoactive effect." Any physician or pharmacy that has been given an investigational drug permit by the FDA is allowed to dispense cannabidiol, but it is unlikely as it relies on federal cooperation. Without an investigational drug permit or other federal permission, patients can only access CBD from a state that allows medical cannabis and allows out-of-state patients to use dispensaries. In addition, in late 2017, the state enacted a pilot program to license industrial hemp production, which may provide a means of access
Wyoming			X	Wyoming allows "hemp extracts" with up to 0.3% THC content and at least 5% CBD content for residents who suffer from intractable epilepsy or seizure disorders. Minors qualify if a parent or legal guardian monitors their use. The health department issues registration cards to qualifying patients. There are no means of access in the state, and any extracts must have an accompanying certificate of analysis verifying its THC/CBD content.

State	Effective Medical Cannabis Law	Low-THC Law With Access	CBD Law Without Access	Description
Totals	**38**	**3**	**8**	Idaho is the only state without any type of medical cannabis or low-THC law.

Medical Cannabis by the Numbers

States Recognizing the Medical Value of Cannabis

- **38** states have effective medical cannabis laws.
- **11** states have laws pertaining to low-THC, high-CBD cannabis.
- **0** states have repealed effective medical cannabis laws.
- In total, **49** states acknowledge the medical benefits of cannabis.

Medical Cannabis and Opioids

- **64%** decrease in opioid use among chronic pain patients in Michigan who used medical cannabis[1]
- **48%** reduction in patients' opioid useafter three months of medical cannabis treatment[2]
- **78%** of patients either reduced or stopped opioid use altogether[3]
- **1,826** fewer doses of painkillers on average per year**,** per state**,** for patients participating in Medicare Part D[4]

Prescription Medications

- Nearly **247,000** people died in the United States from overdoses involving prescription opioids from 1999 to 2019. Overdose deaths involving prescription opioids more than quadrupled from 1999 to 2019.[5]
- **20%** of prescriptions are "off label" — prescribed for a condition for which they are not FDA-approved.[6]
- **0** people have died from cannabis overdoses in all of recorded history.

Number of Patients

- **1.5%** of a state's population, on average, enrolls in the medical cannabis program, for a total of nearly 4 million patients.[7]
- In comparison, 32% of American adults received an opioid prescription in the past two years, and 18% received one in the past year. [8]
- **24%** of the U.S. population took three or more prescription drugs in the past 30 days.[9]

Qualifying Conditions

- **38** states' programs include a general category for severe or chronic pain or allow cannabis if opiates have been or could be prescribed for the condition.
- **36** states include PTSD as a qualifying condition. Alaska and South Dakota are the only exceptions.

Research

- **10,000** studies were reviewed by the National Academies of Sciences, Engineering and Medicine, which led them to find:[10]
    - Conclusive or substantial evidence that cannabis or cannabinoids are effective in the treatment of chronic pain, chemotherapy-induced nausea and vomiting, and multiple sclerosis spasticity symptoms;
    - No link between smoking cannabis and lung cancer; and
    - No gateway effect.
- **50%** of Crohn's patients who used medical cannabis entered complete remission and **45%** found significant improvement in symptoms.[11]
- **75%** reduction in symptom scores were reported when PTSD patients were using cannabis compared to when they were not.[12]
- **Hundreds of thousands** of patients suffering from HIV/AIDS, glaucoma, cancer, multiple sclerosis, Crohn's disease, seizure disorders, chronic, severe, and persistent pain, and other debilitating illnesses find that cannabis provides relief from their symptoms.

Support for Allowing Medical Cannabis

- **76%** of doctors[13]
- **93%** of Americans[14]
- **83%** of veterans[15]

---

[1] KF Boehnke, et al., "Medical Cannabis Use Is Associated With Decreased Opiate Medication Use in a Retrospective Cross-Sectional Survey of Patients With Chronic Pain," Journal of Pain, June 2016.

[2] Staci A. Gruber, et al.,"Splendor in the Grass? A Pilot Study Assessing the Impact of Medical Marijuana on Executive Function," Front. Pharmacol. 13 October 2016, Vol. 7.

[3] "The Cannabis and Opioid Survey," Healer.com, 4 October 2016.

[4] Ashley C. Bradford et al., "Medical Marijuana Laws Reduce Prescription Medication Use In Medicare Part D," Health Aff.July 2016, Vol. 35 no. 7.

[5] Centers for Disease Control and Prevention, "Drug Overdose Overview," available at https://www.cdc.gov/drugoverdose/deaths/prescription/overview.html.

[6] Radley, David C., Finkelstein Stan N., and Stafford, Randall S., “Off-label Prescribing Among Office-Based Physicians," Archives of Internal Medicine 166 (9), 2006: 1021–1026.

[7] www.mpp.org/issues/medical-marijuana/state-by-state-medical-marijuana-laws/medical-marijuana-patient-numbers/

[8] "One-Third of Americans Have Received an Opioid Prescription in the Past Two Years ," NORC at the University of Chicago, Sept. 27, 2018.

[9] "Health, United States," Centers for Disease Control and Prevention, 2019, table 39.

[10] “The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research,” National Academies of Sciences, Engineering and Medicine, January 2017.

[11] Timna Naftali, et al., "Treatment of Crohn’s Disease with Cannabis: An Observational Study,” Israel Medical Association Journal (2011).

[12] Greer, GR, et al., “PTSD symptom reports of patients evaluated for the New Mexico Medical Cannabis Program,” Journal of Psychoactive Drugs, 2014 January-March;46(1):73-7.

[13] Journal of New England Medicine survey, February 2013.

[14] Quinnipiac University Poll, March 2019.

[15] The American Legion, “Survey shows veteran households support research of medical cannabis,”November 2017.

Marijuana Policy Project
P.O. Box 77492
Washington, DC 20013
p: (202) 462-5747 • f: (202) 232-0442
info@mpp.org • www.mpp.org

"We change laws."

Medical Marijuana Dispensaries and Their Effect on Crime

Opponents of medical marijuana sometimes speculate that medical marijuana dispensaries will lead to increased crime rates in surrounding areas.[1] These dispensaries, they claim, will attract thieves and robbers to the facilities and breed secondary crimes in surrounding areas. Such claims have prompted empirical and statistical analyses by researchers and law enforcement agencies. In what should not come as a surprise, given the robust security at most medical marijuana facilities, these studies have routinely shown that, contrary to these concerns, dispensaries are not magnets for crime. Instead, these studies suggest that dispensaries are no more likely to attract crime than any other business, and in many cases, by bringing new business and economic activity to previously abandoned or run-down retail spaces, dispensaries actually contribute to a reduction in crime.

While the data is reassuring, one public safety challenge for dispensaries and adult use marijuana stores has been that many have been forced to operate as cash-only businesses because of banks' concern about federal legal issues. However, with new guidance that was issued by the federal government in February 2014, it is expected that more small banks and credit unions will open accounts for marijuana businesses.

What follows is a brief summary of anecdotal and scientific evidence, including law enforcement data analyses and academic research on medical marijuana dispensaries and their effect on crime. For more information on dispensaries, medical use of marijuana, state laws, and other issues related to medical marijuana, please visit mpp.org/medical.

2009 Los Angeles Police Department survey — In response to debate over medical marijuana regulations by the Los Angeles City Council, and claims from medical marijuana opponents that dispensaries were magnets for crime, Los Angeles Police Chief Charlie Beck asked his department to produce a report comparing the robbery rates of L.A. banks and medical marijuana dispensaries. The report indicated that there were 71 robbery reports filed with the LAPD at the city's 350 banks. Despite there being far more medical marijuana dispensaries — more than 800 at the time according to Beck — there were fewer robbery reports filed at dispensaries: just 47.

When asked about the report, and claims that dispensaries are crime magnets, Beck said, "I have tried to verify that because, of course, that is the mantra. It really doesn't bear out. … Banks are more likely to get robbed than medical marijuana dispensaries."[2]

2009 Denver Police Department survey — An analysis of robbery and burglary rates at medical marijuana dispensaries conducted by the Denver Police Department at the request of the Denver City Council found that the robbery and burglary rates at dispensaries were lower than

---

[1] "'Across the state, we're seeing an increase in crime related to dispensaries,' said Ernie Martinez, a Denver police detective who is president of the Colorado Drug Investigators Association." "Medical marijuana dispensaries' effect on crime unclear," *The Denver Post*, January 24, 2011. http://www.denverpost.com/news/marijuana/ci_17178820#ixzz1ngbvMOlI.

[2] "LAPD Chief: Pot clinics not plagued by crime," *Los Angeles Daily News*, January 17, 2010. http://www.dailynews.com/news/ci_14206441.

area banks and liquor stores and on par with those of pharmacies. Specifically, the report found a 16.8 percent burglary and robbery rate for dispensaries, equal to that of pharmacies. That's lower than the 19.7 percent rate for liquor stores and the 33.7 percent rate for banks, the analysis found.[3]

2010 Denver Police Department analysis — In late 2010, the Denver Police Department looked at crime rates in areas in and around dispensaries. The analysis showed that through the first nine months of 2010, crime was down 8.2% relative to the same period in 2009. The decrease was comparable to the city's overall drop in crime of 8.8%.[4] *The Denver Post* completed a similar analysis and found that crime rates in some areas with the highest concentration of dispensaries saw bigger decreases in crime than neighborhoods with no dispensaries.[5]

2010 Colorado Springs Police Department analysis — An analysis by the Colorado Springs Police Department found that robbery and burglary rates at area dispensaries were on par with those of other businesses. Specifically, the department's data indicated that there were 41 criminal incidents reported at the city's 175 medical marijuana businesses in the 18-month period ending August 31, 2010. Meanwhile, over that same period, there were 797 robberies and 4,825 burglaries at other city businesses. These findings led the department's spokesman, Sgt. Darrin Abbink, to comment, "I don't think the data really supports [dispensaries] are more likely to be targeted at this point."[6]

October 2011 UCLA study, "Exploring the Ecological Link Between Crime and Medical Marijuana Dispensaries," — Researchers from UCLA, funded by the National Institute on Drug Abuse, used data from 95 census tracts in Sacramento to analyze two types of crime (violent and property) in areas with varying concentrations of dispensaries. What they found was that while factors traditionally understood to lead to increased crime — for example, large percentages of land zoned for commercial rather than residential use, a high percentage of one-person households, the presence of highway ramps, and a higher percentage of the population being ages 15-24 — were positively associated with crime in those areas, "the density of medical marijuana dispensaries was not associated with violent or property crime rates." In their conclusion, the researchers said, "[t]hese results suggest that the density of [medical marijuana dispensaries] may not be associated with increased crime rates or that measures dispensaries take to reduce crime (i.e., doormen, video cameras) may increase guardianship, such that it deters possible motivated offenders."[7]

Specifically, the study applied the "routine activity theory" of crime, which suggests that crime is more likely when three criteria are met: (1) a motivated offender, (2) a suitable target, as defined by factors like value, visibility, and access, and (3) a lack of guardianship such as low residency or poor security. The authors hypothesized that the lack of a relationship between dispensaries and crime could be attributable to either of two possible conclusions: either medical marijuana dispensaries were no more valuable a target than other businesses in the area — a possibility supported by the law enforcement surveys in L.A. and Denver discussed above — or heightened security at dispensaries was sufficient to deter criminal activity in the area.

---

[3] "Analysis: Denver pot shops' robbery rate lower than banks," *The Denver Post*, January 27, 2010. http://www.denverpost.com/ci_14275637.
[4] See note 1, *supra.*
[5] *Id*.
[6] "Marijuana shops not magnets for crime, police say," *Fort Collins Gazette*, September 14, 2010. http://www.gazette.com/articles/wall-104598-marijuana-brassfield.html.
[7] http://www.uclamedicalmarijuanaresearch.com/node/10.

June 2011 Regent University study — Researcher Maura Scherrer of Regent University looked at the perception of crime, and medical marijuana dispensaries' impact on crime, among residents of Denver neighborhoods with varying socio-economic profiles. In so doing, she found that most crimes, including robbery, vandalism, and disorderly conduct increased in Denver from 2008 to 2009. However, in areas within 1,000 feet of a dispensary, rates were down for most types of crime, including burglary, larceny, and a 37.5% reduction in disorderly conduct citations. In her conclusion the author notes, "it appears that crime around the medical marijuana centers is considerably lower than citywide crime rates; a much different depiction than originally perceived."[8]

February 2014 *Urban Geography* — Researchers from the University of South Florida, the University of Colorado, and the New York City Criminal Justice Agency set out to determine whether medical marijuana dispensaries in Denver could be considered locally undesirable land uses (LULUs), land uses that people do not want to live close to, but which provide services to the community.[9] The researchers studied 275 medical marijuana centers in 75 Denver neighborhoods and concluded that:

> "[w]hile public officials, and especially law enforcement, clearly warn residents about the negative effects of these centers on the communities in which they are situated, there is little evidence that residents are listening, as these centers do not appear to have any impact on the urban landscape — and therefore on the health of the communities in which they are located."[10]

The study did find that medical marijuana centers are more likely to be opened in areas that have higher crime rates, but that is not unusual because crime follows retail concentrations. "In short, medical marijuana facilities appear to … be more similar to drugstores and coffee houses than they are to LULUs."[11]

Los Angeles crime trends — Los Angeles has frequently been cited as the city with the most dispensaries and the least regulation of those dispensaries. It is also the most populous city in the state that has the oldest and the broadest medical marijuana law, where any medical condition qualifies. While L.A. voters do prefer some regulation and control — and they approved a ballot measure to create a regulatory system in May 2013 — the city that has been cited as having more dispensaries than Starbucks certainly has not suffered a crime epidemic as a result of its permissive policies. On the contrary, overall crime in Los Angeles has dropped dramatically since dispensing collectives became legal in 2004. Crime rates have plummeted in the past 11 years, with decreases each of those 11 years. They are now the lowest they have been since 1949.[12]

The Effect of Medical Marijuana Laws on Crime: Evidence from State Panel Data, 1990-2006[13] — Researchers Robert Morris, Michael TenEyck, J.C. Barnes, and Tomislav Kovandzic

---

[8] Study available at http://adr.coalliance.org/codr/fez/view/codr:983.
[9] Lyndsay N. Boggess, Deanna M. Pérez, Kathryn Cope, Carl Root & Paul B. Stretesky, Urban Geography (2014): Do medical marijuana centers behave like locally undesirable land uses? Implications for the geography of health and environmental justice, *Urban Geography*.
[10] *Id.* at p. 15
[11] *Id.* at p.16
[12] Kathy Mather, "L.A. crime falls for 11th year; officials note historic drops," *L.A. Times*, Jan. 13, 2014. http://www.latimes.com/local/lanow/la-me-ln-crime-falls-20140113,0,3357277.story#axzz2vJ6f1xlX
[13] Morris RG, TenEyck M, Barnes JC, Kovandzic TV (2014). "The Effect of Medical Marijuana Laws on Crime: Evidence from State Panel Data, 1990-2006." *PLoS ONE* 9(3): e92816. doi: 10.1371/journal.pone.0092816

analyzed the association between the enactment of a medical marijuana law and state crime rates for all Part 1 offenses — homicide, rape, robbery, assault, burglary, larceny, and auto theft — as collected by the FBI. The purpose was to help inform the debate on whether passage of medical marijuana laws leads to increased crime rates. The researchers used fixed-effects panel design to identify what, if any, effect passage of a medical marijuana law has on crime rates. This design analyzes changes individual states see in their respective crime rates over time and compares the changes to the crime rate trends among states that enacted medical marijuana laws and those that did not.

While all states experienced a reduction in Part 1 offenses during the period studied, those that had passed a medical marijuana law experienced greater reductions in those offenses than those states that had not. The researchers conclude that enactment of a medical marijuana law "is not predictive of higher crime rates and *may* be related to reductions in rates of homicide and assault."[14] They note that the most "important finding . . . is the lack of evidence of any increase in robbery or burglary, which are the type of crimes one might expect to gradually increase over time if the [medical marijuana laws lead to increased crime] theory was correct."[15]

[14] *Id.* at 5.
[15] *Id.*

Do Medical Cannabis Laws Increase Teen's Cannabis Use?

Since states first began considering medical cannabis laws, claims have frequently been made that the laws "send the wrong message" to adolescents, causing their cannabis use to increase. Now, more than 25 years since the passage of the nation's first effective state medical cannabis law, a considerable body of data has found that those fears were not warranted.

Thirty-seven states and Washington, D.C. now have effective medical cannabis laws.[1] In 32 of the states, government surveys have produced before-and-after data on teens' cannabis use. In 23 states, the data indicates overall decreases, 11 of which were outside confidence intervals. Only a single state's data indicates an increase outside of the confidence interval. Other researchers and health experts have examined the data in recent years and have also found the data to be reassuring. As an exhaustive 2019 study published in *JAMA Pediatrics* concluded, "Consistent with the results of previous researchers, there was no evidence that the legalization of medical marijuana encourages marijuana use among youth."[2] In a 2021 follow-up, the researchers found, "In the fully adjusted models, [medical marijuana law] adoption also was not associated with current marijuana use or frequent marijuana use."[3]

Below is a review of the most comprehensive data on teens' current (past 30 day) cannabis use in each of medical cannabis states. In all states where such data is available, rates are presented for all high schoolers. In states where data is not available, this uses data from the oldest grade with before-and-after data.

State	Pre-Law Current Use Rates	Most Recent Use Rates	Trend?	Data Source
California (1996)	25.9% (11th graders, 1995/1996)	18.1% (11th graders, 2019)	decrease (within confidence interval; changed survey)	California Student Survey and the CDC's Youth Risk Behavior Surveillance System (YRBSS)
Alaska (1998)	28.7% (1995)	21.5% (2019)	decrease	The CDC's YRBSS
Oregon (1998)	21% (11th graders, 1998)	20.4% (11th graders, 2019)	decrease (within confidence interval; changed survey)	Oregon Public Schools Drug Use Survey and Oregon Healthy Teens

[1] Twelve additional states have some other type of law that acknowledges the medical benefits of at least certain strains and preparations of cannabis. Only three of them have workable systems for in-state access.

[2] Anderson DM, Hansen B, Rees DI, Sabia JJ. "Association of Marijuana Laws With Teen Marijuana Use: New Estimates From the Youth Risk Behavior Surveys," *JAMA Pediatrics.* 2019;173(9):879–881.

[3] Anderson DM, et al. Association of Marijuana Legalization With Marijuana Use Among US High School Students, 1993-2019. JAMA Netw Open. 2021;4(9):e2124638. doi:10.1001/jamanetworkopen.2021.24638

State	Pre-Law Current Use Rates	Most Recent Use Rates	Trend?	Data Source
Washington (1998)	28.7% (12th graders, 1998)	15.9% (12th graders, 2021)	decrease (changed survey)	Washington State Survey of Adolescent Health Behaviors and Healthy Youth Survey
Maine (1999)	30.4% (1997)	22.3% (2019)	decrease	The CDC's YRBSS
Hawaii (2000)	24.7% (1999)	17.2% (2019)	decrease	The CDC's YRBSS
Nevada (2000)	25.9% (1999)	19.8% (2019)	decrease	The CDC's YRBSS
Colorado (2000)	The only before-and-after data available for Colorado is from the National Survey on Drug Use & Health (NSDUH). However, the NSDUH advises that data from 2002 and later is not comparable to prior years' data due to methodological changes.[4]			
Vermont (2004)	28.2% (2003)	26.5% (2019)	decrease	The CDC's YRBSS
Montana (2004)	23.1% (2003)	21.1% (2019)	decrease (within confidence interval)	The CDC's YRBSS
Rhode Island (2006)	25% (2005)	23.0% (2019)	decrease (within confidence interval)	The CDC's YRBSS
New Mexico (2007)	26.2% (2005)	27.7% (2019)	increase (within confidence interval)	The CDC's YRBSS
Michigan (2008)	18.0% (2007)	21.6% (2019)	increase	The CDC's YRBSS
New Jersey (2010)	20.3% (2009)	20.1% (2019)	decrease (within confidence interval)	The CDC's YRBSS
Arizona (2010)	23.7% (2009)	26.1% (2019)	increase (within confidence interval)	The CDC's YRBSS
Delaware (2011)	25.8% (2009)	26.1% (2017)	increase (within confidence interval)	The CDC's YRBSS

[4] Were one to compare the 1999 data to the most recent data (2019-2020) despite this admonition, it would indicate a decrease among 12-17 year olds from 10.3 to 8.45%.

State	Pre-Law Current Use Rates	Most Recent Use Rates	Trend?	Data Source
Connecticut (2012)	24.1% (2011)	21.7% (2019)	decrease (within confidence interval)	The CDC's YRBSS
Massachusetts (2012)	27.9% (2011)	26.0% (2019)	decrease (within confidence interval)	The CDC's YRBSS
New Hampshire (2013)	28.4% (2011)	26.1% (2019)	decrease	The CDC's YRBSS
Illinois (2013)	23.1% (2011)	21.8% (2019)	decrease (within confidence interval)	The CDC's YRBSS
Maryland (2014)	19.8% (2013)	17.6% (2019)	decrease	The CDC's YRBSS
Minnesota (2014)	16.6% (11th graders, 2013)	15.5% (11th graders, 2019)	decrease	Minnesota Student Survey
New York (2014)	21.4% (2013)	19.1% (2019)	decrease	The CDC's YRBSS
Louisiana (2016)	17.5% (2013)	19.0% (2019)	increase (within confidence interval)	The CDC's YRBSS
Pennsylvania (2016)	18.2% (2015)	19.6% (2019)	increase (within confidence interval)	The CDC's YRBSS
Ohio (2016)	20.7% (2013)	15.8% (2019)	decrease (within confidence interval)	The CDC's YRBSS
Arkansas (2016)	17.8% (2015)	17.5% (2019)	decrease (within confidence interval)	The CDC's YRBSS
Florida (2016)	21.5% (2015)	19.6% (2019)	decrease	The CDC's YRBSS
North Dakota (2016)	15.2% (2015)	12.5% (2019)	decrease	The CDC's YRBSS
West Virginia (2017)	16.5% (2015)	18.9% (2019)	increase (within confidence interval)	The CDC's YRBSS
Oklahoma (2018)	15.9% (2017)	17.0% (2019)	increase (within confidence interval)	The CDC's YRBSS

State	Pre-Law Current Use Rates	Most Recent Use Rates	Trend?	Data Source
Missouri (2018)	19.9% (2017)	16.3% (2019)	decrease (within confidence interval)	The CDC's YRBSS
Utah (2018)	8.1% (2017)	10.0% (2019)	increase (within confidence interval)	The CDC's YRBSS
Virginia (2020)	No "after" data available, law is too new.			
South Dakota (2020)	No "after" data available, law is too new.			
Alabama (2021)	No "after" data available, law is too new.			
Mississippi (2022)	No "after" data available, law is too new.			

This data should put to rest claims that removing criminal penalties from seriously ill patients' medical use of cannabis increases teens' cannabis use.

Law Enforcement Before-and-After Quotes: Well-Regulated Medical Cannabis Laws Aren't Causing Problems

In states with medical marijuana laws, it is not uncommon for law enforcement to initially be wary or opposed to the proposal. However, once those laws are implemented, even previously opposed law enforcement officials tend to recognize the laws do not cause problems. Law enforcement organizations that had opposed medical marijuana bills in several states — including Illinois and Minnesota — also came to see the laws did not cause problems once they were implemented.

Dennis Flaherty, Minnesota Police and Peace Officers Association executive director, before passage:

“We do not support the legalization of marijuana for any purpose. It’s illegal on the federal level and we’re not going to support any legislation that would put us in conflict with … federal law.” (“Medical marijuana faces tough road in Minnesota,” *Associated Press*, December 12, 2012)

The *Associated Press* noted, “Law enforcement leaders say marijuana is an addictive gateway drug that is associated with violent crime and can lead to use of other illicit drugs. They also say states that have legalized marijuana have enforcement problems. They point to California, where federal authorities are cracking down on dispensaries. Flaherty says anyone there can get a buyer's card for just about any reason.”

Dennis Flaherty after passage:

The *Twin Cities Pioneer Press* reported that Mr. Flaherty did not oppose adding intractable pain to the program. Flaherty “said police are unaware of any problems with the current cannabis program and do not expect any now that pain will be included.” (“Minnesota OKs medical marijuana use for pain,” *Pioneer Press*, December 1, 2015)

Illinois Chiefs of Police Association before passage:

“There's a lot of stuff in marijuana that's not good for you … It's like people taking meth. People feel a lot better after ingesting methamphetamine.” (Keegan Hamilton, “Lobbyist For Illinois Police Chiefs: Medical Marijuana = Meth,” *Riverfront Times*, May 12, 2010)

Illinois Chiefs of Police Association after passage:

“Police have not noticed any significant problems with either law [medical marijuana or a civil fine law], according to Oak Brook Police Chief James Kruger Jr., who is first vice president of the Illinois Chiefs of Police Association. …” (“Illinois lawmakers propose legalizing recreational marijuana,” *Chicago Tribun*e, March 23, 2017)

Mike Schirling, Burlington, Vermont Police Chief, before passage:

Schirling had initially been concerned about having a dispensary in Burlington. (“With few complaints,

state seeks fourth marijuana dispensary," *Burlington Free Press*, August 26, 2013)

Mike Schirling after passage:

Burlington Police Chief Mike Schirling told a reporter, "I'm not aware of any issues," after it opened. ("With few complaints, state seeks fourth marijuana dispensary," *Burlington Free Press*, August 26, 2013)

Well-Regulated Medical Cannabis Laws Do Not Cause Public Safety Problems

In the early 2000s, the General Accounting Office (the investigative arm of Congress, now called the Government Accountability Office) interviewed officials from 37 law enforcement agencies in four states with medical marijuana laws. A key issue they examined was whether those laws had interfered with enforcement of laws regarding nonmedical use. According to the GAO's report, the majority of these officials "indicated that medical marijuana laws had had little impact on their law enforcement activities." Since then, the data has continued to accumulate, showing that medical cannabis laws do not cause public safety problems.

Several studies have shown that medical marijuana laws and medical marijuana dispensaries are not associated with increased crime. In 2012, a study published in the *Journal of Studies on Alcohol and Drugs* found, "Density of medical marijuana dispensaries was not associated with violent or property crime rates."[1] In 2014, a study published in PLoS One found that the passage of laws are "not predictive of higher crime rates and may be related to reductions in rates of homicide and assault."[2] In 2017, researchers published their analysis of more than 20 years of crime data and reported that neither dispensaries nor medical cannabis laws resulted in increased crime rates."[3]

In states with medical marijuana laws, it is not uncommon for law enforcement to initially be wary or opposed to the proposal. However, once those laws are implemented, even previously opposed law enforcement officials often recognize the laws do not cause problems. In July 2006, Vermont released a report that included a statewide survey of law enforcement, including state's attorneys, to determine the effect of the 2004 medical marijuana law on drug enforcement. They found that "[n]one of the state's attorneys thought that the law had made it more difficult to enforce drug laws."

By 2007, Vermont's head law enforcement official publicly recognized that the law had not caused problems, despite his initial misgivings. Four years later, in 2011, Vermont Department of Public Safety Commissioner Keith Flynn testified in favor of adding a regulated dispensary program to Vermont's law. The bill passed, and dispensaries began operating in 2013. The state's program administrator was interviewed about the dispensaries and explained the few complaints she'd heard of were from patients with concerns about access, not from the general public.

Law enforcement organizations that had opposed medical marijuana bills in other states — such as Illinois and Minnesota — also came to see the laws did not cause problems once they were implemented.

Law Enforcement Support for Allowing Medical Marijuana and Statements Explaining the Laws Are Not Causing Problems

Dennis Flaherty, Minnesota Police and Peace Officers Association executive director

The *Twin Cities Pioneer Press* reported that Mr. Flaherty — who had strenuously opposed allowing medical marijuana — did not oppose adding intractable pain to the program. Flaherty "said police are unaware of any problems with the current cannabis program and do not expect any now that pain will be included."

("Minnesota OKs medical marijuana use for pain," *Pioneer Press*, December 1, 2015)

Col. James Baker, then-Director of Vermont State Police

"At this point, four years into this, we're comfortable with what's happening and we believe that the people who are getting it are getting it under the true color of what the law is." (*WCAX-TV*, October 18, 2007)

Sheri Englert of the Vermont Marijuana Registry told the same station,"I haven't seen what I believe to be any abuses thus far. The conditions, the treatments of the conditions, the diseases that the patients have are, it's heart wrenching. It really is."

Mike Schirling, Burlington, Vermont Police Chief

Burlington Police Chief Mike Schirling, who had been worried about having a dispensary in the city, told a reporter, "I'm not aware of any issues," after it opened. ("With few complaints, state seeks fourth marijuana dispensary," *Burlington Free Press*, August 26, 2013)

James Kruger Jr., first vice president of the Illinois Chiefs of Police Association

"Police have not noticed any significant problems with either law [medical marijuana or a civil fine law], according to Oak Brook Police Chief James Kruger Jr., who is first vice president of the Illinois Chiefs of Police Association. …" The association had strongly opposed allowing medical marijuana. ("Illinois lawmakers propose legalizing recreational marijuana," *Chicago Tribun*e, March 23, 2017; "Illinois Senate approves medical marijuana bill," *Chicago Tribune*, May 17, 2013)

Mike Jones, New Mexico, retired Deputy Chief of Police

"As a retired law enforcement officer living in the state of New Mexico, which passed a medical marijuana law in 2007, I can attest to the fact that no societal harm or significant problems for law enforcement resulted from the passage of this law.

"Some people, in and out of law enforcement, fear that passage of a medical marijuana law would increase youth access to marijuana or result in substantial diversion of marijuana into the criminal market. Based on my observations of New Mexico's medical marijuana law and activities after its effective date I can affirm that this is unlikely to be the case.

"As a former member of law enforcement, I can understand the reasoning behind those concerns — indeed, colleagues prior to the passage of our state's medical marijuana law held many of them. However, these concerns have simply not been borne out. Overall compliance with the law has been outstanding.

"In short, these are good laws that protect a limited number of people. In my observation, they do not increase the availability of marijuana to youth or in the criminal market generally, they do not result in additional cost to the state in terms of law enforcement resources, and they do not compromise our

efforts to combat illicit marijuana use. I would encourage the Legislature to pass the medical marijuana bill and the governor to sign it. I would also discourage my counterparts in law enforcement from spending an inordinate amount of their time opposing this legislation. In time, they will find, as I did, that their concerns are largely unfounded."

Ray White, former Deputy Superintendent/Lieutenant Colonel for the Rhode Island State Police

"Rhode Island exempted the terribly ill and their caregivers from criminal penalties for marijuana use, possession, and limited cultivation in 2006. In 2009, we created a regulated system to distribute marijuana to the patients in a safe and comfortable environment. We have seen no significant increase in teen use and the compassion centers have been model businesses having no negative effect on their neighborhoods to speak of. Medical marijuana has been a positive for Rhode Island." (April 30, 2014)

Eric Nason, Hallowell, Maine Chief of Police

In Maine, where medical marijuana was approved in 1999, Hallowell Police Chief Eric Nason said his department sees burglaries related to prescription opiates and other drugs, but not marijuana. His department treats a dispensary in town like any other business. ("Vt., Maine offer marijuana lessons," *Associated Press*, July 18, 2013)

Richard Mello, Lebanon, New Hampshire Chief of Police

"We have [a dispensary] in Lebanon, and I can testify that it is very much under the radar. We don't have any issues… so that seems to be working very well." (November 6, 2017)

John Encarnacao, New Hampshire State Police Captain

"From our standpoint, the program should continue. We don't have any problem with it… I haven't heard anything negative about the program." (October 27, 2017)

---

[1] Kepple, Nancy and Freisthler, Bridget, "Exploring the Ecological Association Between Crime and Medical Marijuana Dispensaries," *Journal of Studies on Alcohol and Drugs*, 73(4), 523–530 (2012).

[2] http://www.sciencedaily.com/releases/2014/03/140326182049.htm

[3] Chu, Yu-Wei Luke and Townsend, Wilbur, Joint Culpability: The Effects of Medical Marijuana Laws on Crime (February 12, 2017). Available at SSRN: https://ssrn.com/abstract=2915909 or http://dx.doi.org/10.2139/ssrn.2915909

MEDICAL MARIJUANA ENDORSEMENTS AND STATEMENTS OF SUPPORT

Leading National and International Medical, Religious, and Legal Organizations Supporting Physician-Supervised Access to Medical Marijuana:

- The American Academy of HIV Medicine (AAHIVM)
- American Anthropological Association
- The American Bar Association (ABA)
- American Civil Liberties Union (ACLU)
- The American Nurses Association (ANA)
- The American Public Health Association (APHA)
- Arthritis Research Campaign
- British Medical Association
- HIV Medicine Association of the Infectious Diseases Society of America
- The Lymphoma Foundation of America (LFA)
- The National Association for Public Health Policy
- National Black Police Association
- The National Nurses Society on Addictions
- The Episcopal Church
- The Presbyterian Church USA
- The United Church of Christ
- The United Methodist Church's Board of Church and Society
- The Union of Reform Judaism
- The Unitarian Universalist Association

State/Local Medical Marijuana Endorsements and Statements of Support:

- AIDS Care Ocean State
- AIDS Foundation of Chicago
- AIDS Project Rhode Island
- Alaska Nurses Association
- Associated Medical Schools of New York
- California Academy of Family Physicians
- California Legislative Council for Older Americans
- California Medical Association
- California Nurses Association
- California Pharmacists Association
- Florida Medial Association
- Hawaii Nurses Association
- Iowa Democratic Party
- King County Bar Association (Washington)
- The Medical Society of the State of New York
- Michigan Democratic Party
- Minnesota Nurses Association
- Minnesota Public Health Association
- Minnesota AIDS Project
- Minnesota Senior Federation
- Mississippi Nurses Association
- Multiple Sclerosis California Action Network
- New Jersey State Nurses Association
- New Mexico Medical Society
- New York AIDS Advisory Council
- New York AIDS Coalition

- New York County Medical Society
- New York State AIDS Advisory Council
- New York State Hospice and Palliative Care Association
- New York State Nurses Association
- New York Statewide Senior Action Council
- North Carolina Nurses Association
- Physicians for Social Responsibility (Oregon)
- Rhode Island ACLU
- Rhode Island Medical Society
- Rhode Island State Nurses Association
- San Francisco Medical Society
- Senior Agenda Coalition (Rhode Island)
- Texas Democratic Party
- Texas Medical Association
- Texas Nurses Association
- United Nurses and Allied Professionals (Rhode Island)
- Virginia Nurses Association
- Whitman–Walker Clinic
- Wisconsin Nurses Association
- Wisconsin Public Health Association

Selected Quotes from Endorsements and Statements of Support:

- "[A] federal policy that prohibits physicians from alleviating suffering by prescribing marijuana for seriously ill patients is misguided, heavy-handed, and inhumane." — Dr. Jerome Kassirer, "Federal Foolishness and Marijuana," editorial, New England Journal of Medicine, January 30, 1997
- "[The AAFP accepts the use of medical marijuana] under medical supervision and control for specific medical indications." — American Academy of Family Physicians, 1989, reaffirmed in 2001
- "Based on much evidence, from patients and doctors alike, on the superior effectiveness and safety of whole cannabis (marijuana) compared to other medicines for many patients — suffering from the nausea associated with chemotherapy, the wasting syndrome of AIDS, and the symptoms of other illnesses … we hereby petition the Executive Branch and the Congress to facilitate and expedite the research necessary to determine whether this substance should be licensed for medical use by seriously ill persons." — American Academy of Family Physicians, 1995
- "[We] recommend … allow[ing] [marijuana] prescription where medically appropriate." — National Association for Public Health Policy, November 15, 1998
- "Therefore be it resolved that the American Nurses Association will: — Support the right of patients to have safe access to therapeutic marijuana/cannabis under appropriate prescriber supervision." — American Nurses Association, resolution, 2003
- "The National Nurses Society on Addictions urges the federal government to remove marijuana from the Schedule I category immediately, and make it available for physicians to prescribe. NNSA urges the American Nurses' Association and other health care professional organizations to support patient access to this medicine." — National Nurses Society on Addictions, May 1, 1995
- "[M]arijuana has an extremely wide acute margin of safety for use under medical supervision and cannot cause lethal reactions … [G]reater harm is caused by the legal consequences of its prohibition than possible risks of medicinal use." — American Public Health Association, Resolution #9513, "Access to Therapeutic Marijuana/Cannabis," 1995
- "When appropriately prescribed and monitored, marijuana/cannabis can provide immeasurable benefits for the health and well-being of our patients … We support state and federal legislation not only to remove criminal penalties associated with medical marijuana, but further to exclude marijuana/cannabis from classification as a Schedule I drug." — American Academy of HIV Medicine, letter to New York Assemblyman Richard Gottfried, November 11, 2003

- "[The LFA] urges Congress and the President to enact legislation to reschedule marijuana to allow doctors to prescribe smokable marijuana to patients in need … [and] urges the US Public Health Service to allow limited access to medicinal marijuana by promptly reopening the Investigational New Drug compassionate access program to new applicants." — Lymphoma Foundation of America, January 20, 1997
- "The American Medical Student Association strongly urges the United States Government … to reschedule marijuana to Schedule II of the Controlled Substance Act, and … end the medical prohibition against marijuana." — American Medical Students Association, March 1993
- "[T]he use of marijuana may be appropriate when prescribed by a licensed physician solely for use in alleviating pain and nausea in patients who have been diagnosed as chronically ill with life threatening disease, when all other treatments have failed; …" — The Medical Society of the State of New York, May 4, 2004
- "[T]here is sufficient evidence for us to support any physician-patient relationship that believes the use of marijuana will be beneficial to the patient." — Rhode Island Medical Society, 2004
- " [The] CMA continue[s] to support scientifically rigorous research, including all FDA-approved Phase II and Phase III clinical trials and examine the current science concerning the therapeutic role of cannabinoid-based pharmaceuticals" — California Medical Association, October 30, 2006
- "[The] CMA continue[s] to support the ability of physicians to discuss and make recommendations concerning the potential benefits or harm to the patient of smoked herbal cannabis consistent with state and federal law and oppose criminal prosecution of patients who possess or use smoked herbal cannabis for medical reasons upon the recommendation of a physician" — California Medical Association, October 30, 2006
- "The SFMS takes a support position on the California Medical Marijuana Initiative [legalizing medical marijuana]." — San Francisco Medical Society, August 1996
- "Present evidence indicates that [cannabinoids] are remarkably safe drugs, with a side-effects profile superior to many drugs used for the same indications…" — British Medical Association, November 1997
- "[We] support pharmacy participation in the legal distribution of medical marijuana." — California Pharmacists Association, May 26, 1997
- "We think people who use cannabis to relieve the pain of arthritis should be able to do so." — Arthritis Research Campaign, October 23, 2001
- "The evidence is overwhelming that marijuana can relieve certain types of pain, nausea, vomiting and other symptoms caused by illnesses like multiple sclerosis, cancer and AIDS — or by the harsh drugs sometimes used to treat them. And it can do so with remarkable safety. Indeed, marijuana is less toxic than many of the drugs that physicians prescribe every day." — Former U.S. Surgeon General Joycelyn Elders, M.D., "Myths About Medical Marijuana," Providence Journal, March 26, 2004
- "We must make sure that the casualties of the war on drugs are not suffering patients who legitimately deserve relief." — Scott Fishman, president of the American Academy of Pain Medicine, February 2006
- "It [medical marijuana] should be an option for patients who have it recommended by knowledgeable physicians." — Dr. Jesse L. Steinfeld, former U.S. Surgeon General, July 2003
- "Whitman-Walker Clinic supports the valid use of marijuana, under a physician's supervision, to help alleviate AIDS wasting syndrome and nausea associated with treatment regimes." — Whitman-Walker Clinic, April 1998
- "[I]t cannot seriously be contested that there exists a small but significant class of individuals who suffer from painful chronic, degenerative, and terminal conditions, for whom marijuana provides uniquely effective relief." — HIV Medicine Association of the Infectious Diseases Society of America; American Medical Students Association; Lymphoma Foundation of America; Dr. Barbara Roberts; and Irvin Rosenfeld, Amicus Curiae brief filed in the U.S. Supreme Court (in the case of Gonzales v. Raich), October 2004
- "Marijuana, in its natural form, is one of the safest therapeutically active substances known … The evidence in this record clearly shows that marijuana has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those

sufferers and the benefits of this substance." — Francis L. Young, DEA Chief Administrative Law Judge, 1988

- "[The American Bar Association] recognizes that persons who suffer from serious illnesses for which marijuana has a medically recognized therapeutic value have a right to be treated with marijuana under the supervision of a physician." — American Bar Association, May 4, 1998
- "I consider the most important recommendation made by the IOM (Institute of Medicine) panel [to be] that physicians be able to prescribe marijuana to individual patients with debilitating or terminal conditions … I believe such compassionate use is justified." — Andrew Weil, M.D., July 1999
- "Cannabinoids and THC also have strong pain-killing powers, which is one reason medical marijuana should be readily available to people with cancer and other debilitating diseases." — Dean Edell, M.D., March 2, 2000
- "I'm an oncologist as well as an AIDS doctor, and I don't think that a drug that creates euphoria in patients with terminal diseases is having an adverse effect." — Dr. Donald Abrams, 2005
- "Cannabis will one day be seen as a wonder drug, as was penicillin in the 1940s. Like penicillin, herbal marijuana is remarkably nontoxic, has a wide range of therapeutic applications and would be quite inexpensive if it were legal." — Dr. Lester Grinspoon, professor of psychiatry at Harvard Medical School, Los Angeles Times, May 5, 2006
- "In states where patients are permitted to use marijuana medicinally for serious and/or chronic illnesses and a patient's physician has recommended its use in accordance with that state law and that state's medical practice standards, the patient should not be subject to federal criminal penalties for such medical use." — HIV Medicine Association, October 30, 2006
- "Well-designed and scientifically rigorous research, including all FDA-approved Phase II and Phase III clinical trials that lead to investigation into the potential therapeutic role and commercial licensure of prescription marijuana should be encouraged, and that production facilities that meet all regulatory requirements should be licensed by the DEA to produce pharmaceutical-grade marijuana for use exclusively in federally approved research." — HIV Medicine Association, October 30, 2006
- "Not everybody needs marijuana for medical illness. But for those who really do, it's very helpful. As more and more states are taking medical marijuana — New Mexico just did it the other day — eventually it will just be overwhelming. And it will happen. But I'm shocked that it's taken this long." — Dr. Thomas Ungerleider, Professor Emeritus of Psychiatry at UCLA and member of President Nixon's National Commission on Marijuana and Drug Abuse, "3rd Degree," interview, LA City Beat, March 29, 2007
- The United Methodist Church's Board of Church and Society has said, "Licensed medical doctors should not be punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial."
- The Presbyterian Church supports "the use of cannabis sativa or marijuana for legitimate medical purposes as recommended by a physician."
- The Episcopal Church urges "the adoption by Congress and all states of statutes providing that the use of marijuana be permitted when deemed medically appropriate by duly licensed medical practitioners."
- The United Church of Christ has stated, "We believe that seriously ill people should not be subject to arrest and imprisonment for using medical marijuana with their doctors' approval."
- The Unitarian Universalist Association issued a resolution in support of ending "the practice of punishing an individual for obtaining, possessing, or using an otherwise illegal substance to treat a medical condition."
- The Union of Reform Judiasm passed a resolution to "advocate for the necessary changes in local, state and federal law to permit the medicinal use of marijuana and ensure its accessibility for that purpose."
- The American Bar Association (ABA) "recognizes that persons who suffer from serious illnesses for which marijuana has a medically recognized therapeutic value have a right to be treated with marijuana under the supervision of a physician."