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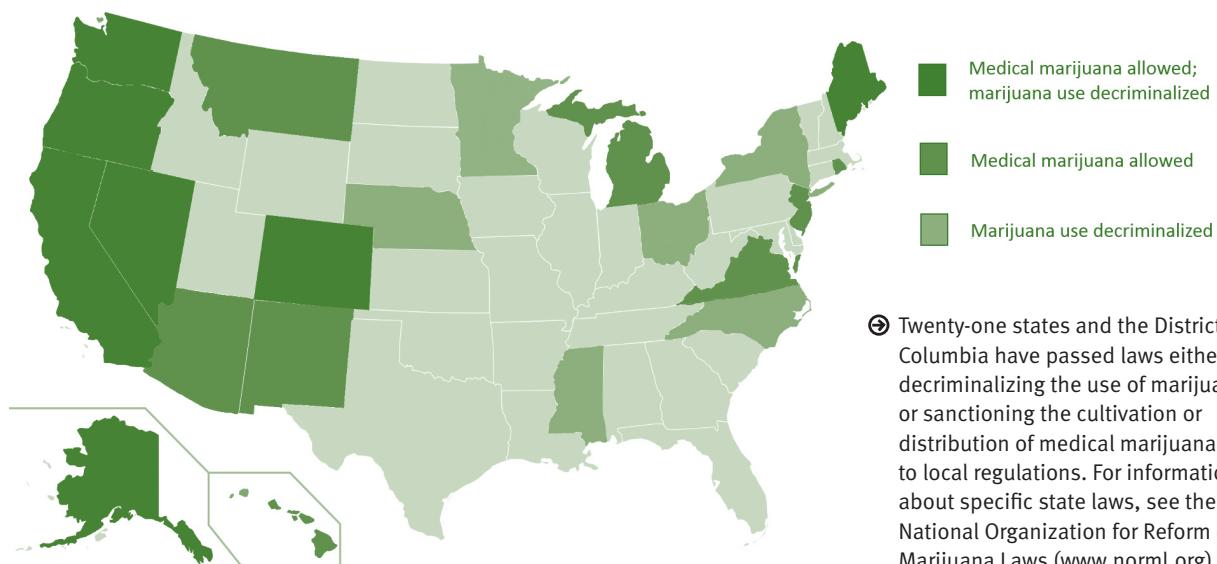
PRACTICE MEDICAL MARIJUANA



The Next Zoning Battleground: Trends and Challenges in Local Regulation of Medical Marijuana

By Deborah M. Rosenthal, AICP, and Alfred Fraijo Jr.

Fifteen states and the District of Columbia currently allow the private possession of small quantities of marijuana for medical use.



- ③ Twenty-one states and the District of Columbia have passed laws either decriminalizing the use of marijuana or sanctioning the cultivation or distribution of medical marijuana subject to local regulations. For information about specific state laws, see the National Organization for Reform of Marijuana Laws (www.norml.org).

The trend, which began with California's adoption of the Compassionate Use Act in 1996, is expected to accelerate in the future, with the majority of state laws passed in just the last six years. Last year alone, 19 states considered measures to legalize medical marijuana, although they were approved in only two states. In most states, medical marijuana possession has initially been approved by ballot measure, not statute. Medical marijuana possession, therefore, enjoys wide public support in an increasing number of jurisdictions.

State statutes decriminalizing marijuana for medical purposes typically do not

govern marijuana cultivation, processing, distribution, and sale. This task is left to individual jurisdictions under the police power, specifically their zoning and business licensing authority. In response to this regulatory vacuum at the state level, local governments have responded with an almost staggering variety of ordinances and regulations over the past few years.

Local land-use approaches range from total exclusion to standard zoning and business permitting systems. To date, there is no national consensus on regulation of medical marijuana, although the need for local ordinances is readily apparent. The

cautionary experiences of cities like Los Angeles, which was rapidly overwhelmed by hundreds of dispensaries after legalization, have led to a recent surge in local ordinances. For purposes of this article, the term "dispensary" is used to refer generally to medical marijuana dispensing facilities without distinction to cooperatives, collectives, or other legal entities defined by state or local law.

This article reviews the most common regulatory issues, emerging trends, and judicial challenges to regulations adopted by local government in response to state law changes permitting possession of medi-

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cal marijuana. We conclude that traditional zoning and business licensing, for the most part, is adequate to address the local land-use issues raised by medical marijuana. However, some problems are unique to medical marijuana and require advance planning, careful policy consideration, and coordination with other local government agencies.

WHAT IS MEDICAL MARIJUANA?

At its simplest, medical marijuana is any form of the plant *Cannabis sativa* L., including its seeds and resin, intended for medical use by qualified patients (California Health & Safety Code, Section 11018). It may consist of the dried plant or products derived from or incorporating the plant, such as foodstuffs or medicines. All laws legalizing medical marijuana require that it be used to treat conditions listed in the

statute—or otherwise determined to be covered—including, but not limited to, chronic pain and terminal illnesses (e.g., Nevada Constitution, Article 33, Section 1.a.). All state statutes mandate written documentation from a physician but cannot require a prescription, which may expose the doctor to penalty under federal law (e.g., Michigan Medical Marijuana Act, MCL 333.26422).

Virtually all state laws cap the amount of marijuana that may be possessed by a qualified patient, and most regulate the number or square footage of marijuana plants that may be grown at a single location. State laws may also limit the type of transaction (e.g., nonprofit or exchange) and the type of provider (e.g., collectives or cooperatives). Most, though not all, states have a registration system to ensure that patients qualify for possession of medical marijuana. A few states, like New Jersey and

Arizona, regulate the total number of dispensaries (New Jersey Compassionate Use Medical Marijuana Act, P.L. 2009, Chapter 307 (2010) and Arizona Medical Marijuana Act, Arizona Revised Statutes, Title 36, Chapter 28.1).

Consistent with the basic legal framework established by state law, local governments are expected to regulate the cultivation, processing, distribution, delivery, dispensing, storage, exchange, and consumption of medical marijuana. Each separate activity may require a different type of regulation, or different regulatory provisions within the municipal code. Local jurisdictions should carefully review existing ordinances governing each type of activity to determine whether special provisions need to be made for medical marijuana. For instance, cities may already regulate agriculture and on-site agricultural sales, but would

④ Under a contract from the National Institute on Drug Abuse, the University of Mississippi Marijuana Project is the only producer of marijuana for medical and research purposes explicitly sanctioned by the federal government.



Many cities and counties have banned dispensaries and the consumption of medical marijuana so as not to violate the federal Controlled Substances Act, which continues to classify marijuana as a Class 1 substance.

be unlikely to have adopted standards for security fencing, setbacks, coverage, and on-site processing and sale that would be applicable to medical marijuana. Similarly, home food delivery, pharmaceutical sales, inventory storage, and alcohol use may share some objective characteristics with, but do not raise the same issues as, medical marijuana.

FEDERAL PREEMPTION

Many cities and counties have banned dispensaries and the consumption of medical marijuana so as not to violate the federal Controlled Substances Act (CSA), which continues to classify marijuana as a Class 1 substance. For example, by the end of 2010, at least 12 counties in California had banned dispensaries.

Local governments are state subdivisions authorized to exercise the state's police power rather than to enforce federal law. Local land-use regulations do not *authorize* the possession or use of medical marijuana; they merely establish local requirements for its distribution in accordance with state law. In the wake of these concerns, however, several states, including Colorado, have amended their laws and issued guidelines to permit municipalities to prohibit dispensaries within their jurisdiction (Colorado House Bill 1284 and Senate Bill 109, effective June 7, 2010).

In October 2009, the U.S. Department of Justice announced that it did not intend to use scarce federal drug enforcement resources in prosecuting individuals "whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana" (U.S. Department of Justice, "Memorandum for Selected U.S. Attorneys on Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana," October 19, 2009). While the memorandum did not legalize marijuana possession at the federal level or provide a defense against federal prosecution, it reduced the likelihood of conflict between

the CSA and state and local land-use regulations. It also clarified that the state and federal governments use different enforcement mechanisms and that local officials are not obligated to act on behalf of federal regulators. It is unclear whether the policy will have an impact on enforcement activities in states without laws permitting dispensaries, though recent suits against the department are testing the policy's reach.

Recent case law suggests that a city's ability to ban the sale or consumption of medical marijuana may be limited in states that have enacted medical marijuana laws. As noted above, several cities and counties

argument has been rejected by the courts. In other cases, cities have moved to ban medical marijuana by limiting or prohibiting dispensaries through local land-use controls—an area of law in which local governments have traditionally enjoyed exclusivity. Other local governments are using nuisance abatement measures to exclude marijuana dispensaries, even if possession is beyond their reach.

The proposition that a city can prohibit the operation of a dispensary by invoking federal preemption of state law was recently rejected in California in *Qualified Patients Association v. City of Anaheim and County of San Diego v. San Diego NORML*. The courts found that, generally, state medical marijuana laws are not preempted by federal law because the state law merely exempts individuals who possess, cultivate, transport, or sell medical marijuana from state criminal prosecution. Accordingly, the local jurisdiction could not justify its law solely under the CSA. According to *Anaheim*, "a city may not stand in for the federal government and rely on purported federal preemption

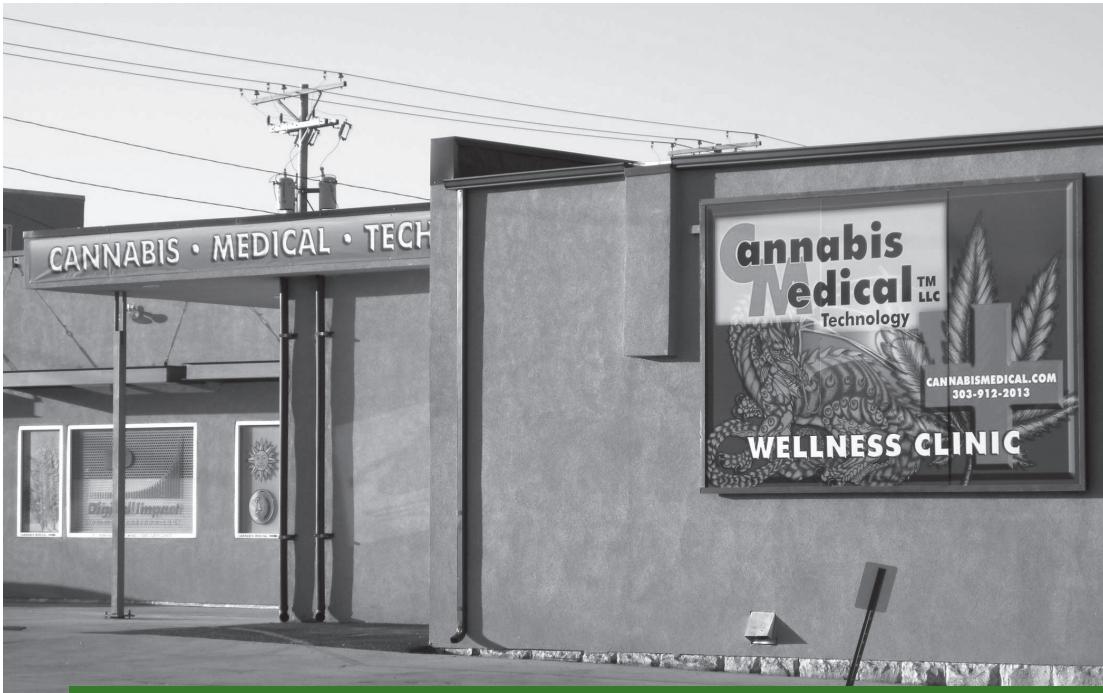


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④ In Los Angeles, many medical marijuana dispensaries choose to cluster along high-traffic corridors such as Ventura Boulevard.

have adopted prohibitions, some through temporary moratoria, on the sale or consumption of medical marijuana and the operation of dispensaries on grounds that the federal prohibition preempts state law. The basic argument in such cases is that local law, like state law, must yield to federal law. However, the rationale for the preemption

to implement federal legislative policy that differs from corresponding, express state legislation concerning medical marijuana." Conversely, the fact that individuals or a collective may elect to act in accordance with state law in a way that violates federal law does not implicate the local jurisdiction in such violation.



Wikimedia Commons/Prazak

Between 2000 and 2007, medical marijuana dispensaries in Colorado were limited to five patients each. After Colorado courts lifted these restrictions, dispensaries proliferated rapidly along commercial corridors in Denver.

LOCAL PROHIBITIONS

As distinguished from federal preemption, many municipalities in states with statutes permitting medical marijuana have adopted local moratoria or prohibitions on the basis of their plenary powers to regulate local land uses and abate a nuisance. These measures have generally been upheld (e.g., *City of Claremont v. Kruse* (2000) 177 Cal.App.4th 1153). In the case of nuisance abatement, local governments may rely on existing ordinances that prohibit any use—as a nuisance per se—that is inconsistent or not specifically authorized by local regulations. In many cases, local governments have not enumerated in local codes the sale, cultivation, or distribution of marijuana as a permitted use or permitted business activity. In these jurisdictions nuisance per se, therefore, can be an effective defensive measure to close or enjoin dispensaries from operating within their limits.

Local governments have also enjoyed considerable latitude to control medical marijuana through land-use regulations even when state laws permit its consumption, cultivation, and distribution. Generally, local governments may make and enforce local land-use and business regulations that

do not conflict with state statutes. Because the majority of state laws permitting medical marijuana do not mandate specific land-use requirements or business permits, such issues are not deemed exclusively a matter of state concern that preempts local governments from adopting regulations that restrict or even prohibit such activities within their limits. Further, many of the new laws narrowly permit the use of marijuana for medical purposes for patients with specific conditions, while keeping the general law criminalizing cultivation, distribution, and use as unlawful. In that sense, local governments may enjoy wider latitude regarding their regulation on grounds of public health and safety or other concerns.

Though local measures to prohibit or restrict medical marijuana cultivation, distribution, and use have been upheld by recent case law, local municipalities will be required to support their enforcement measures with policy and findings of fact that establish a direct link between the restrictions, legitimate government concerns, and local authority. Local governments may also draw regulatory distinctions among activities (e.g., cultivators and dispensaries that implicate different policy consider-

ations). Medical marijuana cultivation for distribution may require different land-use controls or licensing compared to personal cultivation.

UNLISTED USES

There can be considerable controversy when local governments do not adopt ordinances to address changes in state laws that permit medical marijuana. Such changes in state law may create a perception among consumers, dispensaries, and other organizations that distribution, cultivation, or consumption is permitted locally as a matter of state law. Indeed, in California, a lower court judge found that state law permitting the use of medical marijuana created a “statutorily conferred right” to operate a dispensary and to obtain marijuana for medical purposes (*Medical Marijuana Collectives Litig. Americans for Safe Access v. City of Los Angeles*, Case No. BC433942, December 10, 2010). Some local governments have responded many months or years after changes in state law take effect. These jurisdictions must sometimes contend with the lack of clarity in the local permitting process that may result from the existence of dispensaries prior to enacting such local regulations.

There also may be an increase in enforcement or legal costs to local governments if dispensaries are regulated or restricted after facilities have opened and allowed to operate solely under state regulations. To illustrate, in response to a proliferation of dispensaries, Los Angeles adopted a comprehensive medical marijuana ordinance in January 2010 (effective June 2010), nearly 15 years after the statewide initiative legalizing the use of marijuana for medical purposes in California.

In response to a growing number of dispensaries and prior to the enactment of a comprehensive ordinance, Los Angeles adopted an interim control ordinance, or ICO, in August 2007. The ICO permitted the operations of all dispensaries that existed prior to August 1, 2007, and that had submitted a series of documents to the city by November of the same year. The effect was a moratorium on new dispensaries in the city. However, the ICO expired by operation of state law in September 2007.

In January 2010, the city passed a comprehensive ordinance for dispensaries. Among various operating and licensing requirements, the new ordinance limited the operation of collectives to those that had registered by the November deadline. That summer, several dispensaries filed suit against the city alleging numerous constitutional and procedural claims and requested an injunction.

In December 2010, a superior court judge struck down the provisions in the law that only benefited the dispensaries with proof of registration as an unconstitutional violation of procedural due process and equal protection (*Medical Marijuana Collectives*). Because the 2007 deadline was set two months after expiration of the ICO, the judge reasoned, dispensaries that were in operation prior to the 2007 deadline, but that did not register afterward (presumably, because the expiration of the moratorium did not warrant it) were denied equal protection. “[N]o one could have anticipated that compliance with a dead statute would be necessary in order to continue as a collective three years later” (*Medical Marijuana Collectives*, p. 23). The judge also struck other provisions of the law on grounds that it violated the right to privacy (e.g., dispensaries were required to keep contact information of their members).

In contrast, Tucson, Arizona, adopted a comprehensive zoning ordinance the same

month, which voters approved in a statewide referendum, permitting the cultivation, distribution, and consumption of medical marijuana. By addressing problems in advance, Tucson hopes to avoid the problem plaguing the cities that acted after the fact.

Jurisdictions that allow staff or commissions to allow uses determined to be “similar” to specifically enumerated uses may face difficult definitional problems. Medical marijuana may have characteristics similar to agriculture, home occupations, nurseries, adult uses, pharmacies, processing plants, and retail stores, depending on the circumstances and type of applications. Conditional use permits may be desired to ensure compatibility with surrounding uses but may not be available unless the zoning code authorizes them in specified districts.

licenses, may make each vulnerable to legal challenge.

Many jurisdictions already have relevant experience in coordinating licensing for massage establishments and technicians with zoning requirements. As is the case with such businesses, licensing and zoning requirements for medical marijuana will require coordination with state law to avoid conflicting requirements. Many state laws allowing medical marijuana include both licensing and zoning regulations that may require different enforcement mechanisms and statutory treatment by local governments.

Local jurisdictions in states that allow medical marijuana should audit their zoning codes to ensure that they are consistent with state law and local intent. For instance, cities may add medical marijuana cultivation

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BUSINESS VERSUS ZONING REQUIREMENTS

Local jurisdictions may benefit from carefully distinguishing between the land-use issues raised by medical marijuana operations and those issues most appropriately addressed through business licensing and business permitting. For instance, operator qualifications, security patrols, inventory levels, record keeping, and other operational issues are properly the subject of annual licenses that may be monitored by a state licensing board or local agencies like the police department. On the other hand, allowable uses, fencing, coverage, parking access, hours of operation, signage, and separation of uses should be handled through local zoning regulations.

The business license and zoning requirements should be coordinated and include cross-references. For instance, a typical business license condition requires that the proposed location be properly zoned and, accordingly, that the businesses obtain clearances from planning divisions in advance of operating. The zoning ordinance may prohibit any medical marijuana facilities that are operated without a current business license. However, attempting to regulate operations directly through zoning, or to control land uses through business

as a permitted or conditional use in specified districts, with limits on acreage, requirements for indoor cultivation or shielding, and processing controls.

Some jurisdictions require cultivation in residential districts to take place only in owner-occupied structures, with strict limits on the number or size of plants. Processing small amounts may be allowed in residential districts, with larger processing operations reserved to industrial or manufacturing zones. Commercial zones or districts similarly may be restricted by local regulations to specialized activities. Some jurisdictions do not allow cultivation or consumption in commercial zones, although dispensaries are allowed to operate. For example, in Colorado, state law prohibits smoking of medical marijuana on the premises of a dispensary; some jurisdictions have extended such prohibitions on consumption to within a certain radius from the dispensary. Other local governments further address consumption by prohibiting the sale of any food on-site or the sale of smoking devices and paraphernalia.

Most jurisdictions appear to prefer separating medical marijuana dispensaries from sensitive uses, like schools, churches, and each other. For instance, some municipali-

ties require a minimum 1,000-foot distance between the property lines of a site with a dispensary and the nearest residential district. New Mexico prohibits the operation of a dispensary within 300 feet of any school, church, or day care center. However, the Los Angeles experience is that dispensaries may choose to cluster together in high-traffic areas, where they can be easily accessed by potential customers. The zoning regulations should reflect the choices of the local community in how to regulate all aspects of medical marijuana.

COMPREHENSIVE PLAN CONSISTENCY

An important step for local governments addressing medical marijuana use, cultivation, and distribution will be to address the interplay between proposed zoning rules and the local comprehensive plan. As a general matter, zoning and land-use regulations are subordinate to a city or county's comprehensive plan. In some states, inconsistencies between the locally adopted plan and development regulations are vulnerable to legal challenges. This includes any regulations or guidelines that the city may adopt in connection with new land uses. Unfortunately, consistency is not the default law of the land, just a good idea. Many states don't even require a comprehensive plan.

INTERGOVERNMENTAL COOPERATION

In addition to overlapping regulations, local governments are considering intergovernmental cooperation to address the potential impacts of overlapping jurisdictions that regulate the same activity in different ways. In Michigan, for example, many of the townships have adopted ordinances that address coordination with local and state agencies with authority to inspect local businesses, including medical marijuana dispensaries. In a more expansive move, Tuolumne County and the City of Sonora in California are collaborating on regulations for dispensaries. The joint effort is designed to eliminate conflicts between the city's general plan, which listed dispensaries as an accepted use, and the county zoning code, which was silent on their operations.

PRIVACY RIGHTS

Some jurisdictions have expanded their standard business licensing standards

to include more robust public reporting and background check requirements as a prerequisite to licensing dispensaries. These new regulations range from mandated background checks on applicants as well as employees and greater on-site security, lighting, and video protocols to monitor activity inside and outside the facility. Colorado requires a physical inspection of the premises prior to issuing a license. In some jurisdictions, like Fort Bragg, California, local rules mandate maintaining records of all patients and primary caretakers (Municipal Code, Sections 9.30.010–9.30.270). The chief of police also is required to conduct a detailed background investigation into the dispensary, its operator, and employees. Additionally, the ordinance provides broad discretion for denying a license. The police chief must make a determination on the good standing of the applicant, including whether he or she has engaged in any "unfair" or "deceptive" acts (although the ordinance does not define the terms).

The extensive investigation and reporting required for dispensaries are likely to be justified as necessary to ensure public safety. However, these efforts may provoke challenges on grounds that they violate legally protected privacy interests, including a legal mandate for health care providers to protect patients' medical records. The ordinance adopted in Los Angeles exemplifies this dynamic. The ordinance requires dispensaries to keep a log of all members' general contact information and mandates disclosure of the information to the police department and other departments under limited circumstances (Municipal Code, Sections 45.19.6 *et seq.* 45.19.6.6). In *Medical Marijuana Collectives*, the trial court found that patients have a "legally protected privacy interest" in the contact and medical information maintained by the dispensary, and that provisions mandating disclosure to the police violated state law. According to the court, "members of collectives have an objectively reasonable expectation of privacy" (*Medical Marijuana Collectives*, p. 26–27). The court suggested that requiring the dispensary to obtain patient consent to disclose could validate these provisions of the ordinance.

WHERE ARE WE HEADED?

We are now seeing a second wave of state statutes authorizing the use of medical marijuana. As public opinion changes and more states address this issue, officials may benefit from observing the practical impact of older initiatives. There are no common approaches or standard practices nationally or even at the state level. Rather, a balance of local interests, perceptions regarding the effects on public safety and health and, in many cases, the proliferation of unlicensed dispensaries appear to be crucial drivers influencing new legislation. Officials, planners, and lawyers in these states are also challenged by existing state statutes and court decisions that further define the reach of local land-use regulations and licensing procedures. Courts have taken some important steps to clarify the issues; we anticipate further challenges to local regulations and their relationship to legitimate public purpose and procedural due process issues, including public review, rights to a hearing, and appeal.

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IS YOUR COMMUNITY READY FOR MEDICAL MARIJUANA?