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S.F. No. 1973 - Medical Use of Marijuana (Second Engrossment)

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S.F. No. 1973 establishes the legality of the medical use of marijuana.

Section 1 is a conforming amendment related to the issuance of registry identification cards.

Section 2 (152.22) defines the following terms: "allowable amount of marijuana," "commissioner," "debilitating medical condition," "medical use," "practitioner," "primary supplier," "qualifying patient," "registry identification card," "usable marijuana," and "written certification."

Section 3 (152.23) creates protections for the medical use of marijuana.

Subdivision 1 states that a qualifying patient who has a registry identification card in possession shall not be arrested, prosecuted, or subject to any penalty for the medical use of marijuana, so long as the patient does not possess more than 2.5 ounces of usable marijuana.

Subdivision 2 provides the same protection as described in subdivision 1 to a primary supplier for assisting a qualifying patient to whom the supplier is connected through the registration process with the medical use of marijuana, so long as the supplier does not possess more than 12 marijuana plants and 2.5 ounces of useable marijuana for each patient.

Subdivision 3 states that no school, employer, or landlord may penalize a person solely because of the person's status as a qualifying patient or a registered primary supplier.

Subdivision 4 creates a presumption that a qualifying patient or primary supplier is engaged in the medical use of marijuana if the patient or supplier is: (1) in possession of a registry

identification card; and (2) in possession of an amount of marijuana that does not exceed the amount permitted. States that this presumption may be rebutted by evidence showing that conduct related to the marijuana was not for the purpose of alleviating the patient's medical condition or symptoms.

Subdivision 5 permits a primary supplier to receive reimbursement for costs associated with assisting with a registered patient's medical use of marijuana. States that such compensation does not constitute a sale of a controlled substance.

Subdivision 6 provides protection from arrest , prosecution, or penalty solely for providing written certifications or stating that in the practitioner's opinion the potential benefits of the medical use of marijuana would likely outweigh the health risks for a patient.

Subdivision 7 states that any interest in or right to property that is used in connection with the medical use of marijuana is not forfeited. States that a law enforcement agency that seizes and does not return usable marijuana to a registered patient or supplier is liable to the cardholder for the fair market value of the marijuana.

Subdivision 8 states that no person shall be subject to arrest or prosecution for any offense for being in the presence or vicinity of the medical use of marijuana or for assisting a registered patient with using or administering marijuana.

Subdivision 9 provides reciprocity for a registry identification card or its equivalent issued by another state, territory, or District of Columbia that permits the medical use of marijuana by a qualifying patient or permits a person to assist with a patient's medical use of marijuana.

Section 4 (152.24) requires the Commissioner of Health to adopt rules no later than 90 days after the effective date regarding petitions from the public to add debilitating medical conditions and regarding applications for and renewals of registry identification cards for qualifying patients and suppliers.

Section 5 (152.25) describes the registry identification cards.

Subdivision 1, paragraph (a), requires the commissioner to issue registry identification cards to qualifying patients who submit:

(1) a written certification;

(2) an application or renewal fee;

(3) the name, address, and date of birth of the patient unless the patient is homeless;

(4) the name, address, and telephone number of the patient's practitioner; and

(5) the name, address, and date of birth of each primary supplier of the patient.

Paragraph (b) states that the commissioner shall not issue a registry identification card to a qualifying patient under the age of 18 unless:

(1) the practitioner has explained the risks and benefits to the patient and to a parent or guardian of the patient; and

(2) a parent or legal guardian consents in writing to:

(i) allow the patient's use of marijuana;

(ii) serve as one of the patient's primary suppliers; and

(iii) control the acquisition, dosage, and frequency of the medical use of marijuana by the patient.

Paragraph (c) requires the commissioner to verify the information contained in an application or renewal submitted under this section and approve or deny the application or renewal within 15 days of receiving it. Permits the commissioner to deny an application or renewal only if the applicant did not provide the information required or the information was falsified. States that a rejection is a final agency action subject to judicial review and jurisdiction and venue are vested in the district court.

Paragraph (d) requires the commissioner to issue a registry identification card to each primary supplier who is named on a patient's approved application up to a maximum of two primary suppliers per qualifying patient.

Paragraph (e) requires that the registry identification card be issued within five days of approving an application or renewal. States that the card expires one year after the date of issuance. States what information the card must contain.

Subdivision 2, paragraph (a), requires a qualifying patient to notify the commissioner within ten days of any change in the patient's name, address, or primary supplier or if the patient ceases to have a debilitating medical condition.

Paragraph (b) states that failure to notify the commissioner of theses changes is a civil violation, punishable by a fine of no more than $150. States that the card is null and void if the patient ceases to have a debilitating medical condition and is liable for any other penalties that may apply to the nonmedical use of marijuana.

Paragraph (c) requires the registered primary supplier to notify the commissioner within ten days of any change in the supplier's name or address, and failure to do this is a civil violation punishable by a fine of no more than $150.

Paragraph (d) requires the commissioner to issue a new registry identification card within ten days of receiving updated information from a qualifying patient or primary supplier and a $10 fee.

Paragraph (e) states that when a registered qualifying patient ceases to use the assistance of a registered primary supplier, the commissioner must notify the supplier within ten days and the supplier's protections expire ten days after notification.

Subdivision 3 requires a registered qualifying patient or supplier who loses a registry identification card to notify the commissioner and submit a $10 fee within ten days of losing the card. Requires the commissioner to issue a new card with a new random number within five days.

Subdivision 4 states that the possession of, or application for, a registry identification card does not constitute probable cause or reasonable suspicion nor shall it be used to support searching a person or property of the person or otherwise subject the person or property of the person to inspection by any governmental agency.

Subdivision 5, paragraph (a), states that the registration applications and supporting information submitted are private data on individuals or nonpublic data.

Paragraph (b) requires the commissioner to maintain a list of persons who have been issued registry identification cards. The individual names and other identifying information are private data except that:

(1) upon request of a law enforcement agency, the commissioner must verify the validity of a registration card; and

(2) the commissioner may notify law enforcement of fraudulent information submitted to obtain or renew card.

Subdivision 6 requires the commissioner to report annually to the Legislature on the number of applications for cards, the number of patients and suppliers approved, the nature of the debilitating medical conditions, the number of cards revoked, and the number of practitioners providing written certification.

Section 6 (152.26) clarifies that these sections do not permit:

(1) a person to undertake a task while under the influence of marijuana, which might constitute negligence or malpractice;

(2) smoking of marijuana in a school bus or other public transportation, on school grounds, in a correctional facility, or in any public place; and

(3) a person to operate a motor vehicle, aircraft, or motorboat while under the influence of marijuana.

The medical assistance program or private health insurer is not required to reimburse a person for the cost associated with the medical use of marijuana. An employer is not required to accommodate the medical use of marijuana in any workplace.

Section 7 (152.27) states that any fraudulent representation to a law enforcement official of any fact or circumstance relating to the medical use of marijuana to avoid arrest or prosecution is punishable by a fine of $500 in addition to any other applicable penalties.

Section 8 (152.30) provides a severability clause.

Section 9 (152.31) creates a registration system for organizations that acquire, possess, cultivate, manufacture, deliver, transfer, transport, supply, or dispense marijuana, equipment, or supplies to registered qualified patients and suppliers.

Subdivision 1 defines a "registered organization."

Subdivision 2, paragraph (a), requires the commissioner to issue a registered organization license within 20 days to any person who meets the adopted rules and who provides:

(1) the established fee;

(2) the name of the organization;

(3) the addresses of the organization and any other real property where marijuana is to be possessed, cultivated, manufactured, supplied, or dispensed; and

(4) the name, address, and date of birth of any person who is an agent of or employed by the organization.

Paragraph (b) requires the commissioner to issue each agent and employee of a registered organization a registry identification card for a cost of $10 each within ten days of receipt of the identifying information and the fee.

Subdivision 3 states that the license for a registered organization and each employee or agent expires one year after the date of issuance.

Subdivision 4 requires the commissioner to adopt rules no later than 90 days after the effective date to implement this section.

Subdivision 5 authorizes the commissioner to make reasonable inspections of registered organizations with reasonable notice given prior to the inspection.

Subdivision 6, paragraph (a), states that registered organizations must be nonprofit entities and are subject to all applicable state laws governing nonprofit entities.

Paragraph (b) states that a registered organization may not be located within 500 feet of a school or structure used primarily for religious services or worship.

Paragraph (c) requires the operating documents of a registered organization to include procedures for the oversight of the organization and to ensure adequate record keeping.

Paragraph (d) requires the registered organization to notify the commissioner within ten days of when an employee or agent stops working at the organization.

Paragraph (e) requires the registered organization to notify the commissioner before a new agent or employee begins working at the organization, in writing, and to submit a $10 fee for the person's identification card.

Paragraph (f) states that the registered organization is not subject to civil penalty or disciplinary action for acting in accordance with these sections and rules, provided that the organization does not possess an amount of marijuana that exceeds 12 marijuana plants and 2.5 ounces of usable marijuana for each registered qualifying patient.

Paragraph (g) states that no employee, agent, or board member of a registered organization shall be subject to arrest, prosecution, search, seizure, or penalty or disciplinary action for working for a registered organization.

Paragraph (h) prohibits the registered organization from:

(1) obtaining marijuana from outside the state in violation of federal law; or

(2) using marijuana for any purpose other than to assist registered qualifying patients with the medical use of marijuana directly or through a qualifying primary supplier.

Paragraph (i) prohibits a municipality from preventing a registered organization from operating in an area where zoning permits local businesses.

Paragraph (j) states that if these provisions are found to be unconstitutional or enjoined, then enforcing laws against the delivery of marijuana for consideration to registered qualifying patients shall be the lowest priority of law enforcement.

Section 10 provides an effective date.

KT/CT:ph:rer

A bill for an act

relating to health; providing for the medical use of marijuana; providing civil and criminal penalties; amending Minnesota Statutes 2004, section 13.3806, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 152.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 13.3806, is amended by adding a subdivision to read:

Subd. 21. **Medical use of marijuana registry.** Data collected by the commissioner of health relating to registrations for the medical use of marijuana are classified in section 152.25, subdivision 5.

Sec. 2. **[152.22] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of sections 152.22 to 152.31, the terms defined in this section have the meanings given them.

Subd. 2. **Allowable amount of marijuana.** (a) With respect to a qualifying patient, the "allowable amount of marijuana" means 2.5 ounces of usable marijuana. An allowable amount of marijuana for a qualifying patient does not include marijuana plants.

(b) With respect to a primary supplier or registered organization, the allowable amount of marijuana for each patient means:

(1) 12 marijuana plants;

(2) 2.5 ounces of usable marijuana; and

(3) any amount of other parts of the marijuana plant.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 4. **Debilitating medical condition.** "Debilitating medical condition" means:

(1) cancer, glaucoma, acquired immune deficiency syndrome, hepatitis C, or the treatment of these conditions;

(2) a chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: cachexia or wasting syndrome; severe or chronic pain; severe nausea; seizures, including but not limited to those characteristic of epilepsy; severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis and Crohn's disease; or agitation of Alzheimer's disease;

(3) the condition of an HIV-positive patient when the patient's condition has worsened and the patient's physician believes the patient could benefit from consumption of marijuana; or

(4) any other medical condition or its treatment approved by the commissioner under section 152.24.

Subd. 5. **Medical use.** "Medical use" means the acquisition, possession, cultivation, manufacture, use, delivery, transfer, or transportation of marijuana or paraphernalia relating to the consumption of marijuana to alleviate a registered qualifying patient's debilitating medical condition or symptoms associated with the medical condition.

Subd. 6. **Practitioner.** "Practitioner" means a licensed doctor of medicine or licensed doctor of osteopathy licensed to practice medicine.

Subd. 7. **Primary supplier.** "Primary supplier" means a person who is at least 18 years old and who has agreed to assist with a qualifying patient's medical use of marijuana. A primary supplier may assist no more than five qualifying patients with their medical use of marijuana.

Subd. 8. **Qualifying patient.** "Qualifying patient" means a person who has been diagnosed by a practitioner as having a debilitating medical condition. A qualifying patient may not be a primary supplier.

Subd. 9. **Registry identification card.** "Registry identification card" means a document issued by the commissioner that identifies a person as a qualifying patient or primary supplier.

Subd. 10. **Usable marijuana.** "Usable marijuana" means the dried leaves and flowers of the marijuana plant, and any mixture or preparation thereof, but does not include the seeds, stalks, and roots of the plant.

Subd. 11. **Written certification.** "Written certification" means the qualifying patient's medical records, or a statement signed by a practitioner, stating that in the practitioner's professional opinion the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient. A written certification shall only be made in the course of a bona fide practitioner-patient relationship after

the practitioner has completed a full assessment of the qualifying patient's medical history. The written certification shall specify the qualifying patient's debilitating medical condition or conditions.

Sec. 3. **[152.23] PROTECTIONS FOR THE MEDICAL USE OF MARIJUANA.**

Subdivision 1. **Qualifying patient.** A qualifying patient who possesses a registry identification card is not civilly or criminally liable and may not be denied any right or privilege for possession for medical use of an amount of marijuana that does not exceed the allowable amount. This immunity includes a civil penalty or disciplinary action by a business, occupational, or professional licensing board.

Subd. 2. **Primary supplier.** A primary supplier who possesses a registry identification card is not civilly or criminally liable and may not be denied any right or privilege for:

(1) assisting a registered qualifying patient for whom the supplier is a registered primary supplier in obtaining for medical use an allowable amount of marijuana; or

(2) possessing an amount of marijuana that does not exceed the total of the allowable amounts for the registered qualifying patients for whom the supplier is a registered primary supplier.

This immunity includes a civil penalty or disciplinary action by a business, occupational, or professional licensing board.

Subd. 3. **Discrimination prohibited.** No school, employer, or landlord may refuse to enroll, employ, lease to, or otherwise penalize a person solely for the person's status as a registered qualifying patient or a registered primary supplier.

Subd. 4. **Presumption.** (a) There is a presumption that a qualifying patient or primary supplier is engaged in the medical use of marijuana if the qualifying patient or primary supplier:

(1) is in possession of a registry identification card; and

(2) is in possession of an amount of marijuana that does not exceed the amount permitted under sections 152.22 to 152.31.

(b) The presumption may be rebutted by evidence that conduct related to marijuana was not for the purpose of alleviating the qualifying patient's debilitating medical condition or symptoms associated with the medical condition.

Subd. 5. **Supplier's reimbursement.** A primary supplier may receive reimbursement for costs associated with assisting with a registered qualifying patient's medical use of marijuana. Compensation does not constitute sale of controlled substances.

Subd. 6. **Practitioner.** A practitioner shall not be subject to arrest, prosecution, or penalty in any manner or denied any right or privilege, including but not limited to civil penalty or disciplinary action by the Board of Medical Practice or by another business, occupational, or professional licensing board or bureau, solely for providing written certifications or otherwise stating that, in the practitioner's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for a patient.

Subd. 7. **Property rights.** (a) Any interest in or right to property that is possessed, owned, or used in connection with the medical use of marijuana, or acts incidental to such use, is not forfeited.

(b) A law enforcement agency that seizes and does not return usable marijuana to a registered qualifying patient or a registered primary supplier is liable to the cardholder for the fair market value of the marijuana.

Subd. 8. **Arrest and prosecution prohibited.** No person is subject to arrest or prosecution for constructive possession, conspiracy, aiding and abetting, being an accessory, or any other offense for being in the presence or vicinity of the medical use of marijuana as permitted under sections 152.22 to 152.31 or for assisting a registered qualifying patient with using or administering marijuana.

Subd. 9. **Reciprocity.** A registry identification card, or its equivalent, issued under the laws of another state, United States territory, or the District of Columbia to permit the medical use of marijuana by a qualifying patient, or to permit a person to assist with a qualifying patient's medical use of marijuana, shall have the same force and effect as a registry identification card issued by the commissioner.

Sec. 4. **[152.24] RULEMAKING.**

(a) Not later than 90 days after the effective date of this section, the commissioner shall adopt rules governing the manner in which the commissioner shall consider petitions from the public to add debilitating medical conditions to those included under section 152.22, subdivision 4. When considering petitions, the commissioner shall give public notice of and an opportunity to comment at a public hearing upon the petitions. The commissioner shall, after a public hearing, approve or deny petitions within 180 days of submission. The approval or denial of a petition is a final agency action, subject to judicial review. Jurisdiction and venue for judicial review are vested in the district court. The denial of a petition does not disqualify qualifying patients with that condition if they have a debilitating medical condition. The denial of a petition does not prevent a person with the denied condition from raising an affirmative defense.

(b) Not later than 90 days after the effective date of this section, the commissioner shall adopt rules governing the manner in which the commissioner shall consider applications for and renewals of registry identification cards for qualifying patients and primary suppliers. Notwithstanding section 16A.1283, the commissioner shall establish application and renewal fees that generate revenues sufficient to offset all expenses of implementing and administering sections 152.22 to 152.31. The commissioner may vary the application and renewal fees along a sliding scale that accounts for a qualifying patient's income. The commissioner may accept donations from private sources to reduce the application and renewal fees.

Sec. 5. **[152.25] REGISTRY IDENTIFICATION CARDS; ISSUANCE.**

Subdivision 1. **Requirements; issuance.** (a) The commissioner shall issue registry identification cards to qualifying patients who submit:

(1) a written certification;

(2) the application or renewal fee;

(3) the name, address, and date of birth of the qualifying patient, except that if the applicant is homeless, no address is required;

(4) the name, address, and telephone number of the qualifying patient's practitioner; and

(5) the name, address, and date of birth of each primary supplier of the qualifying patient, if any.

(b) The commissioner shall not issue a registry identification card to a qualifying patient under the age of 18 unless:

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

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

(i) allow the qualifying patient's medical use of marijuana;

(ii) serve as one of the qualifying patient's primary suppliers; and

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

(c) The commissioner shall verify the information contained in an application or renewal submitted under this section and shall approve or deny an application or renewal within 15 days of receiving it. The commissioner may deny an application or renewal only if the applicant did not provide the information required under this section or if the commissioner determines that the information provided was falsified. Rejection of an

registered qualifying patient shall not be considered to be under the influence solely for having marijuana metabolites in the patient's system.

(b) Nothing in sections 152.22 to 152.31 shall be construed to require:

(1) a government medical assistance program or private health insurer to reimburse a person for costs associated with the medical use of marijuana; or

(2) an employer to accommodate the medical use of marijuana in any workplace.

(c) Nothing in sections 152.22 to 152.30 prevents a court from limiting or prohibiting the possession or use of marijuana as a condition of probation or conditional release.

Sec. 7. **[152.27] PENALTIES.**

Fraudulent representation to a law enforcement official of any fact or circumstance relating to the medical use of marijuana to avoid arrest or prosecution is punishable by a fine of $500, which shall be in addition to any other penalties that may apply for making a false statement and for the nonmedical use of marijuana.

Sec. 8. **[152.30] SEVERABILITY.**

Any provision of sections 152.22 to 152.31 being held invalid as to any person or circumstances shall not affect the application of any other provision of sections 152.22 to 152.31 that can be given full effect without the invalid section or application.

Sec. 9. **[152.31] REGISTERED ORGANIZATION.**

Subdivision 1. **Definition.** For purposes of this section, "registered organization" means a nonprofit entity registered with the commissioner under this section that acquires, possesses, cultivates, manufactures, delivers, transfers, transports, supplies, or dispenses marijuana, cultivation equipment, related supplies and educational materials, or marijuana seeds to registered qualifying patients and their registered primary suppliers. A registered organization is a primary supplier, although it may supply marijuana to any number of registered qualifying patients who have designated it as one of their primary suppliers.

Subd. 2. **Registration requirements.** (a) The commissioner shall issue a registered organization license within 20 days to any person who complies with rules adopted by the commissioner and provides:

(1) a fee in an amount established by the commissioner notwithstanding section 16A.1283, which shall not exceed $1,000;

(2) the name of the registered organization;

(3) the physical addresses of the registered organization and any other real property where marijuana is to be possessed, cultivated, manufactured, supplied, or dispensed relating to the operations of the registered organization; and

(4) the name, address, and date of birth of any person who is an agent of or employed by the registered organization.

(b) The commissioner shall issue each agent and employee of a registered organization a registry identification card for a cost of $10 each within ten days of receipt of the person's identifying information and the fee. Each card shall specify that the cardholder is an employee or agent of a registered organization.

Subd. 3. **Expiration.** A license for a registered organization and each employee or agent registry identification card expires one year after the date of issuance.

Subd. 4. **Rulemaking.** Not later than 90 days after the effective date of this section, the commissioner shall adopt rules to implement this section, including:

(1) procedures for the oversight of registered organizations, record keeping and reporting requirements for registered organizations, procedures for the transference or sale of seized cultivation equipment and related supplies from law enforcement agencies to registered organizations, and procedures for suspending or terminating the licenses of registered organizations; and

(2) the form and content of the license and renewal applications.

Subd. 5. **Inspection.** Registered organizations are subject to reasonable inspection by the commissioner to determine that applicable rules are being followed. Reasonable notice shall be given prior to the inspections.

Subd. 6. **Organization requirements.** (a) Registered organizations must be organized as a nonprofit corporation under chapter 317A or a similar law of another state.

(b) Registered organizations may not be located within 500 feet of the property line of a public school, private school, or structure used primarily for religious services or worship.

(c) The articles or bylaws of a registered organization shall include procedures for the oversight of the registered organization and procedures to ensure adequate record keeping.

(d) A registered organization shall notify the commissioner within ten days of when an employee or agent ceases to work at the registered organization.

(e) The registered organization shall notify the commissioner before a new agent or employee begins working at the registered organization, in writing, and the organization shall submit a $10 fee for the person's registry identification card.

(f) No registered organization shall be subject to prosecution, search, seizure, or penalty in any manner or denied any right or privilege, including but not limited to civil

penalty or disciplinary action by a business, occupational, or professional licensing board or bureau, for acting according to sections 152.22 to 152.31 and rules adopted thereunder to assist registered qualifying patients to whom it is connected through the commissioner's registration process with the medical use of marijuana, provided that the registered organization possesses an amount of marijuana that does not exceed the total of the allowable amounts of marijuana for the registered qualifying patients for whom the organization is a registered primary supplier.

(g) No employees, agents, or board members of a registered organization shall be subject to arrest, prosecution, search, seizure, or penalty in any manner or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business, occupational, or professional licensing board or bureau, for working for a registered organization according to sections 152.22 to 152.31.

(h) The registered organization is prohibited from:

(1) obtaining marijuana from outside the state in violation of federal law; or

(2) acquiring, possessing, cultivating, manufacturing, delivering, transferring, transporting, supplying, or dispensing marijuana for any purpose except to assist registered qualifying patients with the medical use of marijuana directly or through the qualifying patients' other primary suppliers.

(i) A municipality may not prevent a registered organization from operating according to sections 152.22 to 152.31 in an area where zoning permits retail businesses.

(j) If provisions of this section are enjoined or declared unconstitutional, then enforcing laws against delivery of marijuana for consideration to registered qualifying patients shall be the lowest priority of law enforcement.

Sec. 10. **EFFECTIVE DATE.**

Sections 1 to 9 are effective the day following final enactment.

Senator ..... moves to amend S.F. No. 1973 as follows:

Page 1, delete lines 9 to 11 and insert:

"Subd. 21. **Medical use of marijuana data.** Data collected by the commissioner of health relating to:

(1) registrations for the medical use of marijuana are classified in section 152.25, subdivision 5; and

(2) individuals obtaining marijuana for medical use from registered organizations are classified in section 152.31, subdivision 8."

Page 2, line 7, after the second semicolon, insert "or"

Page 2, line 10, delete "; or" and insert a period

Page 2, delete lines 11 and 12

Page 4, delete section 4

Page 6, line 12, after the semicolon, insert "and"

Page 6, line 13, delete "; and" and insert a period

Page 6, delete line 14

Page 8, line 10, before "Fraudulent" insert "(a)"

Page 8, after line 13, insert:

"(b) In addition to any other penalty applicable in law, a qualifying patient is guilty of a felony and may be sentenced to imprisonment for not more than two years or to payment of a fine of not more than $3,000, or both, if the patient:

(1) sells, transfers, loans, or otherwise gives another person the patient's registry identification card; or

(2) sells, transfers, loans, or otherwise gives another person marijuana obtained under sections 152.22 to 152.31."

Page 8, line 26, after "(a)" insert "Subject to paragraph (c),"

Page 8, line 27, delete everything after "who"

Page 8, line 28, delete everything before "provides"

Page 9, line 3, delete "and"

Page 9, after line 3, insert:

"(4) a bond in the amount of $100,000; and"

Page 9, line 4, delete "(4)" and insert "(5)"

Page 9, after line 9, insert:

"(c) No more than 25 registered organizations may be licensed by the commissioner at one time. The commissioner shall attempt to ensure that licenses are issued in a manner that provides for geographic disbursement of registered organizations throughout the state."

Page 9, delete subdivision 4

Page 9, line 20, delete "5" and insert "4"

Page 9, line 21, delete "rules" and insert "laws"

Page 9, delete subdivision 6 and insert:

"Subd. 5. **Organization requirements.** (a) Registered organizations must be organized as a nonprofit corporation under chapter 317A or a similar law of another state.

(b) Registered organizations may not be located within 500 feet of the property line of a public school, private school, or structure used primarily for religious services or worship.

(c) The articles or bylaws of a registered organization shall include procedures for the oversight of the registered organization and procedures to ensure adequate record keeping.

(d) A registered organization shall notify the commissioner within ten days of when an employee or agent ceases to work at the registered organization.

(e) The registered organization shall notify the commissioner before a new agent or employee begins working at the registered organization, in writing, and the organization shall submit a $10 fee for the person's registry identification card.

(f) No registered organization shall be subject to prosecution, search, seizure, or penalty in any manner or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business, occupational, or professional licensing board or bureau, for acting according to sections 152.22 to 152.31 to assist registered qualifying patients to whom it is connected through the commissioner's registration process with the medical use of marijuana, provided that the registered organization possesses an amount of marijuana that does not exceed the total of the allowable amounts of marijuana for the registered qualifying patients for whom the organization is a registered primary supplier.

(g) No employees, agents, or board members of a registered organization shall be subject to arrest, prosecution, search, seizure, or penalty in any manner or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business, occupational, or professional licensing board or bureau, for working for a registered organization according to sections 152.22 to 152.31.

(h) The registered organization is prohibited from:

(1) obtaining marijuana from outside the state in violation of federal law; or

(2) acquiring, possessing, cultivating, manufacturing, delivering, transferring, transporting, supplying, or dispensing marijuana for any purpose except to assist registered qualifying patients with the medical use of marijuana directly or through the qualifying patients' other primary suppliers.

(i) If provisions of this section are enjoined or declared unconstitutional, then enforcing laws against delivery of marijuana for consideration to registered qualifying patients shall be the lowest priority of law enforcement.

(j) The director of a registered organization shall ensure that all current and prospective employees and agents of the organization have undergone criminal background checks. The check shall include:

(1) systems accessible through the criminal justice data communications network, including, but not limited to, criminal history, predatory offender registration, warrants, and driver license record information from the Department of Public Safety;

(2) the statewide supervision system maintained by the Department of Corrections; and

(3) national criminal history information maintained by the Federal Bureau of Investigation.

The subject of the check shall provide the director with a written authorization to conduct the check of these systems and a set of fingerprints, which shall be sent to the Bureau of Criminal Apprehension. The bureau shall exchange the fingerprints with the FBI to facilitate the national background check. The superintendent may recover fees associated with the background checks from the registered organization.

Subd. 6. **Penalty** The registered organization may not possess an amount of marijuana that exceeds the total of the allowable amounts of marijuana for the registered qualifying patients for whom the organization is a registered primary supplier. The registered organization may not dispense, deliver, or otherwise transfer marijuana to a person other than a qualifying patient or the patient's primary supplier. A knowing violation of this subdivision is a felony punishable by imprisonment for not more than two years or by payment of a fine of not more than $3,000, or both. This penalty is in addition to any other penalties applicable in law.

Subd. 7. **Records.** The registered organization shall keep records of the names of qualifying patients and primary suppliers receiving marijuana from the organization and the amounts received. The organization shall forward these records to the commissioner on a quarterly basis. The commissioner shall maintain this data as private data on individuals."

Page 10, line 25, delete "9" and insert "8"

4.1 Renumber the sections in sequence and correct the internal references

4.2 Amend the title accordingly

Medical Marijuana: Myths Versus Reality

There are many myths about S.F. 1973 and whether terminal and chronically ill Minnesota patients should have access to limited amounts of marijuana if their physician has recommended its use in writing.

Myth: The public opposes allowing terminal and chronically ill patients to use marijuana if their physician has recommended it as a treatment option.

> **Reality:** In a statewide Zogby survey of likely voters, Minnesotans said by a two to one margin that they support allowing "people with cancer, MS and other serious illnesses to use and grow their own marijuana for medical purposes, as long as their physician approves." A national poll of respondents 45 and older conducted by AARP found that 72% agree that adults should be allowed to legally use marijuana for medical purposes if a physician recommends it. And a December 2002 Time/CNN poll showed 80% support nationwide.

Myth: Permitting terminal and chronically ill patients to posses and use marijuana with their physician's recommendation sends the wrong message to children.

> **Reality:** Again, by a two to one margin in the statewide Zogby poll, Minnesota adults said enacting medical marijuana legislation "would not send the wrong message to children." Minnesota's parents know that their children understand patients using marijuana and morphine or other narcotics in a hospice with their physician's approval is different than using these drugs outside a medical setting.

Myth: Law enforcement officials in states with medical marijuana laws find them a problem.

> **Reality:** The reality is that, to the best of our knowledge, no law enforcement organization in any of the 11 states is seeking repeal of the medical marijuana law in their state. A federal Government Accountability Office (GAO) report entitled "Marijuana: Early Experiences with Four States' Laws That Allow for Medical Purposes" reported "Law enforcement officials in the selected states also told us that, given the range of drug issues, other illicit drug concerns, such as rampant methamphetamine abuse or large-scale marijuana production are higher priorities than concerns about abuse of medical marijuana." (page 33).

Myth: The federal government has made terminal and chronically ill patients using marijuana a top priority.

> **Reality:** "We have never targeted the sick and dying, but rather criminals engaged in drug trafficking,"-- Drug Enforcement Administration spokesperson, Bill Grant. "From an enforcement standpoint, the federal government is not going to be

crashing into people's homes trying to determine what kind of medicine they're taking," -- Asa Hutchinson, former DEA Administrator.

Myth: We can't approve medical marijuana legislation because it violates federal law.

Reality: According to the Congressional Research Service's 2006 report, Medical Marijuana: Review and Analysis of Federal and State Policies, "State medical marijuana laws do not attempt to overturn or otherwise violate federal laws that prohibit doctors from writing prescriptions for marijuana and pharmacies from distributing it. In the 10 states with medical marijuana programs, doctors do not actually prescribe marijuana, and the marijuana products used by patients are not distributed through pharmacies. Rather, doctors *recommend* marijuana to their patients, and the cannabis products are grown by patients or their caregivers, or they are obtained from cooperatives or other alternative dispensaries."

Myth: Minnesota's doctors and nurses oppose medical marijuana

Reality: The Minnesota Nurses Association has endorsed S.F. 1973. Thousands of Minnesota physicians and nurses have signed a petition in support of allowing their patients to use medical marijuana, when appropriate. The Minnesota Medical Association does not oppose this bill. Further, the Minnesota Public Health Association, the Minnesota AIDS Project and the Minnesota Senior Federation have all endorsed allowing terminal and chronically ill patients to use marijuana in consultation with their physician.

Myth: National medical organizations oppose medical marijuana

Reality: The American Medical Association changed its position in 1997 on medical marijuana from "oppose" to "neutral" in light of the medical evidence that marijuana provides significant medical benefits to certain patients. Further, the AMA supports a physician's right to discuss marijuana therapy with patients. The American Academy of Family Physicians, the American Academy of HIV Medicine and the American Nurses Association have endorsed medical marijuana. It is believed that no state or national health care provider organization supports incarcerating seriously ill patients who use medical marijuana with their physicians' recommendations.

Myth: There is no real evidence that marijuana provides medical benefits to terminal and chronically ill patients.

Reality: The Institute of Medicine of the National Academy of Sciences issued a report in 1999 titled "Marijuana and Medicine: Assessing the Science Base". The conclusion of these federal medical researchers was that "The accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation." The scientists who wrote the report also concluded that "there are

some limited circumstances in which we recommend smoking marijuana for medical uses."

Myth: Minnesota would be the first state to enact this law. Let another state go first.

Reality: Eleven other states – Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, Oregon, Rhode Island, Vermont and Washington have laws that protect medical marijuana patients from arrest and prison. These 11 states contain over 60 million residents, more than 20% of the nation's population. In 8 of these states – 4 Red and 4 Blue -- the law was enacted by a vote of the people through a statewide ballot initiative. The most recent initiative was in Montana in 2004, where a medical marijuana initiative received 62% of the vote, compared to President Bush's 57% vote total.

Myth: Passage of S.F. 1973 will result in more marijuana use by Minnesota's youth.

Reality: Nationwide, teenage marijuana use has decreased in the ten years since California first enacted its medical marijuana law. Overall, the trends in states with medical marijuana laws are slightly more favorable than the trends nationwide, according to a statistical analysis of drug use data among youth in states.

Myth: The medical marijuana laws passed by other states have failed and political leaders in those states are seeking their repeal.

Reality: To our knowledge, no governor, attorney general or legislative leader in any of the 11 states that have enacted medical marijuana laws are seeking the repeal of the medical marijuana law in their state. Medical marijuana laws are popular with voters, who believe that terminal and chronically ill patients -- and their physicians --should be free to make treatment decisions without the intrusion of politicians.

Myth: S.F. 1973 weakens criminal penalties on terminal and chronically ill patients with marijuana.

Reality: S.F. 1973 *toughens* criminal penalties on patients who possess more than the permitted 2.5 ounces of marijuana. S.F. 1973 increases the penalty for terminal and chronically ill patients possessing more than 2.5 ounces of marijuana to a felony.

Myth: Patients in other states have abused their state's medical marijuana laws.

Reality: A study by the Colorado Department of Public Health and the Environment found that only one patient has been arrested for violating the law's provisions since Colorado's medical marijuana law took effect in 2001. This is a compliance rate that exceeds 99.9%.

"[W]e concluded that there are some limited circumstances in which we recommend smoking marijuana for medical uses."

— from Principal Investigator Dr. John Benson's opening remarks at IOM's 3/17/99 news conference

Questions about medical marijuana answered by the Institute of Medicine's report

Marijuana and Medicine: Assessing the Science Base*

Excerpts compiled by the Marijuana Policy Project

What conditions can marijuana treat?

"The accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation." [p. 3]

"[B]asic biology indicates a role for cannabinoids in pain and control of movement, which is consistent with a possible therapeutic role in these areas. The evidence is relatively strong for the treatment of pain and, intriguing although less well established, for movement disorders." [p. 70]

"For patients such as those with AIDS or who are undergoing chemotherapy and who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad-spectrum relief not found in any other single medication. The data are weaker for muscle spasticity but moderately promising." [p. 177]

"The most encouraging clinical data on the effects of cannabinoids on chronic pain are from three studies of cancer pain." [p. 142]

Why can't patients use medicines that are already legal?

"[T]here will likely always be a subpopulation of patients who do not respond well to other medications." [Pp. 3, 4]

"The critical issue is not whether marijuana or cannabinoid drugs might be superior to the new drugs, but whether some group of patients might obtain added or better relief from marijuana or cannabinoid drugs." [p. 153]

"The profile of cannabinoid drug effects suggests that they are promising for treating wasting syndrome in AIDS patients. Nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana. Although some medications are more effective than marijuana for these problems, they are not equally effective in all patients." [p. 159]

What about Marinol®, the major active ingredient in marijuana in pill form?

"It is well recognized that Marinol's oral route of administration hampers its effectiveness because of slow absorption and patients' desire for more control over dosing." [Pp. 205, 206]

Why not wait for more research before making marijuana legally available as a medicine?

"[R]esearch funds are limited, and there is a daunting thicket of regulations to be negotiated at the federal level (those of the Food and Drug Administration, FDA, and the Drug Enforcement Administration, DEA) and state levels." [p. 137]

"Some drugs, such as marijuana, are labeled Schedule I in the Controlled Substance Act, and this adds considerable complexity and expense to their clinical evaluation." [p. 194]

"[O]nly about one in five drugs initially tested in humans successfully secures FDA approval for marketing through a new drug application." [p. 195]

"From a scientific point of view, research is difficult because of the rigors of obtaining an adequate supply of legal, standardized marijuana for study." [p. 217]

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"In short, development of the marijuana plant is beset by substantial scientific, regulatory, and commercial obstacles and uncertainties." [p. 218]

"[D]espite the legal, social, and health problems associated with smoking marijuana, it is widely used by certain patient groups." [p. 7]

Do the existing laws really hurt patients?

"G.S. spoke at the IOM workshop in Louisiana about his use of marijuana first to combat AIDS wasting syndrome and later for relief from the side effects of AIDS medications. ... [He said,] 'Every day I risk arrest, property forfeiture, fines, and imprisonment.' " [Pp. 27, 28]

Why shouldn't we wait for new drugs based on marijuana's components to be developed, rather than allowing patients to eat or smoke natural marijuana right now?

"Although most scientists who study cannabinoids agree that the pathways to cannabinoid drug development are clearly marked, there is no guarantee that the fruits of scientific research will be made available to the public for medical use." [p. 4]

"[I]t will likely be many years before a safe and effective cannabinoid delivery system, such as an inhaler, is available for patients. In the meantime there are patients with debilitating symptoms for whom smoked marijuana might provide relief." [p. 7]

"[W]hat seems to be clear from the dearth of products in development and the small size of the companies sponsoring them is that cannabinoid development is seen as especially risky." [Pp. 211, 212] *[IOM later notes that it could take more than five years and cost $200-300 million to get new cannabinoid drugs approved—if ever.]*

"Cannabinoids in the plant are automatically placed in the most restrictive schedule of the Controlled Substances Act, and this is a substantial deterrent to development." [p. 219]

Isn't marijuana too dangerous to be used as a medicine?

"[E]xcept for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications." [p. 5]

"Until the development of rapid onset antiemetic drug delivery systems, there will likely remain a subpopulation of patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. It is possible that the harmful effects of smoking marijuana for a limited period of time might be outweighed by the antiemetic benefits of marijuana, at least for patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. Such patients should be evaluated on a case-by-case basis and treated under close medical supervision." [p. 154]

"Terminal cancer patients pose different issues. For those patients the medical harm associated with smoking is of little consequence. For terminal patients suffering debilitating pain or nausea and for whom all indicated medications have failed to provide relief, the medical benefits of smoked marijuana might outweigh the harm." [p. 159]

What should be done to help the patients who already benefit from medical marijuana, prior to the development of new drugs and delivery devices?

"Patients who are currently suffering from debilitating conditions unrelieved by legally available drugs, and who might find relief with smoked marijuana, will find little comfort in a promise of a better drug 10 years from now. In terms of good medicine, marijuana should rarely be recommended unless all reasonable options have been eliminated. But then what? It is conceivable that the medical and scientific opinion might find itself in conflict with drug regulations. This presents a policy issue that must weigh—at least temporarily—the needs of individual patients against broader social issues. Our assessment of the scientific data on the medical value of marijuana and its constituent cannabinoids is but one component of attaining that balance." [p. 178]

"Also, although a drug is normally approved for medical use only on proof of its 'safety and efficacy,' patients with life-threatening conditions are sometimes (under protocols for 'compassionate use') allowed access to unapproved drugs whose benefits and risks are uncertain." [p. 14]

"Until a nonsmoked rapid-onset cannabinoid drug delivery system becomes available, we acknowledge that there is no clear alternative for people suffering from *chronic* conditions that might be relieved by smoking marijuana, such as pain or AIDS wasting. One possible approach is to treat patients as *n*-of-1 clinical trials (single-patient trials), in which patients are fully informed of their status as experimental subjects using a harmful drug delivery system and in which their condition is closely monitored and documented under medical supervision. ..." [p. 8] *[The federal government's "compassionate use" program, which currently provides marijuana to seven patients nationwide, is an example of an n-of-1 study.]*

The IOM report doesn't explicitly endorse state bills and initiatives to simply remove criminal penalties for bona fide medical marijuana users. Does that mean that we should keep the laws exactly as they are and keep arresting patients?

"This report analyzes science, not the law. As in any policy debate, the value of scientific analysis is that it can provide a foundation for further discussion. Distilling scientific evidence does not in itself solve a policy problem." [p. 14]

If patients were allowed to use medical marijuana, wouldn't overall use increase?

"Finally, there is a broad social concern that sanctioning the medical use of marijuana might increase its use among the general population. At this point there are no convincing data to support this concern. The existing data are consistent with the idea that this would not be a problem if the medical use of marijuana were as closely regulated as other medications with abuse potential. ... [T]his question is beyond the issues normally considered for medical uses of drugs and should not be a factor in evaluating the therapeutic potential of marijuana or cannabinoids." [Pp. 6, 7]

"No evidence suggests that the use of opiates or cocaine for medical purposes has increased the perception that their illicit use is safe or acceptable." [p. 102]

"Thus, there is little evidence that decriminalization of marijuana use necessarily leads to a substantial increase in marijuana use." [p. 104]
[Decriminalization is defined as the removal of criminal penalties for all uses, even recreational.]

Doesn't the medical marijuana debate send children the wrong message about marijuana?

"[T]he perceived risk of marijuana use did not change among California youth between 1996 and 1997. In summary, there is no evidence that the medical marijuana debate has altered adolescents' perceptions of the risks associated with marijuana use." [p. 104]

"Even if there were evidence that the medical use of marijuana would decrease the perception that it can be a harmful substance, this is beyond the scope of laws regulating the approval of therapeutic drugs. Those laws concern scientific data related to the safety and efficacy of drugs for individual use; they do not address perceptions or beliefs of the general population." [p. 126]

Isn't marijuana too addictive to be used as a medicine?

"Some controlled substances that are approved medications produce dependence after long-term use; this, however, is a normal part of patient management and does not generally present undue risk to the patient." [p. 98]

"Animal research has shown that the potential for cannabinoid dependence exists, and cannabinoid withdrawal symptoms can be observed. However, both appear to be mild compared to dependence and withdrawal seen with other drugs." [p. 35]

"A distinctive marijuana and THC withdrawal syndrome has been identified, but it is mild and subtle compared with the profound physical syndrome of alcohol or heroin withdrawal." [Pp. 89, 90]

Drug Category	Proportion Of Users That Ever Became Dependent (%)
Alcohol	15
Marijuana (including hashish)	9

[p. 95]

"Compared to most other drugs ... dependence among marijuana users is relatively rare." [p. 94]

"In summary, although few marijuana users develop dependence, some do. But they appear to be less likely to do so than users of other drugs (including alcohol and nicotine), and marijuana dependence appears to be less severe than dependence on other drugs." [p. 98]

Doesn't the use of marijuana cause people to use more dangerous drugs?

"[I]t does not appear to be a gateway drug to the extent that it is the *cause* or even that it is the most significant predictor of serious drug abuse; that is, care must be taken not to attribute cause to association." [p. 101]

"There is no evidence that marijuana serves as a stepping stone on the basis of its particular physiological effect." [p. 99]

"Instead, the legal status of marijuana makes it a gateway drug." [p. 99]

Shouldn't medical marijuana remain illegal because it is bad for the immune system?

"The short-term immunosuppressive effects are not well established; if they exist at all, they are probably not great enough to preclude a legitimate medical use. The acute side effects of marijuana use are within the risks tolerated for many medications." [p. 126]

Doesn't marijuana cause brain damage?

"Earlier studies purporting to show structural changes in the brains of heavy marijuana users have not been replicated with more sophisticated techniques." [p. 106]

Doesn't marijuana cause amotivational syndrome?

"When heavy marijuana use accompanies these symptoms, the drug is often cited as the cause, but no convincing data demonstrate a causal relationship between marijuana smoking and these behavioral characteristics." [Pp. 107, 108]

Doesn't marijuana cause health problems that shorten the life span?

"[E]pidemiological data indicate that in the general population marijuana use is not associated with increased mortality." [p. 109]

Isn't marijuana too dangerous for the respiratory system?

"Given a cigarette of comparable weight, as much as four times the amount of tar can be deposited in the lungs of marijuana smokers as in the lungs of tobacco smokers." [p. 111]

"However, a marijuana cigarette smoked recreationally typically is not packed as tightly as a tobacco cigarette, and the smokable substance is about half that in a tobacco cigarette. In addition, tobacco smokers generally smoke considerably more cigarettes per day than do marijuana smokers." [Pp. 111, 112]

"There is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use. ... More definitive evidence that habitual marijuana smoking leads or does not lead to respiratory cancer awaits the results of well-designed case control epidemiological studies." [p. 119]

Don't the euphoric side effects diminish marijuana's value as a medicine?

"The high associated with marijuana is not generally claimed to be integral to its therapeutic value. But mood enhancement, anxiety reduction, and mild sedation can be desirable qualities in medications—particularly for patients suffering pain and anxiety. Thus, although the psychological effects of marijuana are merely side effects in the treatment of some symptoms, they might contribute directly to relief of other symptoms." [p. 84]

What other therapeutic potential does marijuana have?

"One of the most prominent new applications of cannabinoids is for 'neuroprotection,' the rescue of neurons from cell death associated with trauma, ischemia, and neurological diseases." [p. 211]

"There are numerous anecdotal reports that marijuana can relieve the spasticity associated with multiple sclerosis or spinal cord injury, and animal studies have shown that cannabinoids affect motor areas in the brain—areas that might influence spasticity." [p. 160]

"High intraocular pressure (IOP) is a known risk factor for glaucoma and can, indeed, be reduced by cannabinoids and marijuana. However, the effect is too and [sic] short lived and requires too high doses, and there are too many side effects to recommend lifelong use in the treatment of glaucoma. The potential harmful effects of chronic marijuana smoking outweigh its modest benefits in the treatment of glaucoma. Clinical studies on the effects of smoked marijuana are unlikely to result in improved treatment for glaucoma." [p. 177] *[Note that IOM found that marijuana does work for glaucoma, but was uncomfortable with the amount that a person needs to smoke. Presumably, it would be an acceptable treatment for glaucoma patients to eat marijuana. Additionally, MPP believes that IOM would not support arresting patients who choose to smoke marijuana to treat glaucoma.]*

Do the American people really support legal access to medical marijuana, or were voters simply tricked into passing medical marijuana ballot initiatives?

"Public support for patient access to marijuana for medical use appears substantial; public opinion polls taken during 1997 and 1998 generally report 60-70 percent of respondents in favor of allowing medical uses of marijuana." [p. 18]

But shouldn't we keep medical marijuana illegal because some advocates want to "legalize" marijuana for all uses?

"[I]t is not relevant to scientific validity whether an argument is put forth by someone who believes that all marijuana use should be legal or by someone who believes that any marijuana use is highly damaging to individual users and to society as a whole." [p. 14]

The full report by the National Academy of Sciences can be viewed on-line at
http://bob.nap.edu/books/0309071550/html/

Colorado's Medical Marijuana Registry Program
An Historical Overview

Colorado's Medical Marijuana Registry Program was approved by voters in the November 2000 General Election, and was incorporated as an amendment to Colorado's constitution after being signed into law by Governor Owens in 2001. Colorado's Department of Public Health and Environment was tasked with administering the program, and the Registry began accepting applications for the use of medical marijuana on June 1, 2001.

As a voter-approved initiative, Colorado is not unique, as Alaska, California, Maine, Nevada, Oregon, and Washington all put the issue to approve medical marijuana use on their ballots. Colorado and Nevada have initiatives that are constitutional amendments, with all the other states' laws being statutory in nature. Hawaii and Vermont have approved medical marijuana use through their legislative processes, and Maryland has passed an affirmative defense law that protects patients from jail if they are arrested for medical marijuana use.

Colorado's program was modeled after Oregon's, and requires that patients go through an application process that, once completed, allows them to use marijuana for approved conditions, which under Colorado law are defined as cancer, glaucoma, HIV/AIDS, cachexia, severe pain, severe nausea, seizures (including those that are characteristic of epilepsy) and muscle spasms (including those that are characteristic of multiple sclerosis). Conditions may be added by petitioning the Board of Health, however, to date, only two petitions to add conditions have been received (one for Parkinson's disease and one for Bi-Polar disease), and both were denied due to insufficient scientific evidence that treatment with marijuana might have a beneficial effect.

Once a patient has received their doctor's written approval and recommendation that thy believe treatment with marijuana might have a beneficial effect, and once the Registry approves

the application, the patient receives a card that they may present if they are ever stopped or questioned by authorities. Law enforcement agencies around the state have been given trainings by the Registry regarding this program, and patients who are in compliance with the law and who present their Registry ID card have been saved from arrest, prosecution and jail numerous times throughout the past several years.

Colorado's program allows for patients to possess up to two (2) ounces of usable marijuana, as well as grow up to six (6) plants, with no more than three (3) of those plants being flowering or mature at any given time. Patients may also enlist the help of a caregiver, who is a person defined by law as "someone who is over the age of eighteen (18) and who has significant responsibility for managing the health and well-being of the patient." The caregiver is provided all the same protections under the law as the patient with regards to acquisition, transportation, manufacturing, growing and production of marijuana. However, caregivers do not receive cards (as patients do) but the caregiver's name is listed on the patient's card if they have been designated.

Of course, the law does contain several prohibitions for patients, to include using their medicine in public or in a place open to or in view of the general public. Patients may not drive while under the influence of marijuana, and they may not use their medicine in any way that may cause harm to another person's health or well-being. The law does not require health insurance companies to pay for the patient's medicine, and it does not mandate that employers allow their employees to use medical marijuana in the workplace.

There is a fee associated with Colorado's program. When the Registry was implemented, a budgetary overview determined that $140 per patient per year would cover all costs associated with the Registry. (The General Assembly did give the Department of Public Health a $20,000

start-up fee, but no other taxpayer dollars have ever been used to support this program, and it has been self-sufficient since its inception.) The Board of Health is required to review the fee every year, and on June 1st, 2004, the fee was lowered to $110 per patient per year.

Regarding growth of the program, the first year saw approximately 200 people apply to use medical marijuana, and the Registry now has over 1000 new applicants in the 4 ½ years it has been operating. There is approximately a 63% renewal rate among applicants each year, with the other 37% of patients not renewing because they no longer need or want to use medical marijuana, or they have died, or have moved out of state. Monthly updates are published by the Registry, and can be viewed at:

http://www.cdphe.state.co.us/hs/medicalmarijuana/marijuanafactsheet.asp.

Despite the fact that medical marijuana use is not always accepted within the law enforcement community as legitimate, the trainings the Registry has provided state-wide have helped to bring this issue to the attention of police, state troopers, sheriffs, and district attorneys, and to date, there has been only one marijuana-related conviction of a patient on the Registry. Also, no Colorado physicians have experienced federal reprisals, and doctors have also received trainings by the Registry regarding the processes and procedures of approving medical marijuana use for their patients.

One of the biggest challenges the Registry has faced is the questions that have arisen surrounding the interpretation of statutory language. For instance, the law does not clearly state where marijuana plants may be grown, how many patients one caregiver may care for, or if two or more patients and/or caregivers may share one growing space. Statutory language also places certain burdens upon local and state law enforcement officers, such as the requirement of keeping alive plants that are confiscated until a resolution is reached (i.e. a decision not to

prosecute, the dismissal of charges, or an acquittal). Overall, however, the Registry has operated

If you need any further information, please contact Debra Tuenge, Administrator, Colorado Medical Marijuana registry at debra.tuenge@state.co.us, or via phone at 303-692-2184.

Summary of the GAO Report:
Marijuana: Early Experiences with Four States' Laws That Allow Use for Medical Purposes

•This report was conducted at the request of Mark Souder, chairman of the Subcommittee on Criminal Justice, Drug Policy, and Human Resources, Committee on Government Reform, U.S. House of Representatives.

•The bulk of this study provides an assessment of the medical marijuana laws of Oregon, Alaska, Hawai`i, and California.

- •The report cites useful information on the number of medical users in each state and outlines the laws and what maladies are covered by those laws.

- •In this analysis, the researchers comment on the small number of patients who are registered, and the paucity of doctors prescribing.

•The researchers recognize that there is no concrete data on how marijuana related law enforcement has been affected by medical marijuana laws.

• Most of the 37 selected law enforcement organizations interviewed in the report "indicated that medical marijuana laws had had little impact on their law enforcement activities for a variety of reasons." (pg 32) The report mentioned several illustrations of lack of conflict.

- • Specifically, "very few or no encounters involving medical marijuana registry cards or claims of a medical marijuana defense" were cited. (p. 32)

- • "In Alaska, a top official for the State Troopers Drug Unit had never encountered a medical marijuana registry card in support of claimed medical use." (p. 32)

- •"In Los Angeles County, an official in the District Attorney's office stated that only three medical marijuana cases have been filed in the last two years in the Central Branch office, two of the cases involving the same person." (p. 32)

- • "Law enforcement officials in the selected states also told us that, given the range of drug issues, other illicit drug concerns, such as rampant methamphetamine abuse or large-scale marijuana production are higher priorities than concerns about abuse of medical marijuana." (p. 33)

•Two specific questions were worded in such a way that could give an inflated view of the level of concern among law enforcement about medical marijuana laws. Regardless, both instances indicate that only a small minority of law enforcement officials have any problems with their states' medical marijuana laws.

- •"Over one-third of officials from the 37 law enforcement organizations told us that they believe that the introduction of medical marijuana laws have, or could make it, more difficult to pursue or prosecute some marijuana cases." (pp. 33-34)

- •"Officials in over one-fourth of the 37 law enforcement organizations we interviewed indicated they believe there has been a general softening in public attitude toward marijuana or public perception that marijuana is no longer illegal." (p. 34)

- • Given the general wording of the questions, it shows that law enforcement in medical marijuana states have largely made peace with the laws.

The entire report can be downloaded at www.gao.gov/new.items/d03189.pdf

CITY AND COUNTY OF SAN FRANCISCO OFFICE OF THE DISTRICT ATTORNEY

KAMALA D. HARRIS
District Attorney

The position of the San Francisco District Attorney's Office remains consistent: We will not prosecute people who use or provide marijuana for medicinal purposes.

Caretakers and providers who abide by the law deserve no less protection. Taking away safe access to this medicine will not stop patients from using medical marijuana. On the contrary, fear of arrest or prosecution by federal authorities could discourage patients and their caregivers from safely accessing medical marijuana and force them to turn to other, more dangerous means. That threatens the safety of the frail and elderly and puts communities at risk.

We believe it is a much smarter use of law enforcement resources to focus on real threats to community safety, such the as trafficking and production of methamphetamine, heroin, and crack cocaine. My office has been working with a medical marijuana advisory group – a group of leaders from the medical marijuana community—to ensure that patients have safe access to the medicine they need to relieve their pain and prolong their lives.

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My name is Jerome Schaffer, and I am 63 years old. From 1958-1961, I served in the U.S. Air Force. Today I am a retired machinist. In February 2004, I was diagnosed with stage three colorectal cancer. A grueling eight-hour surgery removed a six-pound tumor and almost half of my intestine.

When I regained my strength in May, I began intense chemotherapy treatments. Beyond the complications generally caused by chemotherapy -- the nausea, the pain, the weight loss, the sleep loss -- I suffered severe intestinal blockages that, because of the earlier surgery, were a cause for great concern.

A friend of mine who was also undergoing chemotherapy told me that marijuana was effective at treating his pain and nausea. Unfortunately, my friend is no longer with us, having lost his battle. But I thank him to this day for his advice. I tried the marijuana he gave me, and to my shock and relief it actually worked. A small amount of marijuana has the ability to calm my nausea and to ease my pain. Medical marijuana improves my appetite, and helps to ease the pain so that I can sleep at night. Of all the medication I have taken in my long ordeal, I can safely say that medical marijuana worked better than any other.

I didn't come easily to marijuana. I am a man who believes in following the law and doing what is right. And I fought hard without marijuana. I handled the first two rounds of chemo better than most. I was still able to eat and kept most of my weight on. But the third treatment hit me like a ton of bricks. I couldn't eat or sleep, was extremely nauseated, and went from 170 pounds down to 125. It was only then that I gave medical marijuana a try.

In July 2004, roughly two months after beginning chemo, I was readmitted to the hospital because of, again, severe intestinal blockage. I spent roughly a week and a half there. When I was discharged from the hospital, I was prescribed percodan, a high-powered narcotic, because I had been on a morphine pump while in the hospital. After leaving the hospital, I stopped and bought marijuana. Later, on highway 35E around mid-afternoon, I got a flat tire and called a friend for help. Before he could arrive, the police pulled behind me. Forgetting that one of the medications in the truck was illegal, I made no attempt to conceal the medical marijuana.

Handcuffs were put around my hospital bracelet, and the officers ridiculed me for possessing marijuana. I have never felt so humiliated in all my life. Standing there on the highway, as the rush-hour traffic went by, I thought back on my years of proud service to this nation. There I was, a law-abiding, tax paying citizen, being paraded up and down the highway, handcuffed like a common criminal.

Instead of leaving the hospital for the warm comfort of my own bed, I spent that night locked up in a jail cell. To make matters worse, the police confiscated the percodan the hospital gave me. I wouldn't wish a night like that on my worst enemy.

I was charged with possession of marijuana and given a fine as well as 100 hours of community service and 18 months of supervised probation when my case was adjudicated in September. I now check in with a probation officer on a regular basis who makes sure that I am not using the only medication that relieves the pain, nausea, and discomfort associated with my chemotherapy.

Shortly after my arrest, I told one of my oncologists -- whom I would rather not name at this time -- that I was using medical marijuana. He prescribed me marinol, which is a synthetic derivative, and told me to give it a shot. He told me that he had not had much success with it, but I figured it was worth a try. Not wanting to go back to jail, I tried it. It didn't work.

Despite the consequences, I returned -- with my doctor's blessing -- to medical marijuana. I don't think I belong in jail for doing so. It is still the only medication that gives me relief.

While nothing can change what I have gone through so far, I am proud to be here so that others might not be treated as I was. I look forward to answering any of your questions.

Thank you for giving me this chance to speak, and thank you for considering this important issue.

My name is Darrell Paulsen.

I am 35 years old and live with cerebral palsy. I was diagnosed with this disability about eight months after my birth, and I have lived with intense muscle spasticity ever since. I have little or no use of my legs, and my left arm might as well be nonexistent, because I am unable to do much of anything with it. I live my life from a power wheelchair.

I live with disability. I deal with it every day. I know that I am different from most other people and I have slowly learned to accept and even celebrate this part of me.

I first realized that medical marijuana helped to alleviate my symptoms by reducing my spasticity and increasing my appetite nearly 20 years ago. It has always been effective medicine for me, and I have used it in consultation with my doctor.

About two years ago, my doctor wrote me a prescription for Marinol -- the THC pill -- but I have found it to be far less effective than marijuana in treating my spasticity and stimulating my appetite. Marinol also has more severe side effects, including grogginess, disorientation, and nausea. I can say from personal experience that Marinol is not a sufficient substitute for medical marijuana.

I am inspired to join these patients speaking before you. It takes a lot of courage for us to risk our health care, housing, education, transportation, and most importantly, our liberty, to testify before you today. These are all things that people who aren't disabled take for granted on a daily basis, but they are things that medical marijuana patients are forced to risk simply to live more normal lives.

I would like to leave this committee with one fundamental question: Is Minnesota a better place with me and my fellow patients locked behind bars, or receiving the treatment our doctors recommend?

Thank you for your time.

My name is Jason McDonough but you can call me Jay-Jay. I live in New Richland, Minnesota and am 37 years old.

Seven years ago the helicopter that I was piloting had an inflight mechanical failure. As a result of the crash, I have lost the use of my legs, and am in constant neorogenic pain. My feet have the sensation of being recently burned and also have a stabbing sensation of pins and needles. This pain never stops.

For some time following the accident, friends and family members told me that they had heard that marijuana is often used to reduce pain and nausea, and to increase appetite in those suffering chronic pain. I eventually decided to try medical marijuana, despite my fear of arrest for breaking Minnesota law.

Though medical marijuana is of course no miracle cure, I have found it very effective at reducing my neurogenic pain. By reducing my pain, it has allowed me to rely less heavily on the powerful and addictive pain medications that I am legally prescribed.

I have never discussed my use of medical marijuana with my doctor because of the stigma attached to the use of an illegal drug. In fact, it is only with great fear and apprehension that I sit before you today, but I consider this matter too important for me to remain silent.

It is my hope that this legislation will remove the fear that surrounds medical marijuana, so that I can discuss it with my doctor and determine the best way for medical marijuana to fit into my regimen of daily medications.

Thank you for your time. I look forward to answering any of your questions.

From Ada to Zumbrota and from Duluth to Worthington, more than 2,700 Minnesota doctors and nurses support medical marijuana

"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 criminal sanctions for using marijuana if the patients' physicians have told them that such use is likely to be beneficial."

Signed,

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Please support S.F. 1973, a bill that would protect seriously ill patients who use medical marijuana with their doctors' recommendations from criminal penalties. For more information, please contact Tom Lehman—(763) 377-9167 or tom@thelehmangroup.com—or visit www.minnesotacares.org.

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(1)

Mr. Chairman, members of the Committee, thank you for the opportunity to appear today. My name is Oliver Steinberg, I am a resident of St. Paul, I speak only on my own behalf, and I will be brief.

I wish to present you with a quick retrospective on this issue with respect to Minnesota; to offer an analysis of the legal or legislative issues at stake, and to consider whether this bill is a proper remedy.

Marijuana was first subject to legislative action in this building in 1935. With your permission, I'll read a sentence or two from the historical record:
(Read from book) Sorry — use your imagination

Notwithstanding the passage of state and federal laws against marijuana, Minnesota farmers harvested 30,000 acres of marijuana in 1943 and 11,000 acres in 1944. Each participating farmer received a narcotics permit and the sheriffs had no problems with these thousands of acres of marijuana at that time.

The federal anti-marijuana law was ruled unconstitutional around 1970, and thereafter the federal government and states rewrote their laws as so-called "controlled substances acts."

These laws made no provision for medicinal use of cannabis, and subsequently 35 states including Minnesota, passed various versions of laws trying to give relief to cancer patients who needed marijuana. Our law was called the THC Therapeutic Act, or some similar title, passed around 1980. This act provided for experimentally providing marijuana to cancer patients; however it was not funded and soon became a dead letter.

In 1989, Gordon Hanson of Roosevelt, MN was arrested for growing marijuana, which he used to relieve symptoms of epilepsy. The District and appeals courts refused to allow Hanson to present evidence of marijuana's medical usefulness or necessity as a defense against the criminal charge in his case. He was convicted and sent to jail.

The reasoning used by the appellate court was this: the legislature's passage of the THC Therapeutic act established legislative intent to permit only cancer patients under the protocol of that bill to lawfully use marijuana for medicine. The court reasoned that the lack of reference to other diseases or conditions established, as a matter of law, that the legislature had considered and rejected other situations besides cancer.

I think the court was mistaken. When the THC act was passed, it was intended to relieve cancer sufferers, but I do not think there was any record to show that other diseases had been intentionally excluded, or that the idea of a defense of medical necessity had been intentionally excluded, from Minnesota law.
The court cited no such record or testimony for its deductions.

In the years since then, a variety of medical marijuana bills have been introduced. When Jesse Ventura was elected Governor, after campaigning openly in favor of medical marijuana, it seemed likely that the bill would move. However, at a 1999 hearing, Mr. Charlie Weaver, having just joined the new Governor's cabinet, sabotaged the Governor's bill at a Senate committee hearing that I am sure Senator Berglin remembers well. So we're still stuck.

As you all know, Minnesota's constitution, in article 1, section 8, , says that every person is entitled to a certain remedy in the laws for all injuries or wrongs which he may receive to his person, property, or character, and to obtain justice freely and without purchase, completely and without denial, promptly and without delay, conformable to the laws.

I suggest that because of the ruling in State v. Hanson, there is a gap in our laws, a situation whereby a small class of citizens are denied a remedy in law. Medical marijuana patients cannot obtain jusitce freely and completely.

If you are arrested and charged with manslaughter or some other awful crime, your lawyer may make a defense of necessity, for example, the principle of self-defense, and depending on the circumstances of the case, the jury may take that defense into account. But in the case of a person who uses marijuana for medical

purposes, which manifestly could be a situation of necessity, the law as it stands says that no jury may take that fact into account.

Courts in other states, notably Florida, have recognized this medical defense. The patient doesn't create his or her medical condition, and if the medicinal properties of marijuana alleviate that condition, the patient is not acting with criminal intent in seeking to make use of the relief.

I do not think that most narcotics investigators and most county prosecutors are foolish or inhumane. They can distinguish easily in most cases when a marijuana offender has a bona fide medical condition, and I think most of them would not believe that the safety of the community is threatened by ill and dying patients. It would be helpful to give these authorities a legal pretext for not arresting, or at least not pursuing charges, against bona fide patients. In uncertain or ambiguous cases, we should at least allow a jury to hear the defendant's side of the case, completely and without denial.

The bill you are considering tries to remedy the ruling in State v. Hanson. I hope you will look at it with care. I do not like all its provisions, myself. Although if our farmers could raise tens of thousands of acres of marijuana, as they did in the forties, without peril to public safety, I see no valid public safety reason to fear this far more limited proposal.

Nevertheless, if I were writing it myself, I would simplify it to this:

"Right to fair trial protected:

No Minnesota statute shall be construed, directly or by implication, to deny a defendant in a criminal procedure, or in a civil or administrative hearing, the right to introduce evidence and testimony of a medical need to use cannabis, or a therapeutic benefit derived from cannabis; such evidence or testimony to be offered as a mitigating or exculpatory circumstance in such proceedings."

Thank you for your attention. Have you any questions?

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Senate
State of Minnesota

S.F. No. 2803 - Drug Paraphernalia Crimes

Author: Senator Amy T. Koch

Prepared by: Chris Turner, Senate Research (651/296-4350) CT\Rer

Date: March 23, 2006

The bill amends current drug paraphernalia law by changing the mental state criteria, specifically criminalizing the sale of drug paraphernalia and making the possession of certain listed "drug paraphernalia-type" items a petty misdemeanor.

Section 1 strikes the "knowingly or intentionally" use clause from the definition of drug paraphernalia (the mental state criteria).

Section 2 explicitly makes selling drug paraphernalia a misdemeanor. Currently, the delivery of drug paraphernalia and the possession or manufacture for delivery is a misdemeanor. However, selling is not specifically addressed. The definition of "sell" in the controlled substance chapter of law is broad. So use of the word "sell" includes, among other conduct, delivering and manufacturing. Changes the mental state criteria for the crime from "knowingly or intentionally" to the easier to establish "knows or has reason to know." Adds the selling drug paraphernalia to a minor (currently codified in Minnesota Statutes, section 152.094) to this section.

Section 3 makes knowing possession of a bong, dugout, glass pipe, marijuana pipe, or one-hit pipe a petty misdemeanor.

Section 4 repeals section 152.094, prohibiting the delivery of drug paraphernalia to a minor. This section is essentially being recodified in section 2.

CT:rer

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Presented by

Chief J. Bruce Preece
Director of Public Safety
City of Bemidji

On behalf of the

MINNESOTA CHIEF'S
of
POLICE ASSOCIATION

CHIEF PREECE Background

35 years law enforcement
25 years drug enforcement

2001-current Bemidji Police Department
1975-01 Bureau of Criminal Apprehension
1974-75 Minnesota State Patrol
1973-74 Bemidji Police Department
1971-73 Beltrami County Sheriff's Dept.

April 20, 2005

THE DEA POSITION ON MARIJUANA

The campaign to legitimize what is called "medical" marijuana is based on two propositions: that science views marijuana as medicine, and that DEA targets sick and dying people using the drug. Neither proposition is true. Smoked marijuana has not withstood the rigors of science – it is not medicine and it is not safe. And DEA targets, not the sick and dying, but criminals engaged in cultivation and trafficking. No state has legalized the trafficking of marijuana, including the eleven states that have decriminalized certain marijuana use. [1]

Smoked Marijuana is Not Medicine

There is no consensus medical evidence that smoking marijuana helps patients. Congress enacted laws against marijuana in 1970 based in part on its conclusion that marijuana has no scientifically proven medical value. In 2001, the Supreme Court affirmed Congress's judgment in *United States v. Oakland Cannabis Buyers' Cooperative et al.*, 532 U.S. 438..

The DEA and the federal government are not alone in viewing smoked marijuana as having no documented medical value. The major voices in the medical community likewise do not accept smoked marijuana as medicine:

- The American Medical Association has rejected pleas to endorse marijuana as medicine, and instead has urged that marijuana remain a prohibited, Schedule I drug, at least until more research is done. [2]

- The American Cancer Society "does not advocate inhaling smoke, nor the legalization of marijuana," although the organization does support carefully controlled clinical studies for alternative delivery methods, specifically a transdermal THC skin patch. [3]

- The American Academy of Pediatrics believes that "[a]ny change in the legal status of marijuana, even if limited to adults, could affect the prevalence of use among adolescents," and therefore opposes the legalization of marijuana while supporting scientific research on the possible use of cannabinoids. [4]

- In 1999, The Institute of Medicine (IOM) released a landmark study reviewing the putative medical properties of marijuana. The study is frequently cited by "medical" marijuana advocates, but in fact severely undermines their arguments. The IOM concluded that "[t]here is little future in smoked marijuana as a medically approved medication." In fact, the study found that there is little or no medical value to smoked marijuana for virtually any ailment it examined including muscle spasticity, movement disorders, epilepsy, or glaucoma. While the report recognized that THC may be potentially therapeutic for some conditions, such as vomiting, nausea, pain, and appetite stimulation, the report recommended that further research be conducted into the possible use, in limited circumstances, for the specific active ingredient THC -- but not smoked marijuana. [5]

- The IOM's conclusions with respect to glaucoma are particularly noteworthy. The IOM found that smoked marijuana is, on the present evidence, largely ineffective as a treatment for the disease – the claims of legalizers notwithstanding. There are six classes of approved drugs and multiple surgical techniques available to treat glaucoma which effectively slow its progression by reducing high intraocular pressure (IOP). The THC in smoked marijuana provides only temporary relief from IOP and would have to be smoked several times a day to achieve consistent results. The availability of medically approved once- or twice-a-day eye drops makes IOP control a reality for many patients and provides round-the-clock IOP reduction. [6]

- The National Multiple Sclerosis Society (NMSS) states that studies done to date "have not provided convincing evidence that marijuana benefits people with MS," and thus that marijuana is not a recommended treatment. Furthermore, the NMSS warns that the "long-term use of marijuana may be associated with significant serious side effects." [7]

- The British Medical Association (BMA) has voiced extreme concern that downgrading the criminal status of marijuana would "mislead" the public into believing that the drug is safe. The BMA maintains that marijuana "has been linked to greater risk of heart disease, lung cancer, bronchitis and emphysema." [8] The Deputy Chairman of the BMA's Board of Science has said that "[t]he public must be made aware of the harmful effects we know result from smoking this drug." [9]

- Rethink, a mental health charity, is "calling for clear health warnings to be issued over the increased risk of developing schizophrenia, and other forms of psychosis, from cannabis use." [10]

DEA has approved and will continue to approve research into whether the active ingredient in marijuana, THC, can be adapted for medical use. Over the last few years, DEA has registered every researcher meeting FDA standards to use marijuana in scientific studies. [11] The Center for Medicinal Cannabis Research (CMCR) conducts

studies "to ascertain the general medical safety and efficacy of cannabis and cannabis products and examine alternative forms of cannabis administration." [12] The CMCR currently has 7 on-going studies involving marijuana and the efficacy of cannabis and cannabis compounds as they relate to medical conditions such as HIV, cancer pain, MS, and nausea. In addition, at least 12 other studies have been approved by DEA to conduct research regarding the potential for therapeutic marijuana. [13]

The proposition that smoked marijuana is "medicine" is false – trickery used by those promoting wholesale legalization. When a statute dramatically reducing penalties for "medical" marijuana took effect in Maryland in October 2003, a defense attorney noted that "[t]here are a whole bunch of people who like marijuana who can now try to use this defense." The attorney observed that lawyers would be "neglecting their clients if they did not try to find out what 'physical, emotional or psychological'" condition could be enlisted to develop a defense to justify a defendant's using the drug. "Sometimes people are self-medicating without even realizing it,' he said." [14]

- Ed Rosenthal, senior editor of *High Times*, a pro-drug magazine, once revealed the cynicism behind the "medical" marijuana movement. While addressing an effort to seek public sympathy for glaucoma patients, he said that, with all the discussion about medical marijuana, "I have to tell you that I also use marijuana medically. I have a latent glaucoma which has never been diagnosed. The reason why it's never been diagnosed is because I've been treating it . . . . I have to be honest," he continued, "there is another reason why I do use marijuana . . . and that is because I like to get high. Marijuana is fun." [15]

- In 2000, *The New York Times* interviewed Ethan Nadelmann, Director of the Lindesmith Center. Responding to criticism that the mecial marijuana issue is a stalking horse for drug legalization, Mr. Nadelmann did not demur. "Will it help lead toward marijuana legalization?' he said. 'I hope so.'" [16]

- Considerable funding of the "medical" marijuana movement is provided, not by grass-roots citizens, but by advocates for across-the-board legalization. According to National Families in Action, just four individuals – George Soros, Peter Lewis, George Zimmer and John Sperling – contributed $1,510,000 to the effort to pass a "medical" marijuana law in California in 1996, a sum representing nearly 60 percent of the total contributions. [17]

- Mr. Soros finances the Lindesmith Center and Drug Strategies. In addition, between 1994 and 1997, Mr. Soros gave $5.5 million to the Drug Policy Foundation. Both the Lindesmith Center and the Foundation support the legalization of marijuana. Mr. Soros has also given generously to marijuana advocacy groups which supported and helped pass "medical" marijuana ballot initiatives in some states. [18]

- The legalization movement is not simply a harmless academic exercise. The mortal danger of thinking that marijuana is "medicine" was graphically

illustrated by a tragic story from California. In the spring of 2004, Irma Perez was "in the throes of her first experience with the drug ecstasy" when, after taking one Ecstasy tablet, she became ill and told friends "that she felt like she was 'going to die.'" Two teenage acquaintances did not seek medical care and instead tried to get Perez to smoke marijuana. When that failed due to her seizures, the friends tried to force feed marijuana leaves to her, "apparently because [they] knew that drug is sometimes used to treat cancer patients." Irma Perez lost consciousness and died a few days later when she was taken off life support. She was 14 years old. [19]

Marijuana is Dangerous to the User and Others

Legalization of marijuana, no matter how it begins, will come at the expense of our children and public safety:

- This is not the marijuana of the 1970's. The drug is far more powerful today than it was 30 years ago when baby boomers were trying it. Average THC levels of seized marijuana rose from less than one percent in the mid-1970's to a national average of over eight percent in 2004.[20] And the potency of "B.C. Bud" is roughly twice the national average – ranging from 15% to as high as 25% THC content. [21]

- In 2002, among the approximate 1.7 million adult (18 or older) substance abuse admissions, more than 150,000 were admitted as primary marijuana users. [22]

- Adolescents are at highest risk for marijuana addiction, as they are "three times more likely than adults to develop dependency." [23]

- The admission rates for adolescents reporting marijuana as the primary substance increased between 1992 and 2002 from 23 to 64 percent. [24] Even without legalization, more young people (ages 12-17) entered treatment in 2002 for marijuana dependency than for alcohol and all other illegal drugs combined. [25]

- The admission rates for persons aged 12 and older, listing marijuana as their primary substance, increased 162 per cent nationally, between 1992 and 2002.[26]

- Of the 19.5 million Americans aged 12 or older who were current illicit drug users, 14.6 million are using marijuana, making it the most commonly used illicit drug in 2003. [27]

- In 2002, the second most common illicit drug responsible for treatment admissions was marijuana—outdistancing crack cocaine, the next most prevalent cause. [28]

- Use of marijuana by many young people is a frequent precursor to the use of even more dangerous drugs, and signals a significantly enhanced likelihood of drug problems in adult life. The *Journal of the American Medical Association* reported, based on a study of 300 sets of twins, "that marijuana-using twins were four times more likely than their siblings to use cocaine and crack cocaine, and five times more likely to use hallucinogens such as LSD." [29]

- Long-term studies of patterns of drug usage among young people show that very few of them use other drugs without first starting with marijuana. For example, one study found that 62 percent of the adults who first tried marijuana before they were 15 were likely to go on to use cocaine. By contrast, only slightly more than one-half of one percent of adults who never tried marijuana went on to use cocaine. [30]

- Marijuana use in early adolescence is particularly ominous. Adults who were early marijuana users were found to be five times more likely to develop a need for abuse or dependency on any drug, eight times more likely to have gone on to use cocaine, and fifteen times more likely to have gone on to use heroin. [31]

- In 2003, 3.1 million Americans (aged 12 or older) used marijuana daily or almost daily in the past year. Of those daily marijuana users, nearly two-thirds "used at least one other illicit drug in the past 12 months." More than half (53.3 percent) of daily marijuana users were also dependent on or abused alcohol or another illicit drug compared to those who were nonusers or used marijuana less than daily. In addition, 12.9 percent of daily marijuana users aged 18 to 64 "reported being unemployed compared to less-than-daily marijuana users (7.9 percent), and nonusers (3.9 percent)." [32]

- Results of a recent study show that early marijuana use is associated with lowered income and reduced health later in life. On the other hand, people who abstained from using marijuana had an a lower rate of other drug use, better health, higher levels of educational attainment, and greater life satisfaction. [33]

- Marijuana use can damage a teen's academic performance. "Research shows that students with an average grade of 'D' or below are more than four times as likely to have used marijuana in the past year as teens who reported an average grade of 'A.'" [34]

Potential Health Issues Related to Marijuana:

- The use of marijuana may lead to psychotic symptoms in susceptible individuals, a new report states. In New Zealand, Professor David Fergusson and colleagues from Christchurch School of Medicine and Health Sciences, University of Otago, conducted a study of data gathered over a 25 year period of more than 1,000 New Zealanders born in 1977. The results of that study show that, even controlling for other factors, it was clear that there was an

"increase in rates of psychotic symptoms after the start of regular [marijuana] use, with daily users of cannabis having rates that were over 150% those of non users." [35] Other factors taken into account included current mental disorders, family history, and illicit substance abuse. [36]

- A laboratory-controlled study by Yale scientists found that THC "transiently induced a range of schizophrenia-like effects in healthy people." [37]

- Smoked marijuana has also been associated with an increased risk of the same respiratory symptoms as tobacco, including coughing on most days, phlegm production, chronic bronchitis, shortness of breath, and wheezing. Because cannabis plants are contaminated with a range of fungal spores, smoking marijuana may also increase the risk of respiratory exposure by infectious organisms (i.e. molds and fungi). [38]

- Marijuana takes the risks of tobacco and raises them: marijuana smoke contains more than 400 chemicals and increases the risk of serious health consequences, starting with lung damage. [39]

- Brain scans of regular pot smokers show "holes" (areas of decreased activity and blood flow) in the areas that cover language, memory, facial recognition, anger management, emotional control, and motor coordination. [40]

- According to two studies, marijuana use narrows the arteries in the brain, "similar to patients with high blood pressure and dementia" and may explain why memory tests are difficult for marijuana users. In addition, "chronic consumers of cannabis lose molecules called CB1 receptors in the brain's arteries," leading to blood flow problems in the brain which can cause memory loss, attention deficits, and impaired learning ability. [41]

The foreign experience:

- The government of the Netherlands reconsidered its legalization measures in light of that country's experience: After use of marijuana became normalized, consumption nearly tripled – from 15 percent to 44 percent – among 18-to-20 year-old Dutch youth. [42] As awareness of the harms of marijuana grew, the number of cannabis "coffeehouses" in the Netherlands dropped – from 1179 in 1997 to 782 in 2002, a decrease of 34% in five years. Ninety-seven percent of Dutch towns have a cannabis policy, and 73% of those have a zero-tolerance policy toward coffeehouses. [43]

- In August 2004, the government of the Netherlands announced a significant and crucial shift in its cannabis policy. According to "an inter-ministerial policy paper on cannabis, the Government acknowledged that 'cannabis is not harmless' – neither for the abusers, nor for the community." The government

of the Netherlands intends to reduce the number of coffee shops (especially those near border areas and schools), closely monitor drugs tourism, and implement an action plan to discourage cannabis use. [44]

- In an effort to provide "medical" marijuana to its citizens, the government of the Netherlands instituted a "medical" marijuana policy where patients could obtain marijuana from Dutch pharmacies. Instead, the patients have opted to obtain their marijuana at the cafes. Part of the problem with the policy is that the price of pharmaceutical grade marijuana is prohibitive. According to Bas Kuik, spokesman for the Bureau of Medical Cannabis, another possible problem with the policy is that the pharmaceutical marijuana is made to be infused and drunk like tea or inhaled in a steam treatment, not for smoking. "Maybe that is a disappointment for people expecting to smoke it but of course the ministry of health cannot encourage smoking." [45]

- Dr. Ernest Bunning of Holland's Ministry of Health, a principal proponent of that country's liberal drug philosophy, has acknowledged that, "[t]here are young people who abuse soft drugs . . . particularly those that have [a] high THC [content]. The place that cannabis takes in their lives becomes so dominant they don't have space for the other important things in life. They crawl out of bed in the morning, grab a joint, don't work, smoke another joint. They don't know what to do with their lives." [46]

- Liberalization of marijuana laws in Switzerland has likewise produced damaging results, albeit in other ways. After liberalization, Switzerland became a magnet for drug users from many other countries. In 1987, Zurich permitted drug use and sales in a part of the city called Platzpitz, dubbed "Needle Park." By 1992, the number of regular drug users at the park had reportedly swelled from a few hundred in 1987 to 20,000. The area around the park became crime-ridden to the point that the park had to be shut down, and the experiment has since been terminated. [47]

- U.S. consumption of cocaine decreased 70 percent in the past 15 years while European consumption increased, just as the drug legalization movement was taking hold in Europe. [48]

- Marijuana use by Canadian teenagers is at a 25 year peak in the wake of an aggressive decriminalization movement. At the very time a decriminalization bill was before the House of Commons, the Canadian government released a report showing that marijuana smoking among teens is "at levels that we haven't seen since the late '70's when rates reached their peak," noted a spokesman for the Canadian Centre for Substance Abuse. After a large decline in the 1980's, marijuana use among teens increased during the 1990's, as young people apparently became "confused about the state of federal pot law." [49]

- In March 2005, Home Secretary Charles Clarke of England took the unprecedented step and "called for a rethink on Labour's legal downgrading of cannabis" from a Class B to a Class C substance. Mr. Clarke requested that the Advisory Council on the Misuse of Drugs complete a new report, taking into account the recent studies showing a link between cannabis and psychosis and also considering the more potent cannabis referred to as "skunk." Although Mr. Clarke stated that the British Crime Survey did not show an increase in usage of cannabis since 2004, a Metropolitan Police report states that at the end of last year, "the number of people caught with cannabis had risen by nearly a third, while arrests had gone down by almost half." [50]

Marijuana harms more than just users:

- In 2002, the percentage of young people engaging in delinquent behaviors "rose with [the] increasing frequency of marijuana use." According to an NSDUH report, 42.2% of youths who smoked marijuana 300 or more days took part in serious fighting at school or work while 37.1% of those who smoked marijuana 50-99 days engaged in the activity. Only 18.2% of those who did not use marijuana in the past year engaged in serious fighting. Similarly, the percentage of youths engaging in the following delinquent behaviors was highest among youths who smoked marijuana 300 days or more versus youths who smoked marijuana 50-99 days and those who had not used marijuana in the past year: stealing or attempting to steal (31.7% versus 17.6% and 2.9%), selling illegal drugs (57.3% versus 30.6% and 0.9%), carrying a gun (22.2% versus 8.9% and 2.5%), or attacking someone with the intent to seriously hurt them (32.9% versus 21.1% and 5.9%). [51]

- In 2002 and 2003, more than 4 million (21 percent) of 16 to 20 year olds reported that they had driven while under the influence of illicit drugs or alcohol in the past year. Out of this age group, 14 percent reported driving under the influence of illicit drugs and eight percent reported driving under the influence of a combination of illicit drugs and alcohol. [52] In 2002, 11 million Americans aged 12 and older said that, in the past year, they drove while under the influence of illegal drugs. [53]

- A large shock trauma unit, conducting an ongoing study, found that 17% (one in six) of crash victims tested positive for marijuana. The rates were slightly higher for crash victims under the age of eighteen, 19% of whom tested positive for marijuana. [54]

- Despite the higher prevalence of alcohol consumption by teens, approximately 15% of teens reported driving under the influence of marijuana. This is almost equal to the amount of teens who reported driving under the influence of alcohol (16%). [55]

- A study of motorists pulled over for reckless driving showed that, among those who were not impaired by alcohol, 45% tested positive for marijuana. [56]

- In a study of high school classes in 2000 and 2001, about 28,000 seniors each year admitted that they were in at least one accident after using marijuana. [57]

- The National Highway Traffic Safety Administration has found that marijuana has significant adverse side effects, and that these are particularly hazardous when the user is driving.

  General side effects include: Possible psychosis, paranoia, fatigue, mood alterations, memory problems, constipation, urinary retention, lethargy, decreased motor coordination, slurred speech and dizziness. Impaired health effects include behavioral changes, lung damage, cardiovascular, reproductive, and immunological problems. "Regular and chronic marijuana smokers may have many of the same respiratory problems that tobacco smokers have (daily cough and phlegm, symptoms of chronic bronchitis), as the amount of tar inhaled and the level of carbon monoxide absorbed by marijuana smokers is 3 to 5 times greater than among tobacco smokers." [58]

  "Marijuana affects concentration, perception, coordination, and reaction time, many of the skills required for safe driving and other tasks. These effects can last up to 24 hours after smoking marijuana." [59]

  The effects of marijuana smoking on driving are alarming. As the NHTSA note, "Epidemiology data from road traffic arrests and fatalities indicate that after alcohol, marijuana is the most frequently detected psychoactive substance among driving populations." Decreased car handling performance, inability to maintain headway, impaired time and distance estimation, increased reaction times, sleepiness, motor incoordination, and impaired sustained vigilance have all been reported. The time it takes to evaluate situations and to determine the appropriate response increases. [60]

- The U.S. is not the only country concerned with the effects of drugged driving. In Tasmania, Australia, there is a proposed drugged-driving law that would carry the penalty of a $200 fine and a three month license disqualification for a first offense. The drugged driving amendment has been proposed in hopes that it will reduce road deaths that include drugged drivers. From 1999-2003, 22% of drivers involved in fatal car accidents had illegal drugs in their blood. In addition, "[c]annabis was the most commonly detected drug which was represented, either alone or in combination with alcohol and/or other drugs, in 18.2 per cent of samples." [61]

  Some of the consequences of marijuana-impaired driving are startling:

- The driver of a charter bus, who crashed and killed 22 people, had been fired from bus companies in 1989 and 1996 because he tested positive for marijuana four times. A federal investigator confirmed a report that the driver "tested positive for marijuana when he was hospitalized Sunday after the bus veered off a highway and plunged into an embankment." [62]

- A former nurse's aide was convicted of murder and sentenced to 50 years in prison for hitting a homeless man with her car and driving home with his mangled body in the windshield. The incident happened after a night of drinking and taking drugs, including marijuana. After arriving home, the woman parked her car, with the man still lodged in the windshield, and left him there until he died. [63]

- In April 2002, four children and the driver died when a Tippy Toes Learning Academy van hit a concrete bridge abutment after veering off the freeway. Investigators reported that the children nicknamed the driver "Smokey" because he regularly smoked marijuana. The driver was found at the crash scene with marijuana in his pocket. [64]

- Duane Baehler, 47, of Tulsa, Okalahoma was "involved in a fiery crash that killed his teenage son." Police reported that Baehler had methamphetamine, cocaine and marijuana in his system. [65]

Marijuana also creates hazards that are not always predictable. In August 2004, two Philadelphia firefighters died battling a fire that was started because of tangled wires and lamps used to grow marijuana in a basement closet. [66]

Insurance companies are refusing to write policies for doctors who prescribe marijuana. As explained by Donald Fager of Medical Liability Mutual Insurance Co., the largest medical malpractice insurer in the nation, "We don't want to be on the hook for drugs that don't have FDA approval." [67]

ENDNOTES

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United States Department of Justice
Drug Enforcement Administration
April 20, 2005

Senators Koch, Jungbauer, Belanger, Wergin and McGinn introduced–

S.F. No. 2803: Referred to the Committee on Crime Prevention and Public Safety.

A bill for an act

relating to public safety; amending the drug paraphernalia crime to change the mental state requirement, specifically address sales of drug paraphernalia, and consolidate certain drug paraphernalia crimes into a single statutory section; prohibiting the possession of certain items associated with controlled substance use; imposing criminal penalties; amending Minnesota Statutes 2004, sections 152.01, subdivision 18; 152.093; proposing coding for new law in Minnesota Statutes, chapter 152; repealing Minnesota Statutes 2004, section 152.094.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 152.01, subdivision 18, is amended to read:

Subd. 18. **Drug paraphernalia.** (a) Except as otherwise provided in paragraph (b), "drug paraphernalia" means all equipment, products, and materials of any kind, except those items used in conjunction with permitted uses of controlled substances under this chapter or the Uniform Controlled Substances Act, which are ~~knowingly or intentionally~~ used primarily in (1) manufacturing a controlled substance, (2) injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance, (3) testing the strength, effectiveness, or purity of a controlled substance, or (4) enhancing the effect of a controlled substance.

(b) "Drug paraphernalia" does not include the possession, manufacture, delivery, or sale of hypodermic needles or syringes in accordance with section 151.40, subdivision 2.

EFFECTIVE DATE. This section is effective August 1, 2006, and applies to crimes committed on or after that date.

Sec. 2. Minnesota Statutes 2004, section 152.093, is amended to read:

152.093 ~~MANUFACTURE OR DELIVERY~~ SALE OF DRUG PARAPHERNALIA PROHIBITED.

Subdivision 1. **Sales generally.** (a) It is unlawful for any person ~~knowingly or intentionally~~ to ~~deliver~~ sell drug paraphernalia ~~or knowingly or intentionally to possess or manufacture drug paraphernalia for delivery~~, knowing or having reason to know, that the item will be used primarily to:

(1) manufacture a controlled substance;

(2) inject, ingest, inhale, or otherwise introduce into the human body a controlled substance;

(3) test the strength, effectiveness, or purity of a controlled substance; or

(4) enhance the effect of a controlled substance.

(b) Any violation of this ~~section~~ subdivision is a misdemeanor.

Subd. 2. **Sales to minor.** Any person 18 years of age or older who violates subdivision 1 by selling drug paraphernalia to a person under 18 years of age who is at least three years younger is guilty of a gross misdemeanor.

EFFECTIVE DATE. This section is effective August 1, 2006, and applies to crimes committed on or after that date.

Sec. 3. **[152.0955] PROHIBITION ON POSSESSION OF CERTAIN ITEMS ASSOCIATED WITH CONTROLLED SUBSTANCE USE.**

Subdivision 1. **Definitions.** As used in this section, the following terms have the meanings given:

(1) "bong" means any pipe or smoking device, commonly referred to as a bong or water bong, having one or more tubes that attach to or are part of the pipe or device, that allow for a smoked product to be drawn from a reservoir or bowl, through a quantity of water or other liquid substance, or through another tube or opening on the pipe or device;

(2) "dugout" means a storage device, commonly referred to as a dugout, designed with separate reservoirs for marijuana and a one-hit pipe;

(3) "glass pipe" means any pipe or smoking device that has a reservoir capable of holding controlled substances for ingestion;

(4) "marijuana pipe" means any pipe or smoking device, except for a traditional pipe, that is made of solid material, including ivory, onyx, glass, metal, stone, or any other material, having a reservoir and a direct channel or a channel filtered by a screen, leading to an open end, commonly known as a bowl;

(5) "one-hit pipe" means any pipe or smoking device that consists of a reservoir on one end, with a direct channel or a channel filtered by a screen that leads to the opposite end, designed as a linear device, and without a separately attached bowl or reservoir; and

(6) "traditional pipe" means a smoking device that has a sole use for consumption of tobacco, not containing a screen in the bowl section, such as a corncob pipe.

Subd. 2. **Possession prohibited.** A person who knowingly possesses a bong, dugout, glass pipe, marijuana pipe, or one-hit pipe is guilty of a petty misdemeanor.

EFFECTIVE DATE. This section is effective August 1, 2006.

Sec. 4. **REPEALER.**

Minnesota Statutes 2004, section 152.094, is repealed.

EFFECTIVE DATE. This section is effective August 1, 2006.

APPENDIX
Repealed Minnesota Statutes: 06-6193

152.094 DELIVERY OF DRUG PARAPHERNALIA TO A MINOR PROHIBITED.

Any person 18 years of age or older who violates section 152.093 by knowingly or intentionally delivering drug paraphernalia to a person under 18 years of age who is at least three years younger is guilty of a gross misdemeanor.

Senator ..... moves to amend S.F. No. 2803 as follows:

Page 2, delete lines 24 and 25 and insert "water bong, having one tube that attaches to or is part of the pipe or device, that allows for a smoked product to be drawn from a reservoir or bowl, through a quantity of"

Page 2, line 29, after "that" insert "is made of glass and that"

Senator Ortman introduced–

S.F. No. 3192: Referred to the Committee on Crime Prevention and Public Safety.

A bill for an act

relating to public safety; providing for handling of death scene investigations and identifications of remains; proposing coding for new law in Minnesota Statutes, chapter 299A.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[299A.85] REPORTING OF UNIDENTIFIED PERSONS/HUMAN REMAINS.**

Subdivision 1. **Handling of death scene investigations.** (a) The Department of Public Safety shall provide information to local law enforcement agencies about best practices for handling death scene investigations.

(b) The Department of Public Safety shall identify any publications or training opportunities that may be available to local law enforcement agencies or law enforcement officers concerning the handling of death scene investigations.

Subd. 2. **Law enforcement reports.** (a) After performing any death scene investigation considered appropriate under the circumstances, the official with custody of the human remains shall ensure that the human remains are delivered to the appropriate medical examiner.

(b) A person with custody of human remains that are not identified within 24 hours of discovery shall promptly notify the Department of Public Safety of the location of those remains.

(c) A person with custody of remains who cannot determine whether or not the remains found are human shall notify the Department of Public Safety of the existence of possible human remains.

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S.F. No. 3192 - Death Scene Investigations

Author: Senator Julianne E. Ortman

Prepared by: Chris Turner, Senate Research (651/296-4350) CT

Date: March 23, 2006

Section 1, subdivision 1 requires the Department of Public Safety to provide information to local law enforcement agencies about best practices for handling death scene investigations.

Subdivision 2 requires the official with custody of the human remains after a death scene investigation to ensure that the remains are delivered to the appropriate medical examiner. If the remains are not identified within 24 hours, or if it cannot be determined whether the remains are human, the person with custody of the remains must notify the Department of Public Safety.

CT:rer

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S.F. No. 3249 - Unidentified Bodies And Missing Persons

Author: Senator Jane B. Ranum

Prepared by: Chris Turner, Senate Research (651/296-4350) CT

Date: March 23, 2006

Section 1 requires the local law enforcement agency in the location where a missing person was last seen to take a missing person report from an interested party. If this cannot be determined, the law enforcement agency where the missing person last resided must take the report.

Section 2, subdivision 1 requires the Bureau of Criminal Apprehension (BCA), in coordination with federal, state, and local law enforcement, medical examiners, coroners, and others to reduce the state's reporting, date entry, and record keeping backlog relating to missing persons and unidentified bodies.

Subdivision 2 requires the superintendent of the BCA, by February 1, 2007, to report to the Legislature on the effort to reduce the backlog cited in subdivision 1. The report must account for the appropriation in subdivision 3, and make recommendations for changes in state law regarding missing persons and unidentified bodies.

Subdivision 3 makes a blank onetime appropriation to the superintendent of the BCA for the purposes of the bill.

Section 3, subdivision 1 requires the superintendent, in consultation with the Minnesota Sheriffs Association and the Minnesota Chiefs of Police Association to develop a model policy to address law enforcement efforts and duties regarding missing persons and to provide training to local law enforcement on this model policy.

Subdivision 2 requires the superintendent, by February 1, 2007, to report to the Legislature on the model policy and training efforts.

CT:rer

Senator Ranum introduced–

S.F. No. 3249: Referred to the Committee on Crime Prevention and Public Safety.

A bill for an act

relating to public safety; requiring the Bureau of Criminal Apprehension to oversee efforts to reduce the record keeping backlog for missing persons and unidentified bodies cases; clarifying responsibility for receiving missing persons reports; requiring a model policy relating to missing adults; requiring reports; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 299C.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[299C.565] MISSING PERSON REPORT.**

The local law enforcement agency having jurisdiction over the location where a person has ~~gone~~ been missing or was last seen has the responsibility to take a missing person report from an interested party. If this location cannot be clearly and easily established, the local law enforcement agency having jurisdiction over the last verified location where the missing person last resided has the responsibility to take the report.

EFFECTIVE DATE. This section is effective August 1, 2006.

Sec. 2. **MISSING PERSONS, UNIDENTIFIED BODIES; RECORDS AND DATA ENTERING BACKLOG; APPROPRIATION.**

Subdivision 1. **Bureau of Criminal Apprehension to address backlog.** The superintendent of the Bureau of Criminal Apprehension shall coordinate with federal and local units of government; federal, state, and local law enforcement agencies; medical examiners; coroners; odontologists; and other entities to reduce the state's reporting, data entry, and record keeping backlog relating to missing persons and unidentified bodies. To the degree feasible, the superintendent shall ensure that all necessary data and samples,

including, but not limited to, DNA samples and dental records get entered into all relevant federal and state databases.

Subd. 2. **Report to legislature.** By February 1, 2007, the superintendent shall report to the chairs and ranking minority members of the senate and house committees and divisions having jurisdiction over criminal justice policy and funding on the efforts under subdivision 1 to reduce the state's backlog. The report must give detailed information on how the appropriation in subdivision 3 was spent and how this affected the backlog. In addition, the report must make recommendations for changes to state law, including suggested legislative language, to improve reporting, data entry, and record keeping relating to future cases involving missing persons and unidentified bodies.

Subd. 3. **Appropriation.** $..... is appropriated to the superintendent of the Bureau of Criminal Apprehension from the general fund for the fiscal year ending June 30, 2007, to implement this section. This is a onetime appropriation.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 3. **MODEL POLICY; REPORT.**

Subdivision 1. **Model policy.** The superintendent of the Bureau of Criminal Apprehension, in consultation with the Minnesota Sheriffs Association and the Minnesota Chiefs of Police Association, shall develop a model policy to address law enforcement efforts and duties regarding missing adults and provide training to local law enforcement agencies on this model policy.

Subd. 2. **Report.** By February 1, 2007, the superintendent shall report to the chairs and ranking minority members of the senate and house committees and divisions having jurisdiction over criminal justice policy and funding on the model policy and training described in subdivision 1.

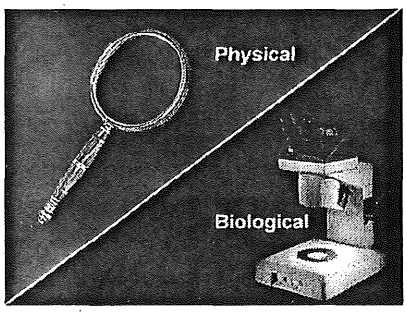
EFFECTIVE DATE. This section is effective the day following final enactment.

PRESIDENT'S DNA INITIATIVE *Advancing Justice Through DNA Technology*

DNA Evidence Collection

Crime Scene Integrity | Chain of Custody | Contamination | Transportation and Storage | Sources and Locations of DNA Evidence

Physical evidence is any tangible object that can connect an offender to a crime scene. Biological evidence, which contains DNA, is a type of physical evidence. However, biological evidence is not always visible to the naked eye. DNA testing has expanded the types of useful biological evidence. All biological evidence found at crime scenes can be subjected to DNA testing. Samples such as feces and vomit can be tested, but may not be routinely accepted by laboratories for testing.



Crime Scene Integrity

Protection of the crime scene is essential to the protection of evidence. Safeguarding and preserving evidence is fundamental to the successful solution of a crime. Remember, while documenting evidence at the crime scene, to include descriptions of whether evidence was found wet or dry. An example of this documentation would include blood spatters.

The risk of contamination of any crime scene can be reduced by limiting incidental activity. It is important for all law enforcement personnel at the crime scene to make a conscious effort to refrain from smoking, eating, drinking, littering or any other actions which could compromise the crime scene. Because DNA evidence is more sensitive than other types of evidence, law enforcement personnel should be especially aware of their actions at the scene to prevent inadvertent contamination of evidence.

Chain of Custody

The chain of custody of evidence is a record of individuals who have had physical possession of the evidence. Documentation is critical to maintaining the integrity of the chain of custody. Maintaining the chain of custody is vital for any type of evidence. In addition, if laboratory analysis reveals that DNA evidence was contaminated, it may be necessary to identify persons who have handled that evidence.

In processing the evidence, the fewer people handling the evidence, the better. There is less chance of contamination and a shorter chain of custody for court admissibility hearings.

Contamination

Because extremely small samples of DNA can be used as evidence, greater attention to contamination issues is necessary when identifying, collecting, and preserving DNA evidence. DNA evidence can be contaminated when DNA from another source gets mixed with DNA relevant to the case.

Transportation and Storage

As a first responding officer, you may be called upon to transport evidence from a crime scene. As with any evidence, ensure that the chain of custody is maintained. In addition, be aware that direct sunlight and

warmer conditions may degrade DNA. Avoid storing evidence in places that may get hot, such as the trunk of the police car. To best preserve DNA evidence, store in a cold environment.

Sources and Locations of DNA Evidence

Some of the challenging cases in recent law enforcement history have been solved by DNA evidence found in unusual places. The following excerpts are from cases in which DNA was found in non-traditional locations. A threatening letter was sent to a newspaper editor. The FBI Lab sampled the envelope flap and recovered some cells (saliva) that were then typed for DNA. The profile from the envelope flap was compared to a known suspect's profile and was found to match.

In 1997, two women from Florida were victims of sexual assault and robbery. One year later, the police developed a suspect. Plain-clothed police officers monitored the suspect for months looking for clues that would build their case. During surveillance, the officers saw the suspect spit on the street. One of the officers grabbed a napkin and collected the spittle. The saliva, which contained cells, provided enough DNA evidence to charge the man with the two attacks. (View and hear demonstration from *What Every Law Enforcement Officer Should Know About DNA Evidence*).

Content on this page is excerpted from the online training coures What Every Law Enforcement Officer Should Know About DNA Evidence.

PRESIDENT'S DNA INITIATIVE *Advancing Justice Through DNA Technology*

Steps in DNA Sample Processing

Following is a a review of the steps involved in processing forensic DNA samples with STR markers. STRs are a smaller version of the VNTR sequences first described by Dr. Jeffreys. Samples obtained from crime scenes or paternity investigations are subjected to defined processes involving biology, technology, and genetics.

Biology

Following collection of biological material from a crime scene or paternity investigation, the DNA is first extracted from its biological source material and then measured to evaluate the quantity of DNA recovered. After isolating the DNA from its cells, specific regions are copied with a technique known as the polymerase chain reaction, or PCR. PCR produces millions of copies for each DNA segment of interest and thus permits very minute amounts of DNA to be examined. Multiple STR regions can be examined simultaneously to increase the informativeness of the DNA test. See also Basic Biology of DNA.

Technology

The resulting PCR products are then separated and detected in order to characterize the STR region being examined. The separation methods used today include slab gel and capillary electrophoresis (CE). Fluorescence detection methods have greatly aided the sensitivity and ease of measuring PCR-amplified STR alleles. After detecting the STR alleles, the number of repeats in a DNA sequence is determined, a process known as sample genotyping.

The specific methods used for DNA typing are validated by individual laboratories to ensure that reliable results are obtained and before new technologies are implemented. DNA databases, such as the one described earlier in this chapter to match Montaret Davis to his crime scene, are valuable tools and will continue to play an important role in law enforcement efforts.

Genetics

The resulting DNA profile for a sample, which is a combination of individual STR genotypes, is compared to other samples. In the case of a forensic investigation, these other samples would include known reference samples such as the victim or suspects that are compared to the crime scene evidence. With paternity investigations, a child's genotype would be compared to his or her mother's and the alleged father(s) under investigation. If there is not a match between the questioned sample and the known sample, then the samples may be considered to have originated from different sources. The term used for failure to match between two DNA profiles is 'exclusion.'

If a match or 'inclusion' results, then a comparison of the DNA profile is made to a population database, which is a collection of DNA profiles obtained from unrelated individuals of a particular ethnic group. For example, due to genetic variation between the groups, African-Americans and Caucasians have different population databases for comparison purposes.

Finally a case report or paternity test result is generated. This report typically includes the random match probability for the match in question . This random match probability is the chance that a randomly selected individual from a population will have an identical STR profile or combination of genotypes at the DNA markers tested.

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Senate

State of Minnesota

S.F. No. 3226 - Blakely-Related Changes

Author: Senator Jane B. Ranum

Prepared by: Kenneth P. Backhus, Senate Counsel (651/296-4396) KB

Date: March 21, 2006

Sections 1 to 3 amend provisions enacted last year in response to the United States Supreme Court's decision in Blakely v. Washington that specify the procedures to be used when imposing aggravated durational departures. The amendments apply the procedures to situations where the state is requesting an aggravated sentence under any sentencing enhancement statute or a mandatory minimum sentence under Minnesota Statutes, section 609.11 (minimum sentences for crimes committed with dangerous weapons). The amendments have an immediate effective date.

Section 4 amends the Career Offender Sentencing Law. That law currently authorizes a judge to impose an aggravated durational departure from the guidelines' presumptive sentence up to the statutory maximum sentence for persons convicted of a felony where the fact finder determines that the offender has five or more prior felony convictions and the present offense is committed as part of a pattern of criminal conduct. This section strikes the requirement that the fact finder determine that the present offense was part of a pattern of criminal conduct.

Section 5 amends section 609.11 by replacing references to court determinations with fact finder determinations. These changes are necessitated by last year's Minnesota Supreme Court decision in State v. Barker. Also strikes language requiring the prosecutor to present evidence related to the defendant's use of a firearm or a dangerous weapon during the commission of an offense.

Section 6 adds a subdivision to the sex offender sentencing statute enacted last year. This new subdivision is a recodification of the Patterned Offender Sentencing Law currently codified at section 609.108 (which is being repealed in **section 14** of this bill).

Section 7 amends the sex offender sentencing statute enacted last year. Provides that certain determinations must be made by the fact finder (this is consistent with the Blakely decision) and makes other clarifying changes.

Section 8 amends the sex offender sentencing statute enacted last year. Adds language currently contained in the Patterned Offender Sentencing Law requiring the Commissioner of Corrections to develop a plan to pay for the cost of treatment of conditionally released offenders.

Sections 9 to 12 remove the sunset from the Blakely procedural provisions enacted last year (three of which are being amended by **sections 1 to 3** of this bill). These provisions are set to expire on February 1, 2007.

Section 13 requires the Revisor of Statutes to replace statutory references to the Patterned Offender Sentencing Law with references to **section 6**.

Section 14 repeals the Patterned Offender Sentencing Law (which is being recodified by this bill in **section 6**) and the mandatory sentencing provisions related to repeat sex offenders in section 609.109.

KPB:ph

Senators Ranum, Betzold, Ortman, Ruud and Foley introduced–

S.F. No. 3226: Referred to the Committee on Crime Prevention and Public Safety.

A bill for an act

relating to public safety; modifying the career offender sentencing law; recodifying the patterned offender sentencing law; removing the sunset provision for Blakely hearing provisions and applying these provisions to other sentencing enhancements; amending Minnesota Statutes 2004, section 609.11, subdivision 7; Minnesota Statutes 2005 Supplement, sections 244.10, subdivisions 5, 6, 7; 609.1095, subdivision 4; 609.3455, subdivisions 4, 8, by adding a subdivision; Laws 2005, chapter 136, article 16, sections 3; 4; 5; 6; repealing Minnesota Statutes 2004, sections 609.108, subdivision 5; 609.109, subdivisions 1, 3; Minnesota Statutes 2005 Supplement, sections 609.108, subdivisions 1, 3, 4, 6, 7; 609.109, subdivisions 2, 4, 5, 6.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2005 Supplement, section 244.10, subdivision 5, is amended to read:

Subd. 5. **Procedures in cases where state intends to seek an aggravated departure.** (a) When the prosecutor provides reasonable notice under subdivision 4, the district court shall allow the state to prove beyond a reasonable doubt to a jury of 12 members the factors in support of the state's request for an aggravated departure from the Sentencing Guidelines or the state's request for an aggravated sentence under any sentencing enhancement statute or the state's request for a mandatory minimum under section 609.11 as provided in paragraph (b) or (c).

(b) The district court shall allow a unitary trial and final argument to a jury regarding both evidence in support of the elements of the offense and evidence in support of aggravating factors when the evidence in support of the aggravating factors:

(1) would be admissible as part of the trial on the elements of the offense; or

(2) would not result in unfair prejudice to the defendant.

The existence of each aggravating factor shall be determined by use of a special verdict form.

Upon the request of the prosecutor, the court shall allow bifurcated argument and jury deliberations.

(c) The district court shall bifurcate the proceedings, or impanel a resentencing jury, to allow for the production of evidence, argument, and deliberations on the existence of factors in support of an aggravated departure after the return of a guilty verdict when the evidence in support of an aggravated departure:

(1) includes evidence that is otherwise inadmissible at a trial on the elements of the offense; and

(2) would result in unfair prejudice to the defendant.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to sentencing hearings and sentencing departures sought on or after that date.

Sec. 2. Minnesota Statutes 2005 Supplement, section 244.10, subdivision 6, is amended to read:

Subd. 6. **Defendants to present evidence and argument.** In either a unitary or bifurcated trial under subdivision 5, a defendant shall be allowed to present evidence and argument to the jury or factfinder regarding whether facts exist that would justify an aggravated ~~durational~~ departure or an aggravated sentence under any sentencing enhancement statute or a mandatory minimum sentence under section 609.11. A defendant is not allowed to present evidence or argument to the jury or factfinder regarding facts in support of a mitigated departure during the trial, but may present evidence and argument in support of a mitigated departure to the judge as factfinder during a sentencing hearing.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to sentencing hearings and sentencing departures sought on or after that date.

Sec. 3. Minnesota Statutes 2005 Supplement, section 244.10, subdivision 7, is amended to read:

Subd. 7. **Waiver of jury determination.** The defendant may waive the right to a jury determination of whether facts exist that would justify an aggravated sentence. Upon receipt of a waiver of a jury trial on this issue, the district court shall determine beyond a reasonable doubt whether the factors in support of the state's motion for aggravated departure or an aggravated sentence under any sentencing enhancement statute or a mandatory minimum sentence under section 609.11 exist.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to sentencing hearings and sentencing departures sought on or after that date.

Sec. 4. Minnesota Statutes 2005 Supplement, section 609.1095, subdivision 4, is amended to read:

Subd. 4. **Increased sentence for offender who commits a sixth felony.** Whenever a person is convicted of a felony, and the judge is imposing an executed sentence based on a Sentencing Guidelines presumptive imprisonment sentence, the judge may impose an aggravated durational departure from the presumptive sentence up to the statutory maximum sentence if the factfinder determines that the offender has five or more prior felony convictions ~~and that the present offense is a felony that was committed as part of a pattern of criminal conduct~~.

EFFECTIVE DATE. This section is effective August 1, 2006, and applies to crimes committed on or after that date.

Sec. 5. Minnesota Statutes 2004, section 609.11, subdivision 7, is amended to read:

Subd. 7. **Prosecutor shall establish.** ~~Whenever reasonable grounds exist to believe that the defendant or an accomplice used a firearm or other dangerous weapon or had in possession a firearm, at the time of commission of an offense listed in subdivision 9, the prosecutor shall, at the time of trial or at the plea of guilty, present on the record all evidence tending to establish that fact unless it is otherwise admitted on the record.~~ The question of whether the defendant or an accomplice, at the time of commission of an offense listed in subdivision 9, used a firearm or other dangerous weapon or had in possession a firearm shall be determined by the ~~court on the record~~ factfinder at the time of a verdict or finding of guilt at trial or the entry of a plea of guilty based upon the record of the trial or the plea of guilty. The ~~court~~ factfinder shall also determine ~~on the record at the time of sentencing~~ whether the defendant has ~~been convicted of a second or subsequent~~ a prior conviction for an offense in which the defendant or an accomplice, at the time of commission of an offense listed in subdivision 9, used a firearm or other dangerous weapon or had in possession a firearm.

EFFECTIVE DATE. This section is effective August 1, 2006, and applies to crimes committed on or after that date.

Sec. 6. Minnesota Statutes 2005 Supplement, section 609.3455, is amended by adding a subdivision to read:

Subd. 3a. **Mandatory sentence for certain engrained offenders.** (a) A court shall commit a person to the commissioner of corrections for a period of time that is not less than double the presumptive sentence under the sentencing guidelines and not more than the statutory maximum, or if the statutory maximum is less than double the presumptive sentence, for a period of time that is equal to the statutory maximum, if:

(1) the court is imposing an executed sentence on a person convicted of committing or attempting to commit a violation of section 609.342, 609.343, 609.344, 609.345, or 609.3453;

(2) the factfinder determines that the offender is a danger to public safety; and

(3) the factfinder determines that the offender's criminal sexual behavior is so engrained that the risk of reoffending is great without intensive psychotherapeutic intervention or other long-term treatment or supervision extending beyond the presumptive term of imprisonment and supervised release.

(b) The factfinder shall base its determination that the offender is a danger to public safety on any of the following factors:

(1) the crime involved an aggravating factor that would justify a durational departure from the presumptive sentence under the sentencing guidelines;

(2) the offender previously committed or attempted to commit a predatory crime or a violation of section 609.224 or 609.2242, including:

(i) an offense committed as a juvenile that would have been a predatory crime or a violation of section 609.224 or 609.2242 if committed by an adult; or

(ii) a violation or attempted violation of a similar law of any other state or the United States; or

(3) the offender planned or prepared for the crime prior to its commission.

(c) As used in this section, "predatory crime" has the meaning given in section 609.341, subdivision 22.

EFFECTIVE DATE. This section is effective August 1, 2006, and applies to crimes committed on or after that date.

Sec. 7. Minnesota Statutes 2005 Supplement, section 609.3455, subdivision 4, is amended to read:

Subd. 4. **Mandatory life sentence; repeat offenders.** (a) Notwithstanding the statutory maximum penalty otherwise applicable to the offense, the court shall sentence a person to imprisonment for life if the person is convicted of violating section 609.342, 609.343, 609.344, 609.345, or 609.3453 and:

(1) the person has two previous sex offense convictions;

(2) the person has a previous sex offense conviction and:

(i) the factfinder determines that the present offense involved an aggravating factor that would provide grounds for an upward durational departure under the sentencing guidelines other than the aggravating factor applicable to repeat criminal sexual conduct convictions;

(ii) the person received an upward durational departure from the sentencing guidelines for the previous sex offense conviction; or

(iii) the person was sentenced under this section or section 609.108 for the previous sex offense conviction; or

(3) the person has two prior sex offense convictions, and the factfinder determines that the prior convictions and present offense involved at least three separate victims, and:

(i) the factfinder determines that the present offense involved an aggravating factor that would provide grounds for an upward durational departure under the sentencing guidelines other than the aggravating factor applicable to repeat criminal sexual conduct convictions;

(ii) the person received an upward durational departure from the sentencing guidelines for one of the prior sex offense convictions; or

(iii) the person was sentenced under this section or section 609.108 for one of the prior sex offense convictions.

(b) Notwithstanding paragraph (a), a court may not sentence a person to imprisonment for life for a violation of section 609.345, unless the person's previous or prior sex offense convictions that are being used as the basis for the sentence are for violations of section 609.342, 609.343, 609.344, or 609.3453, or any similar statute of the United States, this state, or any other state.

EFFECTIVE DATE. This section is effective August 1, 2006, and applies to crimes committed on or after that date.

Sec. 8. Minnesota Statutes 2005 Supplement, section 609.3455, subdivision 8, is amended to read:

Subd. 8. **Terms of conditional release; applicable to all sex offenders.** (a) The provisions of this subdivision relating to conditional release apply to all sex offenders sentenced to prison for a violation of section 609.342, 609.343, 609.344, 609.345, or 609.3453. Except as provided in this subdivision, conditional release of sex offenders is governed by provisions relating to supervised release. The commissioner of corrections may not dismiss an offender on conditional release from supervision until the offender's conditional release term expires.

(b) The conditions of release may include successful completion of treatment and aftercare in a program approved by the commissioner, satisfaction of the release conditions specified in section 244.05, subdivision 6, and any other conditions the commissioner considers appropriate. The commissioner shall develop a plan to pay the cost of treatment of a person released under this subdivision. The plan may include co-payments from offenders, third-party payers, local agencies, or other funding sources as they are identified. This section does not require the commissioner to accept or retain an offender in a treatment program. Before the offender is placed on conditional release, the commissioner shall notify the sentencing court and the prosecutor in the jurisdiction where the offender was sentenced of the terms of the offender's conditional release. The commissioner also shall make reasonable efforts to notify the victim of the offender's crime of the terms of the offender's conditional release. If the offender fails to meet any condition of release, the commissioner may revoke the offender's conditional release and order that the offender serve all or a part of the remaining portion of the conditional release term in prison.

EFFECTIVE DATE. This section is effective August 1, 2006, and applies to crimes committed on or after that date.

Sec. 9. Laws 2005, chapter 136, article 16, section 3, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective the day following final enactment and applies to sentencing hearings, resentencing hearings, and sentencing departures sought on or after that date. ~~This section expires February 1, 2007.~~

Sec. 10. Laws 2005, chapter 136, article 16, section 4, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective the day following final enactment and applies to sentencing hearings, resentencing hearings, and sentencing departures sought on or after that date. ~~This section expires February 1, 2007.~~

Sec. 11. Laws 2005, chapter 136, article 16, section 5, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective the day following final enactment and applies to sentencing hearings, resentencing hearings, and sentencing departures sought on or after that date. ~~This section expires February 1, 2007.~~