10 Marijuana Myths and Facts:

1. Marijuana is Not Medicine.

Not true. Marijuana (Cannabis) has been used all over the world in many forms as a medicine, food, fiber, and fuel for the past 5000 years. Current research is finding more medical uses every day and the results are very encouraging. We need more and better research and we need the Federal government to remove barriers to continued medical research.

2. Marijuana is Addictive.

It is true that some people become dependent upon Cannabis. Addiction is another issue. Cannabis is about as "addictive" as coffee and just about as hard to quit. The reason for this is that Cannabis acts differently in the body than other traditionally addictive substances such as heroin, cocaine or alcohol.

3. Marijuana is a "Gateway Drug".

Although many addicts of other drugs claim past marijuana use, most cannabis users will not progress to other, more addictive, substances. There is no credible research that proves any "gateway drug" finding.

4. Medical Marijuana Collectives Cause Crime.

Lawful medical marijuana collectives, in compliance with State Law, are very security conscious. Most have "good-neighbor" policies and are proactive with policies regarding neighborhood issues such as diversion, crime and loitering. Many studies show a decrease in crime statistics in neighborhoods with medical marijuana collectives.

5. Medical Marijuana Causes an Increase in Teen use.

Since the passage of prop 215 in California (1996), Teen use of Marijuana has remained the same or has slightly decreased depending upon the study cited. Past fears of massive increases in teen use and associated harmful consequences have just not materialized.

6. Marijuana Causes Traffic Collisions.

Marijuana can cause problems with driving in high enough doses and can double the chances of becoming involved in an accident over a sober person. However, to put it into perspective, Alcohol is 13 times more dangerous than Marijuana in vehicle collision statistics. Overall traffic collision death numbers have seen a steady decline in the past several decades. These numbers show no spike when medical marijuana or recreational marijuana legislation is introduced. Recent research has indicated States with medical marijuana laws and adult use laws have seen a slight decrease in alcohol related DUI and a decreases in fatal collisions.

7. Marijuana is Dangerous for Young Minds.

There are studies that have shown some developmental problems for very young (10-14 years old) heavy users of marijuana. IQ test results and other cognitive problems have been shown in these studies. Studies in adults do not show similar results even considering heavy adult use. Youth education, sensible policies and access controls, along with harm reduction efforts need to be pursued to minimize pre-adult use. More research needs to be done in this area.

8. Marijuana is More Potent Now Than Ever Before.

Due to advancements in cultivation techniques, plant nutrients, and use methods, marijuana potency has increased in the past few decades. Concurrently, the amount of individual use has declined. In other words, it may be more potent but people are using less of it to get the same effects. Despite increased potency, marijuana remains a safe substance. Unlike alcohol and other drugs, there has never been a marijuana caused overdose death recorded.

9. Marijuana Causes People to be Lazy and Unproductive.

Our first three Presidents grew Cannabis (and hemp), our last three Presidents used it. There are many examples in every walk of life that provides a list of productive, intelligent, successful users of marijuana. Business and technology giants, academics, and a few professional and gold medal winning Olympic athletes.

10. We Don't Need Collectives. Anybody Can Grow Medical Marijuana.

Not true. If you are sick enough to need it, you might not be well enough to grow it. In addition, many factors can prevent a person from growing what they need. Some people lack the basic gardening skills, the finances, or the physical ability to do so. Others have living situations that prevent them from being able to grow for themselves. Collectives and cooperatives are vital in helping to insure safe and reasonable access to medical marijuana for qualified patients.

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3 Ways Marijuana Helps Sick People Live Normal Lives

By Anthony Rivas
Tue, May 20, 2014

To say that marijuana's making a comeback would be an understatement. Since California enacted a medical marijuana law in 1996, 20 other states and the District of Columbia have followed suit, with eight of them passing laws in the past four years alone. Two of them — Washington and Colorado — have even passed full-blown legalization of the drug. And none of that includes the many states that are currently in the process, such as New York and Minnesota. This huge shift in public opinion can be credited, in large part, to a wide range of studies and patient testimonies supporting the drug's health benefits. So, what are some of them?

Stress, Anxiety, and PTSD — It's a Mixed Bag

No matter how you ingest marijuana, there are possible side effects to the drug — pro-pot advocates will claim they're never as bad as pharmaceutical side effects — including anxiety and paranoia. These effects can subsequently lead to a higher blood pressure, arrhythmia, and other effects common to anxiety. In this way, it's a gamble when taking marijuana. For those who know how much they're taking and what to expect, however, may experience the opposite effect: calm, relaxation, and happiness.

For people with post-traumatic stress disorder (PTSD), one of the worst possible anxiety disorders, marijuana might be able to alleviate symptoms. Although there's a scarcity of human research into the association, anecdotal evidence is heavy, and states, such as Main and New Hampshire, have begun allowing its use. The Department of Health and Human Services also signed off recently, on a study to test its benefits in PTSD patients.

The use of marijuana for anxiety disorders, and just plain stress, comes from the fact that the brain naturally produces cannabinoids, which are the active chemicals in marijuana — namely, delta-9 tetrahydrocannabinol, or THC — and what help regulate how fear is processed in the brain.

A May 2013 study found that people with PTSD showed lower levels of a certain endocannabinoid known as anandamide in the area of their brains associated with fear and anxiety. Thus, fewer cannabinoid receptors were being activated, spurring PTSD along. In theory, using marijuana would boost concentrations of these beneficial cannabinoids, reducing symptoms of PTSD. "We know very well that people with PTSD who use marijuana often experience more relief from their symptoms than they do from antidepressants and other psychiatric medications," said lead author Dr. Alexander Neumeister, of the Departments of Psychiatry and Radiology at New York University, in a press release.

In part, these calming effects could be the reasons why marijuana use has been linked to a 10 percent reduction in suicide rates, while also being considered for use in some Swiss prisons.

Cerebral Palsy and Other Neurodegenerative Diseases

Neurodegenerative diseases affect millions of people in the U.S. Parkinson's disease, for example, affects an estimated one million people, while cerebral palsy affects as many as 764,000 children and adults. These diseases and more are all debilitating in their own way, as they affect the nervous system's ability to connect with the brain, therefore affecting a person's ability to move. Marijuana has shown *huge* promise in saving these people.

Multiple sclerosis (MS), which occurs when the immune system attacks the nerve's myelin sheaths, causes the nerves to become unable to communicate with each other. In turn, this causes weakness in limbs, partial to complete loss of vision, and tremors. Studies on marijuana use among animals with MS showed that THC and other cannabinoids were able to target the inflammation-causing cells produced by the immune system, subsequently leading to less destruction of myelin. Another UK study found that 12 weeks of marijuana treatment helped relieve muscle stiffness in 30 percent of almost 300 patients suffering from MS.

Marijuana has also been shown to reduce symptoms of Parkinson's disease (PD), which include rigid muscles, slow movement, and tremors. In a study of 22 patients who were all about 66 years old, tremor scores dropped after using marijuana. "The study suggests that cannabis might have a place in the therapeutic armamentarium of PD," the researchers wrote. "Larger, controlled studies are need to verify the results."

In such patients, the results really do need to be seen to be believed. In December, *Medical Daily* reported the story of Jacqueline Patterson, a Missouri mother of four whose cerebral palsy had left her with a severe stutter caused by muscle stiffness, which has also caused her severe pain and the inability to use her right arm correctly. With marijuana, she becomes a totally different person, able to speak, move, and overall become less tense.

Cancer

The big one right here. Pretty much any state that legalizes marijuana for medical use lists cancer as one of the first conditions it can be used for. People undergoing chemotherapy for whatever their cancer may be often experience nausea, vomiting, loss of appetite, and pain, according to the National Institutes of Health (NIH). Marijuana has been shown to alleviate all of these side effects. In fact, two FDA-approved medications, dronabinol and nabilone, are derived from THC and used in cancer patients and HIV/AIDS patients to treat nausea and vomiting. Dronabinol was also shown last year to ease pain in cancer patients. As for increasing appetite, well, they don't call it the munchies for nothing.

Beyond chemo, there's also evidence that marijuana can help prevent the growth of tumors. According to the NIH, another cannabinoid, cannabidiol, has been shown to relieve pain as well as lower inflammation. Cannabinoids such as these have been shown to block cell growth, prevent the growth of blood vessels that aid metastasis (the spread of tumors), and kill tumor cells. Some researchers have even found a way to harness this power without the psychoactive effects.

"Cannabinoids have a complex action; it hits a number of important processes that cancers need to survive," oncologist Dr. Wai Liu told *The Huffington Post*. "For that reason, it has really good potential over other drugs that only have one function. I am impressed by its activity profile, and feel it has a great future, especially if used with standard chemotherapies."

January 7, 2013 | Feb 6, 2014

Mayor and City Council | Planning Commission

The California Compassionate Use Act was passed in 1996 and SB 420 was passed in 2004 providing legitimacy and guidelines to California medicinal cannabis patients. The Americans with Disabilities Act was enacted in 1990. It provided citizens with disabilities equal access to public facilities and services. In the spirit of the ADA, I want to especially commend those on this Council who have the compassion to understand the critical need of people who are sick and/or disabled to access medical cannabis.

However, limiting medical marijuana dispensaries to LB industrial zones is tantamount to displacing all of the pharmacies because of prescription drug abuse. As a nation, we seem readily able to tolerate the ever-growing misuse of physician prescribed medications but vilify a much safer herbal compound. Meds issued by pharmacies kill over 100,000 Americans every year, yet there has not been one documented death from medical cannabis.

One of the myths touted as a reason to close these clinics is that they create crime. In fact, a fairly recent independent Rand study handily proved otherwise. The report was so profound that political forces who have a vested monetary interest in perpetuating this myth put pressure on Rand to squash it. The reality is that should what amounts to be a partial ban be enacted, the juvenile gangs will be more than happy to step up to the plate making regulation an impossibility.

I often hear naïve suggestions that the patients should grow their medicine, in their own backyards. Imagine yourself one day receiving the news from your doctor that you have cancer and may only have a few months to live--you must begin chemotherapy in a week. How will you have the resources, expertise, energy and time to grow the medicine that you will need? What if you live in an apartment? What if you are just too sick or disabled? How can you force a plant to grow to maturity in a week? The whole concept is absurd.

Until the Long Beach City Council is ready to close all of the pharmacies and drug stores, the bars and liquor stores, the tobacco and convenience stores, it is ludicrous for them to target the medical marijuana dispensaries. For the patients who are ill and/or disabled, it is cruel and inhumane.

Instead, the Council needs to work with the clinics and citizens to find a rational solution and reasonable regulations. All Districts should allow access to their constituents in need. Limiting distribution to industrial areas severely restricts access and potentially places patients in harm's way.

In addition, this body must aggressively petition the state of California to fulfill their obligation —to "implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana" as declared in the Compassionate Use Act of 1996.

Peace be with you,

Diana Lejins
Advocates for Disability Rights

Colorado's Recreational, Medical Marijuana Sales Giving Millions To Schools While Crime Rates Are Down

The taxes imposed on both medical marijuana and recreational marijuana sales have apparently been pulling in a lot of money to Colorado's education system. Also, against all predictions made by law enforcement, Colorado's crime rate has supposedly dropped since marijuana legalization went into effect.

In a related report by *The Inquisitr*, a poll on Florida's medical marijuana amendment scheduled for this November shows that even many seniors and conservatives believe that medicinal implements of cannabis are worthwhile. On the Federal level, even one Republican recently proposed a Federal bill to legalize pot and consider it a controlled substance similar to certain medications like painkillers. But the medical angle is still openly being disputed, with a study from Harvard researchers claiming that even occasional recreational marijuana users have "significant brain abnormalities." Of course, the caveat to this statement is that researchers are not sure if the changes in brain structure are positive or negative, so they're working on another study to tackle that particular question.

Speaking of questions, everyone wants to know whether Colorado's marijuana laws is helping or hindering the state, and already the results are under dispute. For example, in March alone, the sale of recreational marijuana netted $19 million and 10 percent of that — $1.9 million — will go toward education. According to *PolicyMic*, Colorado's marijuana sales from the 97 recreational marijuana dispensaries will make $30 million this year in pot taxes alone, although some people believe this underestimates the potential for the market. In addition, medical marijuana is not included in these figures, although medical marijuana is not taxed nearly as heavily as recreational legal weed.

The city of Denver is also reporting that **crime is down by 10.6 percent** compared to January of this year. The biggest change is the number of **murders, which has dropped by 52.9 percent**. Overall, crimes rates in the Colorado city are down, although the number of crimes related to arson have jumped by 135 percent. Of course, this is hardly a long term study so it's difficult to say whether or not legal weed played a positive role in these results.

CRITIQUE OF LONG BEACH MMj ORDINANCE of CITY ATTORNEY

page 5: Business manager designated by "owner" of the medical marijuana business. There is no "owner" in a collective.

page 7: Medical marijuana plant. Why is the portion of the plant harvested not considered part of the plant?

page 11: Costs of inspection, enforcement, and abatement. Why should the property owner be responsible for these costs?

page 13: (requirements for conditional use permit) 6. A statement indicating whether any of the named owners, members, business managers, financiers, primary caregivers, or persons named in the application have been:

a) Denied an application for conditional use permit...or had such a license or permit suspended or revoked. This requirement is arbitrary, capricious, and totally unreasonable. The collective is a group of people coming together to help each other obtain medical marijuana. An examination of their total life and business history would constitute a totally unnecessary disclosure of private information that is not at all necessary to achieve their joint purpose of obtaining medical marijuana.

b)Convicted of violating any law, other than a traffic violation infraction, or completed any portion of a sentence due to a violation of any law. "Convicted of violating any law" would include many inconsequential misdemeanors. Regardless of the severity of the infraction, if the applicant has finished any sentence and parole, the applicant should be free to move forward in a positive manner and pursue his or her version of the American Dream.

page 18: Persons prohibited as permittees and business managers.

4. Any person who operates or manages or who has operated or managed a medical business contrary to the provisions of this Chapter, any other applicable law, rule or regulation or conditions imposed on land law use or license approvals, or contrary to the terms of the plans submitted with the permit application, or amended as permitted by this Chapter or has operated a business in violation of any law. This broad-brush exclusion is in the first place an ex post facto law because it creates legal sanctions for behavior before the law is enacted. And it is broad enough that local politicians could select permittees for approval based on factors entirely outside of the operation of a good collective.

page 19: Location of medical marijuana businesses.

The limitation of medical marijuana business to two per district or nine for the city, besides being too small to serve the current medical marijuana patients, doesn't allow for additional population growth.

page 20: b Suitability of security plan

1. The applicants security plan includes the presence of security personnel on premises twenty-four (24) hours per day. This requirement would be a large, unnecessary expense which would serve no logical purpose. Especially since the new rules would have collectives closing at 7PM.

page 22: F. Separation from schools, parks, and other medical marijuana uses.

The limitation of 1500 feet from a high school is excessive and out of touch with effective regulations used in other cities. The federal "standard" is one thousand feet.

page 24: Owner or business manager required on property. Most businesses have assistant managers to operate the business while the manager takes care of business outside of the business.

page 28: P. 1. No medical marijuana business may produce concentrated cannabis. Concentrated cannabis in the form of a concentrate known as Rick Simpson Oil has been used by many health practitioner as a viable remedy for many ills including cancer. And concentrates are effective additions to skin salves.

page 36: Prohibited acts

1. Cultivate, distribute, possess, or produce marijuana in plain view of, or in a place open to the public. This rule would be overly broad and by its words would forbid a patient from carrying their medicine across a street.

page 38: Indicates that if a conditional permit expires, the permittee would have to submit a late filing fee of $5,000 to file the renewal application. But on page 39, it states that no renewal applications would be accepted after expiration. Which way is it?

- Amy Bodek
- Apr 29

To diana lejins

- jeffrey.winklepleck@longbeach.gov
- Jacque Gilmore

Ms. Lejins,
Thank you for your email. I wish to let you know that your original email was provided to the Planning Commission at their last meeting per your request. I understand that you were not able to attend the meeting; please know that there will be more public forums to discuss the ordinance as we finalize it.

To that end, I'd be happy to set up a meeting with you and your team to discuss the draft ordinance and how it should be modified. If you would let me know who you would like to bring with you to a meeting, I will ask my assistant, Jacque, to set something up. Also, if you have written suggestions, or a draft ordinance you've prepared that you'd like to share with Jeff and I, we'd appreciate that information as well. Our intent is to craft an ordinance that is workable from an advocate perspective, an owner/operator perspective, and from a land use perspective as well. We welcome your input.

Amy J. Bodek, AICP
Director

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Cc: "dianalejins@yahoo.com" <dianalejins@yahoo.com>
Date: 04/25/2014 04:58 PM
Subject: City Planning Commission - Medical Marijuana Ordinance

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To Whom It May Concern
City Employees--Please effectuate delivery of this letter to the Planning Commission and to the medical marijuana ordinance agenda item prior to the May meeting.
The following letter was submitted to the Planning Commission in April 2014. It is my understanding that they agreed with the premise that various stakeholders in the community should be included in an advisory committee re this issue (as ordered by the City Council).
As I have asked numerous times about this committee and ordinance, I am very disappointed that I have not heard from City Hall about it. Stonewalling taxpayers is not a proven method of endearing them to the government. In fact, the "government" is showing an all-time low in the estimation of U.S. citizens--and, that includes cities.

Your "draft ordinance" seems punitive, sorely needs patient/advocate input, and leaves much to be desired. So, a phone call this coming week from the appropriate office would be most appreciated. A number of dates for a meeting (not just a mere token) where stakeholders can actually be heard and their input welcomed should be entertained.

Yours truly,
Diana Lejins
Advocates for Disability Rights
****

City Employees--Please effectuate delivery of this letter prior to or at this meeting.

Dear Planning Commissioners

I just got wind of the (new) MMj ordinance and have done a preliminary review. I am extremely disappointed that those involved had not gotten more notice about this extremely critical edict. I will not be able to attend the Planning Meeting at 5 pm Thursday as I have prior obligations.

Since this proposed ordinance was put into the pipeline by the City Council around Dec 2013, I have been asking about the ordinance, but was always off-put. One excuse after another. I have also asked numerous times about the "creation of an advisory task force" which was mandated by the Council and received the same run-around. The spirit of this provision was such that several public speakers (including myself) had requested this--specifically asking for patients, advocates for disabilities, dispensary operators, etc to be included. After all, isn't this all supposed to be for the benefit of people who use medical marijuana for health reasons?

Now, they have just dumped a 41-page legal document on us with little notice nor time for review. Rather interesting that its arrival was just a week after the primary election. Policiticizing people's disabilities, illnesses and suffering is a pretty sad state of affairs.
I am an advocate for people who have disabilities and was a Chair and member of the Long Beach Citizens Advisory Commission on Disabilities. I have some serious and legitimate concerns about this ordinance.

In light of the fact that the City Attorney's Office has not made any effort to comply with the most important "creation of an advisory task force" that would represent those most impacted by this ordinance, that the previous ordinance was an abysmal failure, and that rushing to make decisions on this critical piece of legislation could well end up in another slew of law suits against the City, I am requesting that any final deliberations include more input from the community and be vetted more thoroughly by those who are most involved.

Please remember that one day we will all grow old and may end up with a disease or disability that could be helped by medical cannabis. Maybe it will be a loved one--your spouse, parent or child. Your empathy and compassion in this matter is greatly appreciated.

Please feel free to call me or write if you have any questions or would like to arrange a discussion of this issue.

Diana Lejins
Advocates for Disability Rights
POB 15027
Long Beach, CA 90815
(562) 421-8012

Working to make the World a better place,
diana

Hospital Errors are the Third Leading Cause of Death in U.S., and New Hospital Safety Scores Show Improvements Are Too Slow

Washington, D.C., October 23, 2013 – New research estimates up to 440,000 Americans are dying annually from preventable hospital errors. This puts medical errors as the third leading cause of death in the United States, underscoring the need for patients to protect themselves and their families from harm, and for hospitals to make patient safety a priority.

Released today, the Fall 2013 update to The Leapfrog Group (Leapfrog) Hospital Safety Score assigns A, B, C, D and F grades to more than 2,500 U.S. general hospitals. It shows many hospitals are making headway in addressing errors, accidents, injuries and infections that kill or hurt patients, but overall progress is slow. The Hospital Safety Score is calculated under the guidance of the Leapfrog Blue Ribbon Expert Panel, with a fully transparent methodology analyzed in the peer-reviewed *Journal of Patient Safety.*

Leapfrog, an independent, national nonprofit organization that administers the Score, is an advocate for patient safety nationwide.

"We are burying a population the size of Miami every year from medical errors that can be prevented. A number of hospitals have improved by one or even two grades, indicating hospitals are taking steps toward safer practices, but these efforts aren't enough," says Leah Binder, president and CEO of Leapfrog. "During this time of rapid health care transformation, it's vital that we work together to arm patients with the information they need and tell doctors and hospitals that the time for change is now."

As result of the push for more public reporting of hospitals' safety efforts, Leapfrog added two new measures to the latest Hospital Safety Score release, including Catheter-Associated Urinary Tract Infections (CAUTIs) and Surgical Site Infections: Colon (SSI: Colon). While CAUTIs and SSI: Colon have not received as much public attention as other measures, they are among the most common hospital infections and claim a combined 18,000 lives each year. With data from the CMS Hospital Compare website as well as the Leapfrog Hospital Survey, Leapfrog now has the publicly available data needed to calculate these critical measures into the Score.

CAUTI and SSI: Colon are among the 28 measures of publicly available hospital safety data used to produce a single grade representing a hospital's overall safety rating.

The Hospital Safety Score is a public service available at no cost online or on the free mobile app at www.hospitalsafetyscore.org. A full analysis of the data and methodology used is also available on the Hospital Safety Score website.

Key Findings

- On average, there was no improvement in hospitals' reported performance on the measures included in the score, with the exception of hospital adoption of computerized physician order entry (CPOE). The

expansion in adoption of this lifesaving technology suggests that federal policy efforts to improve hospital technology have shown some success.

- Of the 2,539 general hospitals issued a Hospital Safety Score, 813 earned an "A," 661 earned a "B," 893 earned a "C," 150 earned a "D" and 22 earned an "F."
- While overall hospitals report little improvement in safety, some individual hospitals (3.5 percent) showed dramatic improvements of two or more grade levels.
- The states with the smallest percentage of "A" hospitals include New Hampshire, Arkansas, Nebraska and New Mexico. No hospitals in New Mexico or the District of Columbia received an "A" grade.
- Maine claimed the number-one spot for the state with the highest percentage of "A" hospitals.
- Kaiser and Sentara were among the hospital systems that achieved straight "A" grades, meaning 100 percent of their hospitals received an "A."

For more information about the Hospital Safety Score or to view the list of state rankings, please visit www.hospitalsafetyscore.org. Journalists interested in scheduling an interview should contact LeapfrogMedia@sternassociates.com.

About The Leapfrog Group

The Hospital Safety Score is an initiative of The Leapfrog Group (www.leapfroggroup.org), a national nonprofit organization using the collective leverage of large purchasers of health care to initiate breakthrough improvements in the safety, quality and affordability of health care for Americans. The flagship Leapfrog Hospital Survey allows purchasers to structure their contracts and purchasing to reward the highest performing hospitals. The Leapfrog Group was founded in November 2000 with support from the Business Roundtable and national funders and is now independently operated with support from its purchaser and other members.

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- LEGAL DISCLAIMER: The Leapfrog Group Hospital Safety Score program grades hospitals on their overall performance in keeping patients safe from preventable harm and medical errors. The grades are derived from expert analysis of publicly available data using 28 evidence-based, national measures of hospital safety. No specific representation is made, nor shall be implied, nor shall The Leapfrog Group be liable with respect to any individual patient's potential or actual outcome as a result of receiving services performed at any of these hospitals. Hospital Safety Scores cannot be republished without expressed written permission from The Leapfrog Group.

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Medical cannabis provides dramatic relief for sufferers of chronic ailments, Israeli study finds

Date:
January 24, 2013

Source:
American Friends of Tel Aviv University

Summary:
Though still controversial, medical cannabis has been gaining ground as a valid therapy for cancer, PTSD, and chronic pain. Now a specialist says that residents of an Israel nursing home experienced dramatic physical and mental improvements following cannabis therapy and that the therapy significantly reduced the need for chronic medications for many of them.

Cannabis plant.
Credit: © Opra / Fotolia

[Click to enlarge image]

Though controversial, medical cannabis has been gaining ground as a valid therapy, offering relief to suffers of diseases such as cancer, Post-Traumatic Stress Disorder, ALS and more. The substance is known to soothe severe pain, increase the appetite, and ease insomnia where other common medications fail.

In 2009, Zach Klein, a graduate of Tel Aviv University's Department of Film and Television Studies, directed the documentary Prescribed Grass. Through the process, he developed an interest in the scientific research behind medical marijuana, and now, as a specialist in policy-making surrounding medical cannabis and an MA student at TAU's Porter School of Environmental Studies, he is conducting his own research into the benefits of medical cannabis.

Using marijuana from a farm called Tikkun Olam -- a reference to the Jewish concept of healing the world -- Klein and his fellow researchers tested the impact of the treatment on 19 residents of the Hadarim nursing home in Israel. The results, Klein says, have been outstanding. Not only did participants experience dramatic physical results, including healthy weight gain and the reduction of pain and tremors, but Hadarim staff saw an immediate improvement in the participants' moods and communication skills. The use of chronic medications was also significantly reduced, he reports.

Klein's research team includes Dr. Dror Avisar of TAU's Hydrochemistry Laboratory at the Department of Geography and Human Environment; Prof. Naama Friedmann and Rakefet Keider of TAU's Jaime and Joan Constantiner School of Education; Dr. Yehuda Baruch of TAU's Sackler Faculty of Medicine and director of the Abarbanel Mental Health Center; and Dr. Moshe Geitzen and Inbal Sikorin of Hadarim.

Cutting down on chronic medications

Israel is a world leader in medical cannabis research, Klein says. The active ingredient in marijuana, THC, was first discovered there by Profs. Raphael Mechoulam and Yechiel Gaoni. Prof. Mechoulam is also credited for having defined the endocannabinoid system, which mimics the effects of cannabis and plays a role in appetite, pain sensation, mood and memory.

In the Hadarim nursing home, 19 patients between the ages of 69 and 101 were treated with medical cannabis in the form of powder, oil, vapor, or smoke three times daily over the course of a year for conditions such as pain, lack of appetite, and muscle spasms and tremors. Researchers and nursing home staff monitored participants for signs of improvement, as well as improvement in overall life quality, such as mood and ease in completing daily living activities.

During the study, 17 patients achieved a healthy weight, gaining or losing pounds as needed. Muscle spasms, stiffness, tremors and pain reduced significantly. Almost all patients reported an increase in sleeping hours and a decrease in nightmares and PTSD-related flashbacks.

There was a notable decline in the amount of prescribed medications taken by patients, such as antipsychotics, Parkinson's treatment, mood stabilizers, and pain relievers, Klein found, noting that these drugs have severe side effects. By the end of the study, 72 percent of participants were able to reduce their drug intake by an average of 1.7 medications a day.

Connecting cannabis and swallowing

This year, Klein is beginning a new study at Israel's Reuth Medical Center with Drs. Jean-Jacques Vatine and Aviah Gvion, in which he hopes to establish a connection between medical cannabis and improved swallowing. One of the biggest concerns with chronically ill patients is food intake, says Klein. Dysphagia, or difficulty in swallowing, can lead to a decline in nutrition and even death. He believes that cannabis, which has been found to stimulate regions of the brain associated with swallowing reflexes, will have a positive impact.

Overall, Klein believes that the healing powers of cannabis are close to miraculous, and has long supported an overhaul in governmental policy surrounding the drug. Since his film was released in 2009, the number of permits for medical cannabis in Israel has increased from 400 to 11,000. His research is about improving the quality of life, he concludes, especially for those who have no other hope.

Story Source:

The above story is based on materials provided by **American Friends of Tel Aviv University.** *Note: Materials may be edited for content and length.*

American Friends of Tel Aviv University. "Medical cannabis provides dramatic relief for sufferers of chronic ailments, Israeli study finds." ScienceDaily. ScienceDaily, 24 January 2013. <www.sciencedaily.com/releases/2013/01/130124123453.htm>.

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Oct. 22, 2009 — Last year the UK government reclassified cannabis from a class C to a class B drug, partly out of concerns that cannabis, especially the more potent varieties, may increase the risk of schizophrenia ... *full story*

Ten Years After Decriminalization, Drug Abuse Down by Half in Portugal

Forbes.com July 2011

Drug warriors often contend that drug use would skyrocket if we were to legalize or decriminalize drugs in the United States. Fortunately, we have a real-world example of the actual effects of ending the violent, expensive War on Drugs and replacing it with a system of treatment for problem users and addicts.

Ten years ago, Portugal decriminalized **all** drugs. One decade after this unprecedented experiment, drug abuse is down by half:

Health experts in Portugal said Friday that Portugal's decision 10 years ago to decriminalise drug use and treat addicts rather than punishing them is an experiment that has worked.

"There is no doubt that the phenomenon of addiction is in decline in Portugal," said Joao Goulao, President of the Institute of Drugs and Drugs Addiction, a press conference to mark the 10th anniversary of the law.

The number of addicts considered "problematic" — those who repeatedly use "hard" drugs and intravenous users — had fallen by half since the early 1990s, when the figure was estimated at around 100,000 people, Goulao said.

Other factors had also played their part however, Goulao, a medical doctor added.

"This development can not only be attributed to decriminalisation but to a confluence of treatment and risk reduction policies."

Many of these innovative treatment procedures would not have emerged if addicts had continued to be arrested and locked up rather than treated by medical experts and psychologists. Currently 40,000 people in Portugal are being treated for drug abuse. This is a far cheaper, far more humane way to tackle the problem. Rather than locking up 100,000 criminals, the Portuguese are working to cure 40,000 patients and fine-tuning a whole new canon of drug treatment knowledge at the same time.

<u>Long Beach Police Department May 2014</u>

The following information is provided to assist potential applicants in preparing for the hiring process:

****

P.O.S.T. MINIMUM REQUIREMENTS:

- Be at least 20 years of age or older by October 1, 2013
- US High School Diploma or GED equivalency
- Have no physical or mental limitations that might prevent the completion of any duty assignment
- Have vision correctable to 20/20
- Possess a valid driver's license
- Be a United States citizen or a permanent resident alien who is eligible for and has applied for citizenship (1031.5 Government Code)
- Cannot be on court ordered probation at the time of application or hire
- No felony convictions

LONG BEACH POLICE DEPARTMENT DRUG POLICY

The Long Beach Police Department hiring standard concerning drug usage is as follows:

- **Marijuana -** any use of marijuana in the last **<u>two-years</u>** from the application deadline (September 13, 2013) will result in disqualification from the current hiring process. This is not a life time disqualification; just until a two-year period of no marijuana use has passed
- **Other illegal drug use** (other than marijuana or hard drugs listed below) in the last **<u>three-years</u>** from the application deadline (September 13, 2013), will result in disqualification from the current hiring process. This is not a life-time disqualification; just until a three-year period of no illegal drug use has passed.
- Any use of **hallucinogenic drugs (PCP, LSD, mushrooms, etc.),** illegal **intravenous drugs** (heroin, methamphetamine, etc.), or **bath-salts** is an automatic disqualification from this process. This is a **<u>life-time</u>** ban.

All other drug use will be assessed on a case-by-case basis and a determination will be made based on the applicant's overal qualifications.

Marijuana Does Not Promote Crime, According to Study May 20, 2014

By Michael P. Tremoglie

NEW YORK (MainStreet) — It has been alleged - especially by law enforcement officers - that the legalization of marijuana even for medical purposes will increase crime. But a new study from the University of Texas, Dallas, states legalization of medical cannabis is not an indicator of increased crime.

In fact the study says it actually may be related to reductions in certain types of crime like murder. The lead author of the study, criminology professor Robert Morris said in they are not claiming medical marijuana laws definitely reduce homicide only that they found some evidence of decreasing rates of homicide and assault.

Also See: Does Marijuana Induce Psychosis

The study tracked crime rates across all 50 states between 1990 and 2006, when 11 states legalized marijuana for medical use: Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, Oregon, Rhode Island, Vermont and Washington. Since the time period the study covered, the number of states that have legalized medical marijuana has risen to 20, plus Washington, D.C.

Using FBI crime data the researchers studied rates for homicide, rape, robbery, assault, burglary, larceny and auto theft. None of the seven crime types increased with the legalization of medical marijuana.

Also See: What Cannabis Crime Wave? Marijuana Sales Steady, Colorado Crime Down

Robbery and burglary rates were unaffected by medical marijuana legalization, according to the study. These findings run counter to the claim that marijuana dispensaries and grow houses lead to an increase in victimization because of the opportunities for crime linked to the amount of drugs and cash that are present.

Morris said the models accounted for an exhaustive list of sociodemographic and econometric variables that are well-established links to changes in crime rates, including statistics on poverty, unemployment, college education, prison inmates and even the amount of beer consumed per person per year.

Once data are available, the researchers plan to investigate the relationship between recreational marijuana legalization and crime in Washington and Colorado, where the legalized marijuana marketplace is taking shape.

But even the authors of the study provide a caveat about their work. They clearly state at the end of their study, "Given that the current results failed to uncover a crime exacerbating effect attributable to MML (medical marijuana legalization), it is important to examine the findings with a critical eye. While we report no positive association between MML and any crime type, this does not prove MML has no effect on crime (or even that it reduces crime)."

The study continues by saying "this longitudinal assessment of medical marijuana laws on state crime rates" leads one to think that such laws "do not appear to have any negative (i.e., crime exacerbating) impact on officially reported criminality during the years in which the laws are in effect, at least when it comes to the types of offending explored here."

The study also omitted juvenile offenses. This is something that does cause trepidation among many legalization opponents.

When asked about this caveat, Morris told *MainStreet* that there could be contextual differences in an effect that was beyond the scope of the study.

"Our findings apply specifically to state-level crime rates, not at the neighborhood level, for example, where the findings may be different," he said. "There is one no single study that ever proves something; validation with different contexts is needed."

Though Morris is confident that MML has no crime increasing effect, he believes more studies are necessary to confirm this conclusion further.

"I would say that this study provides considerable evidence to the idea that medical marijuana legalization did not increase crime rates at the state level," he claimed. "The data used were comprehensive and covered a long time period when 11 states transitioned to legalization for medical use. There is more work to be done, but this was a big step."

--Written by Michael P. Tremoglie for MainStreet

May 2014

RE: Proposed Medical Marijuana Ordinance

Dear Planning Commissioners

We, the members of Advocates for Disability Rights, have reviewed the proposed Medical Marijuana Ordinance and have many concerns.

We have included in this package a number of informational pages, a proposed ordinance that we believe would best serve the needs of the patients, and notes regarding the City Attorney's proposed regulations.

Considering the abysmal failure of the last ordinance (5.87) and the abundance of lawsuits it fostered, we sincerely hope that our input will help to create regulations that are not only fair and just but compassionate as well. After all, isn't this about people who are ill and disabled?

We believe that a joint effort would not only serve the democratic process but could circumvent the problems engendered by past policies. Please feel free to contact us at dianalejins@yahoo.com or tele (562) 421-8012.

Yours truly

Diana Lejins
Advocates for Disability Rights
POB 15027
LB, CA 90815

Studies claim medical marijuana may reduce suicide rates, traffic fatalities

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BY Robert Pursell *February 6, 2014 at 1:02 PM EDT*

Two new studies claim that legalizing medical marijuana could be a lifesaver, especially for certain demographic groups. Photo by Tony Avelar/The Christian Science Monitor via Getty Images

Contrary to the claims of outdated anti-marijuana PSA's, a new study published in the the American Public Journal of Health claims that legalizing medical marijuana can reduce suicide rates by five percent among the general population and by as much as 10 percent among young male population.

The study, co-written by professors from Montana State, San Diego State, and the University of Colorado at Denver, analyzed 17 years worth of statistics in search of

shifts in suicide rates per 10,000 people in states where medical marijuana was legal from 1990 to 2007. Using the statistics of states in which marijuana is still illegal as the control group, the study's authors concluded that in states with legal medical marijuana, the suicide rate for males aged 20-29 decreased 10.9 percent, and for men aged 30-39 they saw a decrease of 9.4 percent.

The study stated that estimates for females were less precise and thus required further study.

The researchers explained that, "opponents of legalizing medical marijuana point to the large number of studies showing that marijuana use is positively associated with depression, the onset of panic attacks, psychosis, schizophrenia, and suicidal ideation."

"However," they continued, "the association between marijuana use and outcomes such as these could be attributable to difficult-to-measure (extraneous variables,) such as personality."

While the conclusion stated, "The negative relationship between legalization and suicides among young men is consistent with the hypothesis that marijuana can be used to cope with stressful life events," the researchers noted that some men in stressful situations may also use alcohol as a coping mechanism and that the topic should be further studied.

The study is particularly interesting when looked at in conjunction with author Dr. Daniel I. Rees' May 2013 study, published by the University of Chicago Press, which concluded that traffic fatalities decrease between eight and 11 percent in states where marijuana is legal, the first year after legalization." It also stated that total beer consumption dropped five percent post-legalization and that traffic fatalities in which at least one driver had a positive blood alcohol content level lessened by 13.2 percent.

MEDICAL MARIJUANA ORDINANCE 5.91 - CITY OF LONG BEACH

After previewing this 41-page proposed Medical Marijuana Ordinance, it is our belief that the City Attorney has little interest in creating legislation that will actually work. This regulation is negative and punitive. There is a total disregard for the needs of the patients who it is supposed to be serving. Coupled with the recent Proposition A tax proposal, the whole situation seems to be on a path of despair for those who need it the most. Somehow, the spirit of California Proposition 215 (The Compassionate Use Act) has been lost.

California Proposition 215:

SECTION 1. Section 11362.5 is added to the Health and Safety Code, to read:

11362.5. (a) This section shall be known and may be cited as the Compassionate Use Act of 1996.

(b)(1) The people of the State of California hereby find and declare that the purposes of the Compassionate Use Act of 1996 are as follows:

(A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.

(B) To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction.

(C) To encourage the federal and state governments to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana.

(2) Nothing in this section shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes.

(c) Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes.

(d) Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.

(e) For the purposes of this section, "primary caregiver" means the individual designated by the person exempted under this section who has consistently assumed responsibility for the housing, health, or safety of that person.

SEC. 2. If any provision of this measure or the application thereof to any person or circumstance is held invalid, that invalidity shall not affect other provisions or applications of the measure that can be given effect without the invalid provision or application, and to this end the provisions of this measure are severable.

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The message of this proposed Ordinance comes through loud and clear: We (the City) adhere to the many myths about medical cannabis and will continue to demonize it. But, if we can just make it difficult enough, charge exorbitant fees to fill City coffers, create a nightmarish quagmire of bureaucracy and legal obstacles, violate patients and their privacy rights, and invite a plethora of lawsuits, we might just look the other way.

Until all peoples (including medical marijuana patients) are treated justly and compassionately, no one is safe from cruelty and injustice. We will all die one day; consider what your needs might be—tomorrow may be too late.

DL 5-14

Advocates for Disability Rights

Medical Marijuana Dispensary $$$

While in an ideal world, everyone would be paid the same, all medicines and medical care would be free, education would be available to anyone, the environment would be devoid of all poisons and carcinogens. There would be no famine, war or hatred. But, we do not live in that kind of world. And, most people have the desire to be paid according to risk taken, educational status, effort made, and many other factors. People who establish medical marijuana dispensaries are no different. They provide a service and expect a reasonable return. If we are to disallow that, then we must also control every other service provider in the same manner. DL 5-20-14

Consider the following two articles:

Posted on April 8, 2013 | Posted in Press Statements

Big Pharma Pockets $711 Billion in Profits by Price-Gouging Taxpayers and Seniors

Washington, DC – The 11 largest drug companies took $711.4 billion in profits over the 10 years ending in 2012, according to an analysis of corporate filings by Health Care for America Now (HCAN). The global pharmaceutical industry derived much of that profit from price-gouging the Medicare Part D prescription drug program for seniors and people with disabilities. Americans pay significantly more than any other country for the exact same drugs. In 2012 alone, the drug companies' profits reached $83.9 billion, 62 percent higher than in 2003.

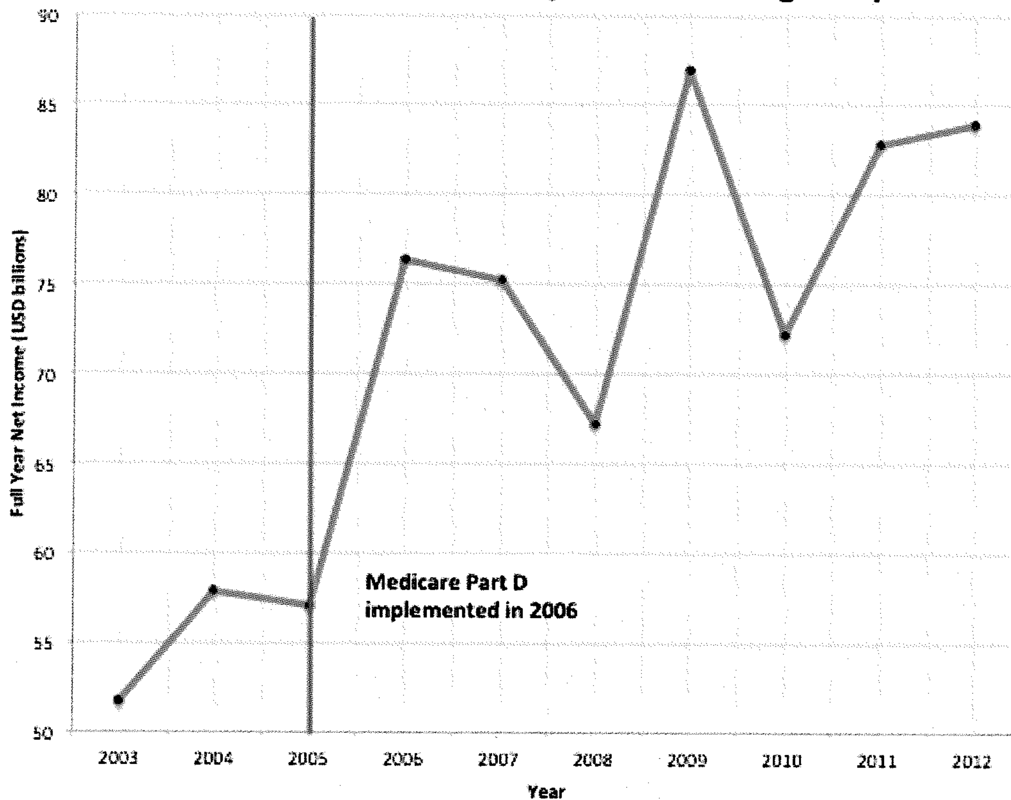
Net Profits for Top 11 Global Pharmaceutical Companies, 2003-2012
(in billions of US dollars)

Company	Net Profits
Johnson & Johnson	$105.8
Pfizer	$100.4
Novartis	$83.1
Merck	$59.1
Roche	$73.3
Sanofi-Aventis	$57.7
GlaxoSmithKline	$77.8
Abbott Laboratories	$40.6
AstraZeneca	$58.9
Eli Lilly	$27.7
Bristol-Myers Squibb	$27.0
Total:	**$711.4 BILLION**

"The drug industry's profits are excessive as a result of overcharging American consumers and taxpayers," said Ethan Rome, HCAN's executive director. "During this period, as millions of Americans struggled to afford their medicines, Republicans in Congress have threatened to cut seniors' benefits while refusing to consider commonsense measures to get a better deal from drug companies."

HCAN reviewed the last decade's financial filings from 11 prescription drug giants: Pfizer, Johnson & Johnson, Novartis, Merck, Roche, Sanofi-Aventis, GlaxoSmithKline, Abbott Laboratories, AstraZeneca, Eli Lilly and Bristol-Myers Squibb. Click here for detailed annual earnings.

Bolstered by its formidable prescription-drug marketing machine, Big Pharma's already huge profits surged to new heights in 2006, the first year of Medicare's Part D prescription drug program – and they've stayed high ever since.



Thanks in part to inflated costs paid by the Part D program, the 11 drug companies booked $76.3 billion in profits in 2006 – an extraordinary 34 percent increase from the previous year, when Part D was not yet in place. Medicare — the largest purchaser in the world's largest drug market – is prohibited by law from seeking better prices. Simply empowering Medicare to get the same bulk purchasing discounts on prescription drugs as state Medicaid programs already get would save the federal government $137 billion over 10 years, according to the Congressional Budget Office.

"Eliminating price-gouging on that scale would go a long way toward addressing the fiscal challenges that are under constant discussion in Washington – without harming seniors and middle-class families," Rome said. This proposal has been supported by President Obama and is in the House Democrats' budget plan.

"When it comes to addressing our country's fiscal challenges, we shouldn't even talk about cutting Medicare or any services people depend on, as the Republicans have proposed," Rome said. "Our politicians give all kinds of tax breaks and subsidies to big corporations that don't need them, and no industry illustrates that better than Big Pharma."

Drug makers charge customers in the U.S. – especially the government – vastly more for the same drugs than they do in places like Canada and Europe, where government health plans bargain with the drug companies to protect their citizens. Per capita drug spending in the U.S. is about 40 percent higher than in Canada, 75 percent greater than in Japan and nearly triple the amount spent in Denmark.

The drug companies say they must impose higher prices in the U.S. to pay for research that enables them to innovate and develop new drugs that save our lives. But that's not true. Half of the scientifically innovative drugs approved in the U.S. from 1998 to 2007 resulted from research at universities and biotech firms, not big drug companies, research shows. And despite their rhetoric, drug companies spend 19 times more on marketing than on research and development.

"Every gift to a special interest, such as allowing Big Pharma to overcharge Medicare, is wasteful spending of scarce tax dollars," Rome said. "Instead of cutting benefits to seniors and families, we should eliminate indefensible special-interest tax breaks and subsidies for big corporations that don't need them."

Ethan Rome in Huffington Post | *Big Pharma Pockets $711 Billion in Profits by Robbing Seniors, Taxpayers*

Health Care for America Now, the nation's leading grassroots health care coalition, led the fight to win health reform. HCAN works to promote the Affordable Care Act, protect Medicare and Medicaid, and keep Congress from being steamrolled by corporate special interests.

Ethan Rome Executive Director, Health Care for America Now

Big Pharma CEOs Rake in $1.57 Billion in Pay

Posted: 05/08/2013 8:19 am

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For people who were blown away to learn recently that the 11 largest global pharmaceutical companies made an astonishing $711 billion in profits over the last decade, here's another measure of the industry's greed: the same companies paid their chief executive officers a combined $1.57 billion in that period. Not bad work if you can get it. They achieved this thanks in part to their systematic exploitation of Medicare and an epidemic of illegal marketing activity.

According to corporate filings analyzed by Health Care for America Now (HCAN), in 2012 the drug companies' CEOs drew total compensation of $199.2 million, two and a half times the total in 2003. In 2006, the first year of the Medicare prescription drug law, the pay of the CEOs jumped by $58.9 million from the previous year, the largest one-year increase in the decade HCAN reviewed.

Inflated Drug Prices

These huge spikes in pay coincided with eye-popping profits bolstered by a provision the pharmaceutical lobby inserted into the law to prohibit Medicare from using its unparalleled purchasing power to obtain discounts or negotiate prices with drug companies. By prohibiting Medicare to get better drug prices, the federal government is effectively subsidizing the greed of the drug makers and their CEOs. As a result, Americans pay vastly higher prices than people in other countries for identical drugs. This is ludicrous and wasteful. It hurts the government, seniors and middle-class families.

It should not be the official policy of the United States to price-gouge our people and government - a practice that's especially offensive at a time when some in Washington are talking about cutting Medicare benefits.

Simply empowering Medicare to buy drugs under the same bulk purchasing discounts used by state Medicaid programs would save the federal government billions. For example, the Medicare Drug Savings Act, introduced by Sen. Jay Rockefeller (D-WV), would save $141 billion over the next 10 years without reducing Medicare benefits. Similar measures are in President Obama's budget proposal and the House Democratic budget plan.

Illegal and Improper Conduct on the Rise

The increases in CEO pay and drug company profits also corresponded with a surge in illegal and improper conduct by the industry. From 2003 to 2012, financial penalties paid by drug manufacturers to settle allegations of illegal marketing, price-gouging of government programs and other violations rose by more than 500 percent, according to a report issued by Public Citizen in September 2012.

In 2003, there were only nine settlements with the federal or state governments, amounting to $967 million in penalties. In 2011, federal and state government agencies reached a record 44 settlement agreements with drug makers. And by July 2012, with the year only half over, drug companies had already agreed to pay nearly $6.6 billion as part of 19 settlements with the government. Data on the second half of 2012 have not yet been compiled by Public Citizen.

Here's the kicker: The most common drug-company violation cited by regulators and law enforcement agencies between 1991 and July 2012 was overcharging government health programs. Really? How much overcharging do they need?

Over the last decade, the drug companies racked up unprecedented penalties for criminal and civil violations. They jacked up prices for seniors and the government. They made excessive profits and gave unconscionable compensation to the CEOs in charge of this all.

End Corporate Tax Giveaways

It is obscene that any lawmakers in Washington -- even the most extremist Republicans who hate civilization as we know it -- are even talking about cutting benefits for seniors in the midst of what amounts to a drug industry scandal.

We shouldn't be making any benefit cuts to Medicare, Medicaid, the Affordable Care Act or Social Security. Not now, not ever. Instead, we should make the wealthiest Americans pay their fair share in taxes and eliminate indefensible special-interest tax breaks and subsidies for big corporations like the companies that ship jobs overseas, Big Oil, and a drug industry that has made a science out of ripping off the American people.

* * * * *

HCAN's analysis of CEO pay focused on 11 companies: Johnson & Johnson, Abbott Laboratories, Pfizer, Novartis, Eli Lilly, Roche, Merck, Bristol-Myers Squibb, Sanofi, GlaxoSmithKline and AstraZeneca. Over the 10-year period, the $1.57 billion in total compensation was split among 27 executives. The top earners in 2012 were Johnson & Johnson's William Weldon, who took in $29.8 million, and Pfizer's Ian Read, who received $25.6 million. By comparison, the median household income in the U.S. last year was $50,054, while half of all Medicare beneficiaries had less than $22,500 in annual income. Click here for details on Big Pharma's annual CEO compensation expenditures. In April, HCAN compiled data showing that the 11 drug companies reported $711.4 billion in profits over the same 10-year span.

Matthew Staver/New York Times/Redux

Study: Marijuana legalization doesn't increase crime

04/15/14 09:04 PM—Updated 04/15/14 11:18 PM

By Erin Delmore

Three months after Colorado residents legalized recreational marijuana with the passage of Amendment 64 in Nov. 2012, Sheriff Tom Allman of Mendocio County, Calif. – a haven for marijuana growers – warned that an onslaught of crime was headed toward Colorado.

"Thugs put on masks, they come to your house, they kick in your door. They point guns at you and say, 'Give me your marijuana, give me your money,'" Allman told a Denver TV station in February. His state became the first to legalize marijuana for medical use in 1996; Colorado followed suit in 2000. But a new report contends that fourteen years later, even after Colorado legalized the sale of small amounts of marijuana for recreational use on Jan. 1 of this year, violent and property crime rates in the city are actually falling.

According to data from the Denver Police Department, violent crime (including homicide, sexual assault, robbery, and aggravated assault) fell by 6.9% in the first quarter of 2014, compared with the same period in 2013. Property crime (including burglary, larceny, auto theft, theft from motor vehicle and arson) dropped by 11.1%.

Time for politicians to get on board with pot

With support for marijuana decriminalization, and even legalization, on the rise, Abby Huntsman explains why politicians need to take a closer look at the benefits of making pot legal.

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A study looking at the legalization of medical marijuana nationwide, published late last month in the journal PLOS ONE, found that the trend holds: Not only does medical marijuana legalization not correlate with an uptick in crime, researchers from the University of Texas at Dallas argue it may actually reduce it.

Using statistics from the FBI's Uniform Crime Report and controlling for variables like the unemployment and poverty rates; per capita income; age of residents; proportion of residents with college degree; number of police officers and prisoners; and even beer consumption, researchers analyzed data from all 50 states between 1990 and 2006. (California became the first state to legalize medical marijuana in 1996; in the decade that followed, 10 states followed suit. Today that number is up to 20 states, plus the District of Columbia.) They wrote:

"The central finding gleaned from the present study was that MML (medical marijuana legalization) is not predictive of higher crime rates and may be related to reductions in rates of homicide and assault. Interestingly, robbery and burglary rates were unaffected by medicinal marijuana legislation, which runs counter to the claim that dispensaries and grow houses lead to an increase in victimization due to the opportunity structures linked to the amount of drugs and cash that are present."

The study drew a link between marijuana and alcohol use, surmising that the legalization of pot could cause the number of alcohol-fueled crimes to decline.

"While it is important to remain cautious when interpreting these findings as evidence that MML reduces crime, these results do fall in line with recent evidence and they conform to the longstanding notion that marijuana legalization may lead to a reduction in alcohol use due to individuals substituting marijuana for alcohol. Given the relationship between alcohol and violent crime, it may turn out that substituting marijuana for alcohol leads to minor reductions in violent crimes that can be detected at the state level."

The pro-legalization group Norml cited a 2002 study by David Boyum and Mark Kleiman arguing that regulating marijuana on the same terms as alcohol "would tend to reduce crime."

As a growing number of states are moving to legalize the use and sale of both medical and recreational marijuana, public opinion has changed dramatically. A Gallup poll from October 2013 showed that for the first time, a majority of Americans favored legalizing marijuana. The 58% of respondents who said they were in favor of legalization last year represented nearly five times the number who said so the first time Gallup asked the question in 1969.

Moderate Marijuana Use Does Not Impair Lung Function, Study Finds

By ANAHAD O'CONNOR
JANUARY 11, 2012 9:38 AM

Jim Wilson/The New York Times Investigating the health effects of marijuana.

A large new government study has found that smoking marijuana on a regular basis, even over several years, does not impair lung function.

Marijuana, the country's most widely used illicit drug, has become increasingly popular and less stigmatized in recent years, particularly among young adults. One government report released in December found that one out of 15 high school students now smokes marijuana nearly every day, a growth fueled in part by the spread of medicinal marijuana, which is legal in 16 states. With its use rising, questions about the drug's long-term medical consequences have garnered more attention.

The new research is one of the most extensive looks to date at whether long-term marijuana use causes pulmonary damage, and specifically whether its impact on the lungs is as harmful as smoking cigarettes. The researchers followed more than 5,000 people over two decades and found that regularly smoking marijuana — the equivalent of up to a joint a day over seven years — did not impair performance on a lung function test. The test, a measure of pulmonary obstruction that looks at the amount of air a person can force out in one second after taking a deep breath, is typically worsened by smoking tobacco.

In something of a twist, the researchers found that compared to nonsmokers, marijuana users performed slightly better on the lung function test, though the improvement was minuscule. "Even with this tiny increase in airflow, I have to admit that I really doubt that there's any real increase in lung health," said Dr. Stefan Kertesz, an associate professor at the University of Alabama at Birmingham school of medicine and an author

of the study. The finding may merely reflect marijuana smokers' years of "training" in taking deep inhalations and holding the smoke, the researchers said.

In the near term, smoking marijuana irritates the airways and can cause coughing, and public health advocates stress that it causes impairment that reduces attention, lowers motivation and heightens the risk of accidents. Over days or weeks, chronic use can lead to problems with learning and memory. But whether smoking marijuana sets off the type of pulmonary changes that lead to lasting damage like chronic obstructive pulmonary disease, a leading cause of death among Americans, was not entirely clear.

Earlier research suggested that the impact of marijuana smoke, which contains some of the same noxious chemicals as tobacco, was not as harmful to lung function as cigarette smoke. But many of the studies were carried out over relatively short periods and contained hundreds, not thousands, of subjects.

In the new study, which was published in The Journal of the American Medical Association and financed by the National Institutes of Health, roughly 5,100 men and women in four cities – Oakland, Calif.; Chicago; Minneapolis; and Birmingham – were interviewed and given lung function tests repeatedly over 20 years. They were on average about age 25 at the start, and more than half smoked marijuana, cigarettes or both.

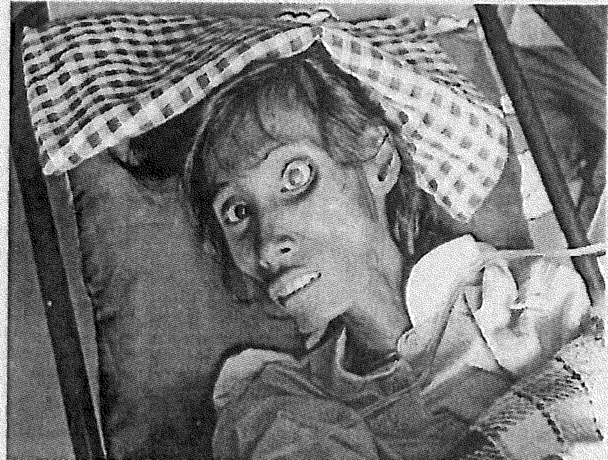
The researchers found that for moderate marijuana smokers, an exposure of up to seven "joint years" — with one joint-year equivalent to smoking 365 joints or filled pipes, or an average of one joint a day for seven years — did not worsen pulmonary function. Dr. Kertesz noted that with heavier marijuana use, described as 10 joint-years of exposure or more, lung function did begin to decline. And for a person who smokes both marijuana and cigarettes, "the net effect is going to be continued loss of lung function."

Dr. Donald Tashkin, a pulmonologist at the University of California, Los Angeles, who has studied marijuana for over 30 years and was not involved in the study, said it confirmed findings from several other studies showing "that essentially there is no significant relationship between marijuana exposure and impairment in lung function." He said one reason marijuana smoke may not be as harmful as tobacco smoke, despite containing similar noxious ingredients, may be the fact that its active ingredient, THC, has anti-inflammatory effects.

"We don't know for sure," he said, "but a very reasonable possibility is that THC may actually interfere with the development of chronic obstructive pulmonary disease."

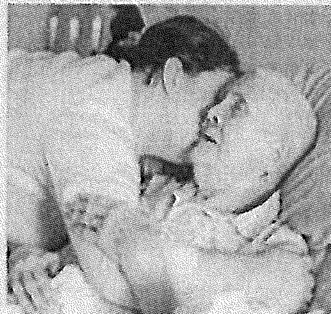
Dr. Tashkin said he and his colleagues had found in their own research — unexpectedly — that even smoking up to three joints a day did not appear to cause a decrease in lung function. "I think that the bottom line is that there does not appear to be any negative impact on lung function of marijuana smoking," he said, "and that therefore marijuana is not a risk factor for the development of C.O.P.D. Tobacco smoking is the most important risk factor for C.O.P.D."

2-16-10
Diana Lejins



"Thank you for guiding me through this experience-it would have been very different if I had done it on my own." - Robert S.

These CANCER and AIDS patients have suffered enough.......



WOULD YOU DENY THEM THEIR RIGHT TO CHOOSE MEDICINE THAT WOULD EASE THEIR SUFFERING AND PAIN?? WOULD YOU DENY THEM ACCESSIBILITY TO THAT MEDICINE?? NONE OF US ARE LEAVING THIS EARTH ALIVE—PLEASE CONSIDER THE CHOICES YOU OR YOUR LOVED ONES MAY NEED TO MAKE ONE DAY!

Advocates for Disability Rights

Ten Years After Decriminalization, Drug Abuse Down by Half in Portugal

Forbes.com   July 2011

Drug warriors often contend that drug use would skyrocket if we were to legalize or decriminalize drugs in the United States. Fortunately, we have a real-world example of the actual effects of ending the violent, expensive War on Drugs and replacing it with a system of treatment for problem users and addicts.

Ten years ago, Portugal decriminalized **all** drugs. One decade after this unprecedented experiment, drug abuse is down by half:

Health experts in Portugal said Friday that Portugal's decision 10 years ago to decriminalise drug use and treat addicts rather than punishing them is an experiment that has worked.

"There is no doubt that the phenomenon of addiction is in decline in Portugal," said Joao Goulao, President of the Institute of Drugs and Drugs Addiction, a press conference to mark the 10th anniversary of the law.

The number of addicts considered "problematic" — those who repeatedly use "hard" drugs and intravenous users — had fallen by half since the early 1990s, when the figure was estimated at around 100,000 people, Goulao said.

Other factors had also played their part however, Goulao, a medical doctor added.

"This development can not only be attributed to decriminalisation but to a confluence of treatment and risk reduction policies."

Many of these innovative treatment procedures would not have emerged if addicts had continued to be arrested and locked up rather than treated by medical experts and psychologists. Currently 40,000 people in Portugal are being treated for drug abuse. This is a far cheaper, far more humane way to tackle the problem. Rather than locking up 100,000 criminals, the Portuguese are working to cure 40,000 patients and fine-tuning a whole new canon of drug treatment knowledge at the same time.

PRESS TELEGRAM

By: PRBuzz
May 16, 2014 at 09:55 AM EDT
Marijuana Task Force to Meet with City Personnel

Long Beach, CA – May 16, 2014 – Members of the Long Beach Medical Marijuana Task Force, formed after inquiries made by commissioners during a Planning Commission meeting held in April, will meet with Long Beach City personnel later this month. The citizen task force, headed by Long Beach disability advocate Diana Lejins, has reviewed several proposed ordinances and will present its findings and recommendations during the upcoming meeting. Included on the task force are Lejins, Nick Morrow, a retired Los Angeles County Sheriff's deputy, Rosemary Chavez, a retired Deputy Los Angeles City Prosecutor, Marla James, a disabled medical marijuana patient, William Brit, also a medical cannabis patient, and Gary and Judi Farris, former managing patients of a Long Beach medical marijuana collective. Lejins said the task force had met several times since being formed.

City of Long Beach Proposed Medical Marijuana Ordinance 5-2014

Rebuttal notes to 5.91 - JF

1) We believe that 5.91 is not going to stand the test of being a viable, legal ordinance any more than 5.87.

2) Pg. 2 #10 whereas this chapter is to be construed to protect the public over medical marijuana related interests.

(MMJ patients are the public. Just because citizens use this medicine they should not be relegated to second class status.)

3) Pg. 3 line 16. The following regulations are intended to apply to all medical marijuana operations in the city whether by a patient or primary caregiver or any med mmj related entity allowed under state law.

(Does that mean that mmj patients growing in their yard or a garden club are all subject to this ordinance?)

4) Pg. 3 line 21 Chapter intended to allow mmj distribution and cultivation only where it will have minimal impact.

5) Pg 4 line 15 #8. Allow mmj related operations by individuals and entities that have demonstrated an intent and ability to comply with this chapter.

(Is this proven by the absurd point system?)

6)

Pg4 line 18 #9. Protect public safety and residential areas by limiting the areas of the city where mmj businesses may operate.

(MMJ Collectives to be located in commercial and industrial areas.

A group of less than ten (10) not be considered a business, consisting of patients growing for those too ill to grow for themselves. (Garden Clubs).

Also patients permitted to grow on their own property without a permit.

7)

Pg. 5 line 11 #2 under C. “Cultivation or Cultivate” means: #2 Preparing (packaging or repackaging labeling or relating of a usable form of marijuana.)

This is not cultivation. Oxford dictionary definition: cultivate 1) prepare and use (soil etc.) for crops or gardening. 2) Raise or produce (crops).

8)

Pg. 6 line 9 I. “Medical Marijuana Business” means: line 10 1. Any association of four (4) or more (states that is a business).

I do not share that thought or agree. If you have two (2) sick cancer patients and two other mmj patients growing that does not constitute a business. (Should be ten (10) or more).

9)

Line 21 #2. Any person that cultivates more than six mature or twelve immature or 8 oz. usable form.

(Kelly law can't limit amount)

(Crop failures, planting needs to be a continuous rotation of small to completion.)

10)

Pg. 6 line 26 #3 Six (6) mature and (12) immature.

(Same Kelly Law)

11)

Pg. 7line 10 #M. "Medical Marijuana Plant" means for this chapter the portion harvested from the plant and converted to a usable form "is not considered part of the plant upon harvesting".
(Huh?)

12)

Pg. 7 line 22 O. "Places open to the General Public"
(Private clubs, vehicles?)
13)

Pg. 9 line 17 5.91.030 Permit Required.
(Permitting system has to go through permission to operate. Cannot it is prohibited by federal law.
Approval is the issue. Same problem as before just calling it a new name.

14)

Pg. 9. Line 22 B. Permit requirement-
Permit illegal under federal law. Why is this in this doc.?

15)

Pg. 10 line 5 #E. A conditional use permit issued pursuant to this chapter shall be null and void upon "the closure of the business for more than seven days."
(True story) Police raid collective (winner of lottery") in court over contesting park issue. Raid without warrant, steal cash, medicine, battering rams destroy locks on doors. Staff members arrested $100. Fine. Judgment in court 5.89 illegal under federal law. $100. Returned to staff arrested but no record of cash, medicine or phones. Damage requires more than seven days to repair.
(Police could easily close dispensaries in this manner. Where did the money and medicine go?)

16)

Pg. 10 line 8. Any relocation shall be deemed a change in location. If by council rule changes, a collective that is in good standing and needs to move because of that rule, the city should help with and accommodate those patients.
17)

Pg. 11 line 1 A. Insurance Required.
(Do pharmacies have the same requirement?)

B. Cost of inspection, enforcement and abatement.
Business shall reimburse city for actual costs of inspection and enforcement.
(Businesses pay for enforcement of an illegal ordinance under federal law?)

18)

Pg11 line 15. All actual cost required by this section shall constitute a lien upon property upon which mmj business situated.
(Federal and State separate cannot make a city enforce federal law.)
19)

Pg. 14 line 24 (IV) Two separate entrances for patient's vs non-patients?

20)

Pg. 15 line 11 (ii) One hour fire separation from cultivation and adjacent business.
(Referring to indoor grows What about outdoors?

21)

Pg. 18 line 18 #4. Any person who has operates or manages or has operated or managed a medical marijuana business contrary to the provisions of this chapter.
(More of the same Permit Scheme)
(Any prior manager from the the former illegal 5.89 ordinance would be deemed ineligible to get ripped off by the city a second time.)

22)

Pg. 18 line 28. A person permitted to operate lawfully, who at time has delinquency for judgments owed to a government.

(The collectives during 5.89 were in court fighting illegal ordinance and and receiving citations adding up to monies owed. They won and did not have to pay the fines but this section would appear to make them be prohibited.)

23)

Pg. 19 line 3 #8. Any person applying for a permit to operate a medical marijuana business who has been permitted to operate another medical marijuana business in the City pursuant to this chapter.
(Anyone in the last fiasco can't apply. The city wants new Stooges they can steal from. What about the patients; little reference in this document to their needs.)

24)

Pg. 19 line 8. Location of mmj business

A. Fixed location required-(No delivery to those seriously ill who cannot get to a collective. Prescription meds delivered but not medical marijuana?)

25)

Pg. 19 line 9. Unlawful to operate mmj business or grow mmj outside.
(This should not apply to garden clubs or small patient groups of less than ten.)

26)

Pg. 19 line 15 & 16. B. & C. Location- permitted use in zoning district zoned for industrial uses. Then B. states 2 per council district. (The writers already know from the past that by just having in industrial areas 2 per district will not be achieved in each district.
Making it more difficult or dangerous going to industrial areas in the evening.)

27)

Pg. 20 line 7. Security plan- 24 hour security personnel in addition to alarm system.
(An unnecessary cost. Do pharmacies have?)

28)

Pg. 20 line 23 C. Suitability of business plan and financial record keeping.
(Liquor store requirement for license?)

29)

Pg. 21 line 22 (iii). Applicants have not operated a medical mj business in violation of any provision of the LB municipal code within 5 years (1 point).
(So violation from illegal 5.89 ordinance automatically deducts a point. Plus you can't be a permit tee anyway per line 18 pg. 18 #4. (Who proofed this?)

30)

Pg. 24 line 12. Hours of operation. Closing at 7:00 pm Can't get their medication, pharmacy available past 7:00 pm for OxyContin.

31)

Pg. 24 line 26. No more mmj than stated amount on permit.(How would you know how many sick patients you will be helping ahead of time?)

32)

Pg. 25 line 10. Sales and tax reports monthly to city.

(Other businesses have to do this?)

33)

Pg. 25 line 14.Reports of all criminal activity or attempts shall be reported to LBPD within 12 hours of occurrence.

(If police (illegal raids) criminal activity who to report to?)

34)

Pg. 26 line 11-12. Which mmj business is (owned) (can't Own) by same person that owns (can't own) the grow facility.

(Can't supply/grow all the necessary strains needed for all the patient needs.)

(Does Pfizer make all the necessary prescription meds necessary? No.)

35)

Pg. 26 line 23-25. No more than half may be mature.

(Need to have harvest staggering and not grow and harvest all at once.)

36)

Pg. 27 line 14.No signs on vehicles, no handbills advertising or flier handouts?

(Why?)

37)

Pg. 28 line 10. No products with logo.(You don't want to know where a product originated from?)

38)

pg. 28 line 23. No mmj business may produce concentrated cannabis.

(Many cancer patients have a need for the concentrates, why not?)

39)

Pg. 29 line 16. Bank Statements.

(What banks are currently ageing to allow collectives to have accounts while still against federal law?)

40)

Pg. 30 line 1-5 Violation against patient privacy(HIPPA)

Line 12-15 same as above.

Line 20. Confidential patient information is okay for police to have access to? I think they need a court order to show cause.)

41)

Pg. 31 line 19-24. Conditional use permit constitutes consent to inspection without a search warrant. (This allowing the police to raid, steal destroy and by not complying you receive a administrative search warrant.)

42)

Pg. 35 line 1-2. This ordinance prevails over state regulations? Even if it violates federal law?

43)

Pg. 36 line 18.Can't grow without a conditional use permit? Does this include patients growing for themselves and small garden clubs should not be included as they are not businesses.)

44)

Pg36 line 23. Prohibited to obtain from a person who is not a permitted mmj business?
(What about garden clubs and home growers? They are not businesses.

45)

Pg. 37 line 1 J. Prohibited to deliver to patient.
(Shut-ins just out of luck... suffer and die in pain?) Pharmacies deliver.

46)

Pg39 line 20-23 591.160.
(New rule changes to get rid of collectives just like before.)

Reduction of Teen Marijuana Use

- diana lejins
- May 9, 2014

To

- jeff.winklepleck@longbeach.gov
- Amy Bodek
- Jacque Gilmore
- 1 More...

Please include this in the next Planning Commission Agenda re Medical Marijuana Ordinance

Further Reduce Teen Marijuana Use

According to the latest report from the federal government, marijuana use by Colorado high school students has dropped since our state and its localities began regulating medical marijuana in 2010. This bucks the national trend of increasing teen marijuana use over the past several years. Nationwide, past-30-day marijuana use among high school students climbed from 20.8 percent in 2009, to 23.1 percent in 2011. Meanwhile, in Colorado, it *dropped* from 24.8 percent to 22 percent.

It was during this same two-year period that Colorado enacted strict state and local regulations on the sale of marijuana for medical purposes, whereas no such regulations were implemented throughout the rest of the country. This suggests that even the partial regulation of marijuana could decrease its availability and use among teens. Amendment 64 would regulate marijuana sales across the board for all adults 21 and older, further reducing teen use.

Earlier this year, research on the impact of medical marijuana laws on teen use arrived at a similar conclusion. In a Study shows no evidence medical marijuana increases teen drug use | Newsroom | University of Colorado Denver issued by the University of Colorado Denver, the researchers said there is "no statistical evidence that legalization increases the probability of [teen] use," and noted that "the data often showed a negative relationship between legalization and [teen] marijuana use."

Scientific History of Medical Cannabis

Cannabis was a part of the American pharmacopoeia until 1942 and is currently available by prescription in the Netherlands, Canada, Spain, and Israel in its whole plant form.

In 1937, the U.S. passed the first federal law against cannabis, despite the objections of the American Medical Association (AMA). Dr. William C. Woodward, testifying on behalf of the AMA, told Congress that, "The American Medical Association knows of no evidence that marijuana is a dangerous drug" and warned that a prohibition "loses sight of the fact that future investigation may show that there are substantial medical uses for Cannabis."

Ironically, the U.S. federal government currently grows and provides cannabis for a small number of patients. In 1976 the federal government created the Investigational New Drug (IND) compassionate access research program to allow patients to receive up to nine pounds of cannabis from the government each year. Today, five surviving patients still receive medical cannabis from the federal government, paid for by federal tax dollars.

In 1988, the DEA's Chief Administrative Law Judge, Francis L. Young, ruled after extensive hearings that, "Marijuana, in its natural form, is one of the safest therapeutically active substances known... It would be unreasonable, arbitrary and capricious for the DEA to continue to stand between those sufferers and the benefits of this substance..." Yet the DEA refused to implement this ruling based on a procedural technicality and resists rescheduling to this day.

In 1989, the FDA was flooded with new applications from people with HIV/AIDS. In June 1991, the Public Health Service announced that the program would be suspended because it undermined federal prohibition. Despite this successful medical program and centuries of documented safe use, cannabis is still classified in America as a Schedule I substance "indicating a high potential for abuse and no accepted medical value. Healthcare advocates have tried to resolve this contradiction through legal and administrative channels to no avail.

In 1996, patients and advocates turned to the state level for access, passing voter initiatives in California and Arizona that allowed for legal use of cannabis with a doctor's recommendation. These victories were followed by the passage of similar initiatives in Alaska, Colorado, Maine, Montana, Nevada, Oregon, Washington, and Washington D.C. The legislatures of Hawaii, Maryland, New Mexico Rhode Island, and Vermont have also acted on behalf of their citizens, and every legislative session sees more bills introduced at the state level across the country.

In 1997, The Office of National Drug Control Policy commissioned the Institute of Medicine (IOM) to conduct a comprehensive study of the medical efficacy of cannabis therapeutics. The IOM concluded in 1990, that cannabis is a safe and effective medicine, patients should have access, and the government should expand avenues for research and drug development. The federal government has completely ignored its findings and refused to act on its recommendations.

Despite the federal barriers to research, hundreds of peer-reviewed studies have been published worldwide since the IOM report. While there is still much to learn, the medical potential is indisputable for a variety of symptoms and conditions.

Medical cannabis patients and current Executive Director Steph Sherer founded Americans for Safe Access (ASA) in 2002 in response to federal raids on patients in California. Ever since then, ASA has been instrumental in shaping the political and legal landscape of medical cannabis. Our successful lobbying, media, and legal campaigns led to positive court precedents, new sentencing standards, more compassionate legislative and administrative policies and procedures, as well as new legislation.

AMERICANS FOR SAFE ACCESS (ASA)

TIME.com

Marijuana as a Gateway Drug: The Myth That Will Not Die

By Maia Szalavitz @maiasz Oct. 29, 2010
Sean Gallup/Getty Images

Of all the arguments that have been used to demonize marijuana, few have been more powerful than that of the "gateway effect": the notion that while marijuana itself may not be especially dangerous, it ineluctably leads to harder drugs like heroin and cocaine. Even Nick Kristof — in a column favoring marijuana legalization — alluded to it this week in the New York *Times*. In what is known as the "to be sure" paragraph, where op-ed writers cite the arguments of opponents, he wrote:

I have no illusions about drugs. One of my childhood friends in Yamhill, Ore., pretty much squandered his life by dabbling with marijuana in ninth grade and then moving on to stronger stuff. And yes, there's some risk that legalization would make such dabbling more common.

The idea that marijuana may be the first step in a longer career of drug use seems plausible at first: when addicts tell their histories, many begin with a story about marijuana. And there's a strong correlation between marijuana use and other drug use: a person who smokes marijuana is more than 104 times more likely to use cocaine than a person who never tries pot, according to the National Institute on Drug Abuse. (**More on Time.com:** 7 Tips for California: How to Make Legalizing Marijuana Smart)

The problem here is that correlation isn't cause. Hell's Angels motorcycle gang members are probably more 104 times more likely to have ridden a bicycle as a kid than those who don't become Hell's Angels, but that doesn't mean that riding a two-wheeler is a "gateway" to joining a motorcycle gang. It simply means that most people ride bikes and the kind of people who don't are highly unlikely to ever ride a motorcycle.

Scientists long ago abandoned the idea that marijuana causes users to try other drugs: as far back as 1999, in a report commissioned by Congress to look at the possible dangers of medical marijuana, the Institute of Medicine of the National Academy of Sciences wrote:

Patterns in progression of drug use from adolescence to adulthood are strikingly regular. Because it is the most widely used illicit drug, marijuana is predictably the first illicit drug most people encounter. Not surprisingly, most users of other illicit drugs have used marijuana first. In fact, most drug users begin with alcohol and nicotine before marijuana — usually before they are of legal age.

In the sense that marijuana use typically precedes rather than follows initiation of other illicit drug use, it is indeed a "gateway" drug. But because underage smoking and alcohol use typically precede marijuana use, marijuana is not the most common, and is rarely the first, "gateway" to illicit drug use. There is no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs.

Since then, numerous other studies have failed to support the gateway idea. Every year, the federal government funds two huge surveys on drug use in the population. Over and over they find that the number of people who try marijuana dwarfs that for cocaine or heroin. For example, in 2009, 2.3 million people reported trying pot — compared with 617,000 who tried cocaine and 180,000 who tried heroin. (**More on Time.com:** See photos of cannabis conventions)

So what accounts for the massive correlation between marijuana use and use of other drugs? One key factor is taste. People who are extremely interested in altering their consciousness are likely to want to try more than one way of doing it. If you are a true music fan, you probably won't stick to listening to just one band or even a single genre — this doesn't make lullabies a gateway to the Grateful Dead, it means that people who really like music probably like many different songs and groups.

Second is marijuana's illegality: you aren't likely to be able to find a heroin dealer if you can't even score weed. Compared with pot dealers, sellers of hard drugs tend to be even less trusting of customers they don't know, in part because they face greater penalties. But if you've proved yourself by regularly purchasing marijuana, dealers will happily introduce to you to their harder product lines if you express interest, or help you find a friend of theirs who can.

Holland began liberalizing its marijuana laws in part to close this particular gateway — and indeed now the country has slightly fewer young pot-smokers who move on to harder drugs compared with other nations, including the U.S. A 2010 Rand Institute report titled "What Can We Learn from the Dutch Cannabis Coffeeshop Experience?" found that there was "some evidence" for a "weakened gateway" in The Netherlands, and concluded that the data "clearly challenge any claim that the Dutch have strengthened the gateway to hard drug use." (**More on Time.com:** Is Marijuana Addictive? It Depends How You Define Addiction)

Of course, that's not the gateway argument favored by supporters of our current drug policy — but it is the one supported by science.

Maia Szalavitz is a neuroscience journalist for TIME.com and co-author of *Born for Love: Why Empathy Is Essential — and Endangered.*

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U.S. Patent 6630507Hemp420 DomainsSitemap

U.S. Patent 6630507

The U.S. Patent Office issued patent #6630507 to the U.S.Health and Human Services filed on 2/2/2001. The patent lists the use of certain cannabinoids found within the cannabis sativa plant as

useful in certain neurodegenerative diseases such as Alzheimer's, Parkinson's, and HIV dementia.

Since cannabis sativa (marijuana) contains compounds recognized and endorsed by an agency of the U.S. government- Why is it that marijuana remains on the Federal Schedule One list of drugs? The issuance of patent #6630507 is a direct contradiction of the governments own definition for classification of a Schedule 1 drug.

US Patent 6,630,507 Cannabinoids as Antioxidants and Neuroprotectants

"Cannabinoids have been found to have antioxidant properties, unrelated to NMDA receptor antagonism. This new found property makes cannabinoids useful in the treatment and prophylaxis of wide variety of oxidation associated diseases, such as ischemic, age-related, inflammatory and autoimmune diseases. The cannabinoids are found to have particular application as neuroprotectants, for example in limiting neurological damage following ischemic insults, such as stroke and trauma, or in the treatment of neurodegenerative diseases, such as Alzheimer's disease, Parkinson's disease and HIV dementia. Nonpsychoactive cannabinoids, such as cannabidoil, are particularly advantageous to use because they avoid toxicity that is encountered with psychoactive cannabinoids at high doses useful in the method of the present invention."...

The DEA (Drug Enforcement Administration) classifies marijuana as a dangerous drug with no medical value. That classification contradicts mounds of evidence showing marijuana to be a very safe and effective medicine. Marijuana is more effective, much less

expensive, and much safer than many drugs currently used in its place. Marijuana can provide excellent relief for those who suffer from cancer, AIDS, glaucoma, multiple sclerosis, chronic pain,

arthritis, rheumatism, asthma, insomnia, and depression.

If knowledge of marijuana's many medicinal uses, its remarkable safety, and hemp's enormous potential as a natural resource become widely known, the DEA fears that support for Marijuana Prohibition will collapse, and thus threaten the DEA's budget. To maintain the myth that marijuana/hemp is useless and dangerous, the DEA prohibits medicinal use of marijuana, denies researchers access to marijuana for use in clinical studies, and rejects all applications to grow industrial hemp.

In 1988--after reviewing all evidence brought forth in a lawsuit against the government's prohibition of medical marijuana--the DEA's own administrative law judge (Judge Francis Young) wrote:

Subject: AIDS Victims - What does a possible medical marijuana patient look like?

From: diana lejins (dianalejins@yahoo.com)

To: dianalejins@yahoo.com;

Date: Tuesday, May 20, 2014 7:57 PM

What does a possible medical marijuana patient look like?

Working to make the World a better place,
diana ☺

WHY IS HEMP REALLY ILLEGAL??

William Randolph Hearst (*Citizen Kane*) and the **Hearst Paper Manufacturing** Division of Kimberly Clark owned vast acreage of timberlands. The Hearst Company supplied most paper products. Patty Hearst's grandfather, a destroyer of nature for his own personal profit, stood to lose billions because of hemp.

In 1937, **DuPont** patented the processes to make plastics from oil and coal. DuPont's Annual Report urged stockholders to invest in its new petrochemical division. Synthetics such as plastics, cellophane, celluloid, methanol, nylon, rayon, Dacron, etc., could now be made from oil. Natural hemp industrialization would have ruined over 80% of DuPont's business.

Andrew Mellon became Hoover's Secretary of the Treasury and DuPont's primary investor. He appointed his future nephew-in-law, Harry J. Anslinger, to head the Federal Bureau of Narcotics and Dangerous Drugs.

Secret meetings were held by these financial tycoons. Hemp was declared dangerous and a threat to their billion-dollar enterprises. For their dynasties to remain intact, hemp had to go. These men took an obscure Mexican slang word: 'marijuana' and pushed it into the consciousness of America.

MEDIA MANIPULATION

A media blitz of 'yellow journalism' raged in the late 1920s and 1930s. Hearst's newspapers ran stories emphasizing the horrors of marijuana. The menace of marijuana made headlines. Readers learned that it was responsible for everything from car accidents to loose morality.

Films like *Reefer Madness* (1936), *Marijuana: Assassin of Youth* (1935) and *Marijuana: The Devil's Weed* (1936) were propaganda designed by these industrialists to create an enemy. Their purpose was to gain public support so that anti-marijuana laws could be passed.

LEGISLATION

On April 14, 1937, the prohibitive Marijuana Tax Law, or the bill that outlawed hemp, was directly brought to the House Ways and Means Committee. This committee is the only one that can introduce a bill to the House floor without it being debated by other committees. The Chairman of the U.S. Senate, Ways and Means Committee, at the time, Robert Doughton, was a DuPont supporter. He insured that the bill would pass Congress.

Dr. James Woodward, a physician and attorney, testified too late on behalf of the American Medical Association. He told the committee that the reason the AMA had not denounced the Marijuana Tax Law sooner was that the Association had just discovered that marijuana was hemp.

Few people, at the time, realized that the deadly menace they had been reading about on Hearst's front pages was in fact passive hemp. The AMA understood cannabis to be a medicine found in numerous healing products sold over the last hundred years.

In September of 1937, hemp became illegal. The most useful crop known became a drug and our planet has been suffering ever since.

Half a million deaths each year are caused by tobacco. Half a million deaths each year are caused by alcohol. No one has ever, ever died from smoking pot!!

In the entire history of the human race, not one death can be attributed to cannabis. Our society has outlawed grass but condones the use of the killers: tobacco and alcohol.

WHO BENEFITS FROM MARIJUANA'S ILLEGALITY?

These are the entrenched interest groups that are spending large sums of money to keep our broken drug laws on the books:

Police Unions: Police departments across the country have become dependent on federal drug war grants to finance their budget. In March, we published a story revealing that a police union lobbyist in California coordinated the effort to defeat Prop 19, a ballot measure in 2010 to legalize marijuana, while helping his police department clients collect tens of millions in federal marijuana-eradication grants. And it's not just in California. Federal lobbying disclosures show that other police union lobbyists have pushed for stiffer penalties for marijuana-related crimes nationwide.

Private Prisons Corporations: Private prison corporations make millions by incarcerating people who have been imprisoned for drug crimes, including marijuana. As Republic Report's Matt Stoller noted last year, Corrections Corporation of America, one of the largest for-profit prison companies, revealed in a regulatory filing that continuing the drug war is part in parcel to their business strategy. Prison companies have spent millions bankrolling pro-drug war politicians and have used secretive front groups, like the American Legislative Exchange Council, to pass harsh sentencing requirements for drug crimes.

Alcohol and Beer Companies: Fearing competition for the dollars Americans spend on leisure, alcohol and tobacco interests have lobbied to keep marijuana out of reach. For instance, the California Beer & Beverage Distributors contributed campaign contributions to a committee set up to prevent marijuana from being legalized and taxed.

Pharmaceutical Corporations: Like the sin industries listed above, pharmaceutical interests would like to keep marijuana illegal so American don't have the option of cheap medical alternatives to their products. Howard Wooldridge, a retired police officer who now lobbies the government to relax marijuana prohibition laws, told Republic Report that next to police unions, the "second biggest opponent on Capitol Hill is big Pharma" because marijuana can replace "everything from Advil to Vicodin and other expensive pills."

Prison Guard Unions: Prison guard unions have a vested interest in keeping people behind bars just like for-profit prison companies. In 2008, the California Correctional Peace Officers Association spent a whopping $1 million to defeat a measure that would have "reduced sentences and parole times for nonviolent drug offenders while emphasizing drug treatment over prison."

JUST FOLLOW THE $$$$$$$$$$$$$$$$

Provided by MEDICAL DAILY – YAHOO HEALTH

3 Ways Marijuana Helps Sick People Live Normal Lives

By Anthony Rivas
Tue, May 20, 2014

To say that marijuana's making a comeback would be an understatement. Since California enacted a medical marijuana law in 1996, 20 other states and the District of Columbia have followed suit, with **eight of them** passing laws in the past four years alone. Two of them — Washington and Colorado — have even passed full-blown legalization of the drug. And none of that includes the many states that are currently in the process, such as **New York** and **Minnesota**. This huge shift in public opinion can be credited, in large part, to a wide range of studies and patient testimonies supporting the drug's health benefits. So, what are some of them?

Stress, Anxiety, and PTSD — It's a Mixed Bag

No matter how you ingest marijuana, there are possible **side effects** to the drug — pro-pot advocates will claim they're never as bad as pharmaceutical side effects — including anxiety and paranoia. These effects can subsequently lead to a higher blood pressure, arrhythmia, and other effects common to anxiety. In this way, **it's a gamble** when taking marijuana. For those who know how much they're taking and what to expect, however, may experience the opposite effect: calm, relaxation, and happiness.

For people with post-traumatic stress disorder (PTSD), one of the worst possible anxiety disorders, marijuana might be able to alleviate symptoms. Although there's a scarcity of human research into the association, anecdotal evidence is heavy, and states, such as **Main and New Hampshire**, have begun allowing its use. The Department of Health and Human Services also signed off **recently**, on a study to test its benefits in PTSD patients.

The use of marijuana for anxiety disorders, and just plain stress, comes from the fact that the brain naturally produces cannabinoids, which are the active chemicals in marijuana — namely, delta-9 tetrahydrocannabinol, or THC — and what **help regulate how fear is processed** in the brain.

A May 2013 study found that people with PTSD showed lower levels of a certain endocannabinoid known as anandamide in the area of their brains associated with fear and anxiety. Thus, fewer cannabinoid receptors were being activated, spurring PTSD along. In theory, using marijuana would boost concentrations of these beneficial cannabinoids, reducing symptoms of PTSD. "We know very well that people with PTSD who use marijuana often experience more relief from their symptoms than they do from antidepressants and other psychiatric medications," said lead author Dr. Alexander Neumeister, of the Departments of Psychiatry and Radiology at New York University, in a **press release**.

In part, these calming effects could be the reasons why marijuana use has been linked to a 10 percent reduction **in suicide rates**, while also being considered for use in some **Swiss prisons**.

Cerebral Palsy and Other Neurodegenerative Diseases

Neurodegenerative diseases affect millions of people in the U.S. Parkinson's disease, for example, affects an estimated **one million people**, while cerebral palsy affects as many as **764,000 children and adults**. These diseases and more are all debilitating in their own way, as they affect the nervous system's ability to connect with the brain, therefore affecting a person's ability to move. Marijuana has shown *huge* promise in saving these people.

Multiple sclerosis (MS), which occurs when the immune system attacks the nerve's myelin sheaths, causes the nerves to become unable to communicate with each other. In turn, this causes weakness in limbs, partial to complete loss of vision, and tremors. Studies on marijuana use **among animals** with MS showed that THC and other cannabinoids were able to target the inflammation-causing cells produced by the immune system, subsequently leading to less destruction of myelin. Another **UK study** found that 12 weeks of marijuana treatment helped relieve muscle stiffness in 30 percent of almost 300 patients suffering from MS.

Marijuana has also been shown to reduce symptoms of **Parkinson's disease (PD)**, which include rigid muscles, slow movement, and tremors. In a **study** of 22 patients who were all about 66 years old, tremor scores dropped after using marijuana. "The study suggests that cannabis might have a place in the therapeutic armamentarium of PD," the researchers wrote. "Larger, controlled studies are need to verify the results."

In such patients, the results really do need to be seen to be believed. In December, ***Medical Daily*** reported the story of Jacqueline Patterson, a Missouri mother of four whose **cerebral palsy** had left her with a severe stutter caused by muscle stiffness, which has also caused her severe pain and the inability to use her right arm correctly. With marijuana, she becomes a totally different person, able to speak, move, and overall become less tense.

Cancer

The big one right here. Pretty much any state that legalizes marijuana for medical use lists cancer as one of the first conditions it can be used for. People undergoing chemotherapy for whatever their cancer may be often experience nausea, vomiting, loss of

appetite, and pain, according to the National Institutes of Health (**NIH**). Marijuana has been shown to alleviate all of these side effects. In fact, two FDA-approved medications, dronabinol and nabilone, are derived from THC and used in cancer patients and HIV/AIDS patients to treat nausea and vomiting. Dronabinol was also shown last year to **ease pain** in cancer patients. As for increasing appetite, well, they don't call it the munchies for nothing.

Beyond chemo, there's also evidence that marijuana can help prevent the growth of tumors. According to the NIH, another cannabinoid, cannabidiol, has been shown to relieve pain as well as lower inflammation. Cannabinoids such as these have been shown to block cell growth, prevent the growth of blood vessels that aid metastasis (the spread of tumors), and kill tumor cells. Some researchers have even found a way to harness this power without the psychoactive effects.

"Cannabinoids have a complex action; it hits a number of important processes that cancers need to survive," oncologist Dr. Wai Liu told ***The Huffington Post***. "For that reason, it has really good potential over other drugs that only have one function. I am impressed by its activity profile, and feel it has a great future, especially if used with standard chemotherapies."

1-19-10 #16

Karl Kemp

Long Beach Medical Marijuana Ordinance
Key Points of Concern and Recommended Changes
January 19, 2010

Cultivation Onsite

- This requirement is extremely onerous and makes it nearly impossible for collectives to operate under the law. The space requirements, overhead, and limitations on necessary medicine production make this requirement unworkable. We respectfully request that the language be changed to allow members of the collective to cultivate medicine for other members of the same collective.

Edibles

- Edibles are an important medical option for members and patients that are unable to use smoking as a delivery method. Most collectives provide edibles as an option, but few if any, have the equipment or expertise to produce the edibles on site. Qualified members are responsible for the production of edibles used by other members within the collective.

Section 5.87.015 – F. (page 3) requires that edibles be produced on site. We are requesting that language throughout the entire document be amended, such that edibles can be produced offsite and locations of that production be made subject to any inspection that would have been required of the actual collective.

Cultivation and Distribution

- 5.87.015 K (page 5) defines a Medical marijuana Collective as, among other things, a place where cultivation is allowed for medical purposes. We respectfully request that this language be amended to include distribution as well. Though it may be taken for granted that this is the function of the collective, we believe that this specific purpose needs to be included.

Application and Hearing Period

- Page 10 says the Director of Financial Management shall call a hearing to be conducted not later that thirty (60) days. We believe this is a minor typo and would like to confirm that it is in fact 60 days not 30 days.

Schools

- Page 12 says that a collective cannot be located within 1500 feet of a school and 1000 feet of child care facilities, playgrounds, youth centers or another medical marijuana collective. We reviewed the tape, and we believe the intent of the

council was to prohibit collectives within 1500 of a **high school** and 1000 feet of **K-8 schools.** We respectfully request that this be clarified in the ordinance.

Federal Law

- Page 14 (N) states that a collective shall comply with all applicable SCAQMD regulations, LA County Sanitation District regulations, City regulations from various departments, as well as **federal**, state and local laws to ensure that the health, safety and welfare of the community, qualified patients and their primary caregivers will not be adversely affected.
- Because there is a lack of clarity between federal and state law related to marijuana, we would appreciate the addition of language that clarifies the intent of this section to be limited to business operations, and not the legality or illegality of the distribution of medical marijuana to patients.

Sale of Soil and Nutrients

- One of the services provided by many collectives is the sale of soil and nutrients to members for the legal cultivation of marijuana plants. This helps to ensure that all plants grown for personal use and for contribution to the collective are as clean and healthy as possible.
- Page 18 (E) seems to require that a separate business license be held by each collective for these sales. We respectfully recommend that this permission be allowed under the Administrative Use Permit

Collective Membership

- Each collective has membership requirements that verify the patients qualifications and requires them to sign documents promising to follow a wide variety of rules and regulations designed to protect the collective, the patient, and the surrounding community. For example, members may be advised that consumption on site, in the parking lot, or within a certain number of feet of the collective is strictly prohibited, and that violation is grounds for termination from the collective. These rules work because well run collectives have security staff and cameras that are used to ensure that the rules are enforceable.
- Page 20 (O) limits patient membership to one collective. It is impossible for any collective to identify or enforce individual patients' membership in any other collective, and our fear is that should someone within a collective be found to have multiple memberships, an innocent collectives right to serve other patients could be jeopardized. We respectfully request that this language be removed or that it is clarified that violation of this section will impact the individual patient and not the entire collective.

Matt.Ferner@huffingtonpost.com

New Report Blasts DEA For Spending 4 Decades Obstructing Marijuana Science

Posted: 06/11/2014 6:53 pm EDT Updated: 06/11/2014 11:59 pm EDT

The Drug Enforcement Administration has been impeding and ignoring the science on marijuana and other drugs for more than four decades, according to a report released this week by the Drug Policy Alliance, a drug policy reform group, and the Multidisciplinary Association for Psychedelic Studies, a marijuana research organization.

"The DEA is a police and propaganda agency," Ethan Nadelmann, executive director of the Drug Policy Alliance, said Wednesday. "It makes no sense for it to be in charge of federal decisions involving scientific research and medical practice."

The report alleges that the DEA has repeatedly failed to act in a timely fashion when faced with petitions to reschedule marijuana. The drug is currently classified as Schedule I, which the DEA reserves for the "most dangerous" drugs with "no currently accepted medical use." Schedule I drugs, which include substances like heroin and LSD, cannot receive federal funding for research. On three separate occasions -- in 1973, 1995 and again in 2002 -- the DEA took years to make a final decision about a rescheduling petition, and in two of the cases the DEA was sued multiple times to force a decision.

The report criticizes the DEA for overruling its own officials charged with determining how illicit substances should be scheduled. It also criticizes the agency for creating a "regulatory Catch-22" by arguing there is not enough scientific evidence to support rescheduling marijuana while simultaneously impeding the research that would produce such evidence.

A spokesperson at the DEA declined to comment on the report.

The feds have long been accused of only funding marijuana research that focuses on the potential negative effects of the substance, but that trend appears to be changing.

According to The Hill, the National Institute on Drug Abuse has conducted about 30 studies to date on the potential benefits of marijuana. NIDA oversees the cultivation, production and distribution of marijuana grown for research purposes at the University of Mississippi in the only federally legal marijuana garden in the U.S. -- a process through which the only federally sanctioned marijuana studies are approved.

The joint report comes less than two weeks after the House approved three amendments taking aim at the DEA and its ability to enforce federal marijuana and hemp laws in states which have legal marijuana operations and industrial hemp programs. The medical marijuana amendment was sponsored by Rep. Dana Rohrabacher (R-Calif.).

"Nobody should be afraid of the truth," Rohrabacher said Wednesday. "There's a lot of other drugs that have harmful side effects. Is the downside of marijuana a harmful side effect? Or is there a positive side that actually does help? That needs to be proven."

The federal government's interest in marijuana certainly appears to be growing. Since 2003, it has approved more than 500 grants for marijuana-related studies, with a marked upswing in recent years, according to McClatchy. In 2003, 22 grants totaling $6 million were approved for cannabis research. In 2012, that number had risen to 69 approved grants totaling more than $30 million.

"The DEA has obstructed research into the medical use of marijuana for over 40 years and in the process has caused immeasurably suffering that would otherwise have been treated by low-cost, low-risk generic marijuana," Rick Doblin, executive director of the Multidisciplinary Association for Psychedelic Studies, said in a statement. "The DEA's obstruction of the FDA approval process for marijuana has -- to the DEA's dismay -- unintentionally catalyzed state-level medical marijuana reforms."

Currently, 22 states and the District of Columbia have legalized marijuana for medical use. Eight other states -- Alabama, Iowa, Kentucky, Mississippi, South Carolina, Tennessee, Utah and Wisconsin -- have legalized CBD oils, made from a non-psychoactive ingredient in marijuana frequently used to treat epilepsy, for limited medical use or for research purposes.

A number of recent studies have shown the medical potential of cannabis. Purified forms may attack some forms of aggressive cancer. Marijuana use also has been tied to better blood sugar control and may help slow the spread of HIV. One study found that legalization of the plant for medical purposes may even lead to lower suicide rates.

Nadelmann said the DEA has "demonstrated a regular pattern of abusing its discretionary powers."

"We believe this authority would be better handled by another government agency in the health realm, or even better still, by an organization that is truly independent, perhaps something that involves the National Academy of Sciences," he said. "We will be working to encourage greater congressional oversight and also to call for reforms of federal law."

HIPAA and Your Private Medical Information By Debra Manzella, R.N. Dec 2006

What does HIPAA mean? HIPAA is the Health Insurance Portability and Accountability Act (HIPAA). It was put into place to protect patient privacy and also ensures privacy of all accumulated health information that belongs to the patient. It was signed into law in 1996 under the United States Department of Health and Human Services. Healthcare providers nationwide were required to comply with the rules and regulations of privacy protection by April of 2003.

What does it mean to me? It means that your private health information is protected by federal law. You have rights regarding your personal information and it provides specific rules and regulations on who may have access to it.

Does my doctor have to sign the HIPAA agreement too? Medical staff do have to sign an agreement at least once a year, stating that they are aware of the provisions of the law, that they understand these laws and that they will uphold these laws. These are kept on file at the facility at which they work. States may differ in their requirements, but the basic privacy laws must be upheld.

What are my rights under the federal HIPAA laws? You can ask to see your records and to get copies of them You can have any corrections that you feel need to be made, included in your chart.

You will be notified if your health information needs to be shared with other healthcare providers or specialists, insurance companies or billing personnel. You can file complaints if you feel your privacy rights were violated in any way.

What kind of information does it protect? It protects any kind of health information such as office visits, tests and procedures, diagnosis, or other facets of medical care. This includes mental health information, therapy, counseling or other aspects of mental health care. Information that is spoken, printed or transmitted electronically all fall under the HIPAA privacy act.

Does my healthcare provider have the right to share my information? Yes. Your healthcare provider does have the right to share your information with:

- Other healthcare professionals involved in your care
- For coordination of your healthcare with other specialiaties
- To report any information that affects public health, such as dog bites, gun shot wounds or infectious diseases
- With any family, friends or other people that YOU determine as acceptable, to help with your medical care or finances and billing

What if I want access to my health information? You should be able to have access to all your health information whenever and wherever you want. This includes office visits, tests and lab results, and communication between healthcare providers. You also have the right to know who your information has been shared with.

Who gets to see my confidential health information? Anyone directly involved in your care would have access to your information. Doctors, nurses, other medical personnel, billing offices and secretarial might all have legal access to it. Any specialists, personnel who perform lab tests and diagnostic tests, or any procedures either outpatient or inpatient may also have access to your records for the time that you are in their care. Basically anyone who is necessary to provide the best medical care that you can receive.

Sources:

"Privacy and Your Health Information." Office for Civil Rights. U.S. Department of Health and Human Services. 5 Dec 2006

"Summary of the HIPAA Privacy Rule." Office for Civil Rights - HIPAA. 05/03. United States Department of Health and Human Services. 5 Dec 2006

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May 30, 2014

VIA E-MAIL AND U.S. MAIL

Ms. Diana Lejins
Chair, Long Beach Medical Marijuana Task Force
c/o Advocates for Disability Rights
P.O. Box 15027
Long Beach, CA 90815

Re: Review of Proposed Medical Marijuana Ordinances

Dear Ms.Lejins:

After speaking with you by phone, I've reviewed two (2) draft medical marijuana ordinances you emailed to me. The first is an ordinance drafted by attorney Jina Nam along with Kendra Carney of the City Attorney's office. The second is one drafted by you and other members of the Long Beach Medical Marijuana Ordinance Task Force.

ORDINANCE 1 (NAM/CARNEY ORDINANCE)

The first ordinance drafted by Ms. Nam and Ms. Carney is 41 pages long. The version I received was updated recently by Ms. Nam. There are several problems with the ordinance:

- Operates through a Conditional Use Permit with parameters included in the approval process that result in approval of medical marijuana distribution by the City;

- Requires individuals/entities to provide information and access to information that forces incrimination of individuals under differing federal law in the same subject area;

- Uses a problematic "scoring" system;

- Is based in-part on regulations from Colorado related to recreational cannabis rather than medical cannabis (see transcript of April Planning Commission meeting and statements by Mike Mais and Kendra Carney);

- Too much of the ordinance and the way it operates is discretionary with the discretion resulting in an impermissible "permitting" process. Indeed, this ordinance results in a "permit" that operates much like the "permit" scheme already stricken in former Chap. 5.87. Changing the name from "marijuana permit" to "conditional use permit" while leaving the discretionary scoring system and conditional requirements rife with approvals of how marijuana activities are conducted renders this proposal defective.

These are just a few problems that leave this ordinance open to litigation. It is a very long ordinance, it is complicated, and it is subject to multiple challenges. This ordinance will be difficult to implement even if it survives or survives following challenge and severance, if it can even be severed given so much of it is challengeable. If this ordinance, even with the recent modifications I reviewed, is enacted and implemented, it would almost certainly be challenged in court and I would likely file a challenge to it based on the aforementioned as well as other reasons.

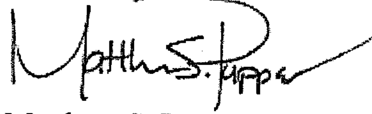
ORDINANCE 2 (LONG BEACH TASK FORCE ORDINANCE)

The second proposed ordinance was drafted by the Long Beach Medical Marijuana Ordinance Task Force. It is far smaller at 29 pages. It is well-designed because it does not incorporate any discretionary provisions – it operates through actions and decisions that are purely ministerial. Nothing is ever approved – no activity is sanctioned – nothing that might be illegal federally is "permitted" by the City in this ordinance. As important, this ordinance uses an inspection system that does not collect or require the maintenance, provision, or intake of documents, materials or paperwork that could be used to incriminate any person under differing federal law on the same subject. This ordinance operates to restrict and limit rather than to approve. The second ordinance also includes provisions that retroactively deal with the debacles associated with former Chap. 5.87 and 5.89.

If the City were to enact and implement the second ordinance – the Long Beach Medical Marijuana Ordinance Task Force ordinance – I would not seek to challenge the ordinance in court. I believe the Task Force ordinance is free of defects that subject it to being invalidated through litigation. Moreover, it provides for those patient groups that have operated in Long Beach in compliance with state law as well as those that were

successful in the October, 2010 lottery. While I disagree with numeric limits or "caps," overall the second ordinance would be difficult to challenge and is, for the most part, very fair and balanced. Accordingly, should the City implement the second ordinance – the Long Beach Medical Marijuana Task Force ordinance -- I will not take action to challenge it and it appears it would be difficult for it to be challenged successfully in court.

Very truly yours,



Matthew S. Pappas

MSP:jm

Office for Civil Rights – U.S. Dept Health & Human Services

Federal civil rights laws and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, together protect your fundamental rights of nondiscrimination and health information privacy. Civil Rights help to protect you from unfair treatment or discrimination, because of your race, color, national origin, disability, age, sex (gender), or religion. Federal laws also provide conscience protections for health care providers.

The Privacy Rule protects the privacy of your health information; it says who can look at and receive your health information, and also gives you specific rights over that information. In addition, the Patient Safety Act and Rule establish a voluntary reporting system to enhance the data available to assess and resolve patient safety and health care quality issues and provides confidentiality protections for patient safety concerns.

Civil Rights

OCR helps to protect you from discrimination in certain health care and social service programs. Some of these programs may include:

- Hospitals, health clinics, nursing homes
- Medicaid and Medicare agencies
- Welfare programs
- Day care centers
- Doctors' offices and pharmacies
- Children's health programs
- Alcohol and drug treatment centers
- Adoption agencies
- Mental health and developmental disabilities agencies

Learn more about civil rights>>

Health Information Privacy Rights

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- Pharmacies
- Hospitals, clinics, and nursing homes
- Health insurance companies
- Health maintenance organizations (HMOs)
- Employer group health plans
- Certain government programs that pay for health care, such as Medicare and Medicaid

OCR also enforces the confidentiality provisions of the Patient Safety Act and Rule.

What Does OCR Do To Protect Your Rights?

- OCR teaches health and social service workers about civil rights, health information privacy, and patient safety confidentiality laws that they must follow.
- OCR educates communities about civil rights and health information privacy rights.
- OCR investigates civil rights, health information privacy and patient safety confidentiality complaints to find out if there is discrimination or violation of the law and takes action to correct problems.

MMJ Ordinance Concerns July 2014 dl

LB Municipal Code Section 3.80.110 - Business licenses are for revenue purposes only. Using a Conditional Use Permit may be viewed as approval of medical marijuana distribution by the City. Using a Business License model should resolve Pack v City of LB issues. There is a recent court litigation on this issue.

This Ordinance models after the Colorado recreational use—not appropriate for strictly medical. There are numerous flaws that leave it open to a landslide of litigation. At least 30 lawsuits have been filed because of the problems with the last ordinance. Shouldn't we do something differently?

All provisions are negative rather than affirmative—it tells clinics what they cannot do but not what they can.

When the City is limited to only a few collectives, it actually creates a nuisance situation—too many people who need the medicine are forced onto fewer locations. This fosters traffic and parking problems and concerns about any heavily-impacted entity. In turn, the police will say that the collective is a "nuisance." It becomes a self-fulfilling prophecy.

Additionally, less competition almost always equals higher costs for the patients members.

There cannot be an "owner" of a non-profit organization. Collectives have "managing patients."

Especially because of HIPPA laws, warrantless searchs are not appropriate. Unfettered access to surveillance cameras also violates patients' rights to privacy. And, we are forgetting the most important U.S. Constitution—4th Amendment re search/seizure.

It requires entities to provide information that could be self-incriminating under federal law. The 5th Amendment protects citizens against self-incrimination.The government cannot force someone to incriminate themselves—any documentation re numbers of plants, etc cannot be turned over to the federal government. This also protects the City from being considered conspirators.

Patient garden clubs (not storefronts) should allow up to at least ten persons. It is neither practical nor reasonable to restrict the number to three.

Before someone is allowed to make any improvements to a property (such a ventilation system), they must get a permit. This ordinance puts the cart before the horse.

Warrantless searches aka "raids" foster bribery and graft, confiscation of property without record, lack of due process, intimidation of patients, and opens the door to serious corruption. And, have we forgotten that the U.S. Constitution 4th Amendment still exists:

> The Fourth Amendment originally enforced the notion that "each man's home is his castle", secure from unreasonable searches and seizures of property by the government. It protects against arbitrary arrests, and is the basis of the law regarding search warrants, stop-and-frisk, safety inspections, wiretaps, and other forms of surveillance, as well as being central to many other criminal law topics and

to privacy law.

HIPPA Laws were also created to protect patients' privacy rights. This includes records and videos.

Generally matters of health are handled by the States. The Tenth Amendment protects States' rights in determining health concerns of its citizens.

Concentrates are allowed by the Attorney General Guidelines. Edibles should be allowed within health department guidelines. Not everyone can "smoke" and various forms of cannabis should be available to facilitate seriously-ill patients.

The "point" system is extremely problematic. Again, the collective operators and employees are held to higher standards than the police and other people who have much more sensitive jobs. While a point system might work, this one needs to be reviewed and revamped.

More on the point system--Many of the "infractions" are due to the various inequitable decisions made by City officials.
Except for convicted felonies excluding marijuana related "crimes", we are suggesting that the slate be wiped clean and we start anew with a more just ordinance. The President is also offering clemency to previously-convicted people with marijuana-related charges. Also, convictions can be appealed and overturned. There are a variety of instances that these provisions should not apply.

Our first three presidents grew and utilized cannabis; our present and past two presidents used cannabis. Our Attorney General Eric Holder used it too. Just saying......

*Please remember that Martin Luther King, Cesar Chavez, Nelson Mandela, Susan B. Anthony, Rosa Parks and many other great people were charged with "crimes" and spent time in jail. We speak today of their bravery and heroic deeds. We name parks after them; they were the pioneers for justice.

Even the guidelines for the LBPD recruits say that they are allowed past drug use and there is a specific look-back time. Should a manager or simple patient employee be held to a higher standard than the police who carry guns and enforce the laws?

Someone who was "caught" with a joint or 30 years ago should not be penalized now.

Previously vetted collectives who have suffered the most losses should be given priority.

Why are medical marijuana collectives treated differently than other "businesses?"
Collectives should be given ample time to "cure" any problems that exist.
Seed-to-sale tracking is utterly ridiculous. Does a liquor store have the same requirement?

There should be some sort of "grandfather" clause that allows established collectives to continue operating if the Council changes zoning or other location issues in the future. When people put their life savings into a collective, they shouldn't lose all because of political whims. Also, if a collective is established and a prohibited entity (schools, etc) opens near it, the collective should be allowed to stay.

Not allowing collectives near parks just about renders it inoperable. Parkland is abundant in this City and includes medians, beaches, mini-park areas, etc. Also mini-malls that may have alleys backing up to residential areas should be allowed. The Ordinance is so restrictive that it will not allow for equal access to patients in all districts—this flies in the face of the ADA and the CA State disability laws. The accessible areas should include commercial, mixed and industrial zoning.

In having excessive restrictions, the City is defeating its own purpose in considering people with disabilities. If these cooperatives are not allowed where citizens have reasonable access through public transportation, wheel chairs, etc, then they will not be able to access the medicine that they need.

Also consider that pharmacies distributing "legitimate" medicines that kill an average of 100,000 Americans every year are granted far more leniency in their choice of locations. (Please note that there has not been one documented death from medical marijuana.)

Additionally, patient safety may be at issue in limiting collectives solely to industrial areas. Industrial zones are typically dark, devoid of pedestrian traffic and have limited access to public transportation. This could easily put patients with mobility issues at great risk.

Medicine should be periodically inspected for safety by a Health Department official. It should be checked for mold, pesticides, etc.

Patients who are working in the collectives should be able to medicate on premise.

Hours of operation should extend to 9 pm.

Delivery should be allowed to people who are unable to travel to a collective. Transportation of Medical Cannabis is legal under state law (per People v. Urziceanu (2005) 132 Cal.App.4th 747,785).

Allowing the City Manager sole discretion in revoking or terminating a permit leaves the door wide open for corruption and bribery. Not a wise idea.

No entity or person should be able to have any financial interest in more than two collectives.

To lessen the impact on surrounding areas and prevent diversion: No patient should be able to enter/obtain medicine from any collective more than once a week. A patient should belong to only one Long Beach collective—a stamp can be used on the back of the recommendation for this purpose. All medicine should be marked in non-washable ink with the patient's individual number.

Additionally, all storefronts must have adequate parking. Their security guard should regularly check surrounding areas—within a block radius of the collective.

The requirement that all medicine be grown (or created in the form of edibles) in the confines of the City of Long Beach and restricted to the "Property" of the coop is unrealistic and overly restrictive (unless Long Beach is willing to provide the land to facilitate this endeavor). Currently, there is very little affordable or suitable land available in Long Beach for this purpose. Indoor grows are also very costly and require considerable amounts of space. Of paramount concern is the cost to legitimate coops. If they are truly patient-oriented, then patients must be able to afford operating them. After all is said and done, isn't it our mission to help the legitimate patients.

All ADA and CA State disability laws should be honored by the collectives and the City.

This current draft was given to the Planning Commission approximately a week after the primary election by the City Attorney's office. Little, if any, consideration has been given to the concerns of stakeholders. It is fraught with problems and litigation traps. A "token" meeting by the City Attorney's office after the ordinance was complete is not sufficient. It was obviously missing two components of the Council's direction: creation of an advisory task force to help craft the ordinance and development of a reasonable mechanism accommodating previously vetted marijuana dispensaries (Dec 17, 2013 Council Meeting). From the outset, it appears designed to fail—just as the original 5.87. So very sad for the people who are sick and/or disabled.

I thank you in advance for your consideration of our concerns. It is my sincere hope that your compassion and wisdom will guide you in this most important issue.

Namaste'
Diana Lejins

Office for Civil Rights – U.S.D.H.H.

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Orange County Register:
http://www.ocregister.com/articles/city-617276-medical-marijuana.html

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As cities across the the county spend thousands of dollars shuttering medical marijuana dispensaries, Santa Ana is considering ending the costly battles by legalizing, regulating and taxing sales.

With some 50 illegal medical marijuana collectives still operating, Santa Ana leaders say they have been somewhat forced into this position after petitioners gathered enough signatures for a ballot measure that would repeal the city's ban on medical marijuana collectives.

"There is no other city where people have gathered enough signatures to get a petition on the ballot," said Mayor Miguel Pulido. "We can't just pretend that it's not on the ballot. "That is putting us in a position where we need to do something proactively."

Already on the ballot, the Medical Cannabis Restriction and Limitation Initiative would set up a process for dispensaries to register with the city and in return pay a 2 percent tax.

On June 17, the City Council will vote whether to place a competing measure on the ballot to require a 5 percent tax and allow about eight or 12 collectives to operate.

In the nearly two decades since California became the first state to allow medical marijuana, the cannabis industry – which remains illegal under federal law – has grown significantly and Orange County cities have dealt with the issue in various ways. Lake Forest has spent nearly $1 million to shut about 40 medical marijuana dispensaries. Garden Grove briefly allowed dispensaries to legally register in its attempt to better regulate them, then switched course less than six months later and started closing down pot shops.

But in Costa Mesa – another battleground city where law enforcement has been called to close shops – medical marijuana activists have circulated a petition to allow eight medical marijuana dispensaries.

Costa Mesa City Councilman Gary Monahan said he's been communicating with petitioners in hopes of coming up with an initiative that works for all. "I think competing ballot measures don't make sense. If we do something together it's going to be a lot better for everybody." But in Santa Ana as Mayor Pro Tem Sal Tinajero phrased it, "We have an ordinance that has received the proper amount of signatures to get on the ballot ... We must react. These other cities don't have what we have facing us and what are we going to do, sit?"

DUELING PROPOSALS

The proposal already on the ballot in Santa Ana would allow dispensaries to operate only in certain zones. The measure also calls for at least one collective or cooperative for every 15,000 residents.

Kandice Hawes – principal officer of the Committee to Support Medical Marijuana Ballot Initiative PAC – has said the initiative's guidelines were worked out after proponents met with police to learn about resident complaints. Under the measure, loitering and smoking on the premises is forbidden, and patients are restricted to be at least 18 years old. "We feel that people do want medical marijuana collectives," Hawes said. "They want them to be controlled and safe, and they want the participation of the city and the police departments."

City officials said the city-backed initiative could permit a maximum of about eight collectives, establish distance requirements from schools and parks, and place a separation requirement from other medical marijuana collectives. Officials said the measure already on the ballot is alarming because there would be no maximum on the number of

collectives permitted and its proposed licensing method is a lot less than what other cities regulating such facilities require.

The city estimates that through its sales tax and other fees, their competing measure could bring the city about $1 million in revenue a year. Tinajero also talked about the possibilities of expanding the number of collectives to 12 to increase revenue.

At the council meeting, Douglas Lanphere, with Temecula-based Cooperative Patients' Services, called the city's competing measure "disingenuous." "To you, a medical necessity commodity is a revenue source ... The City Council does not propose such a sin taxation for other medications," Lanphere said. "Local government would never consider taxation of insulin, blood pressure medications. Why would the city consider pilfering from the sick and dying citizens of their city?"

Tuesday night, four council members – with Michele Martinez and Vincent Sarmiento absent – agreed with placing the city-sponsored initiative. Councilman David Benavides did not support it. Benavides expressed concern about the number of youths, who he said, get high in dispensary storefronts and drive while under the influence.

"That is not going to go away if we legalize the dispensaries," Benavides said. "I think we have the option to put some teeth to what we have in the books right now."

HARD TO REGULATE

Despite a 2007 measure that outlaws storefront medical-marijuana dispensaries, Santa Ana police and the city attorney's office have struggled with shutting down illegal collectives. Residents, nonetheless, complain about a proliferation of marijuana dispensaries, especially along 17th Street.

As of May 1, there were 50 illegal medical marijuana collectives in the city, according to a city staff report. That number is up from a low of 16 last year, but down from the high of 68 the year before, the report said. "It's not an opinion. It's a fact that since the ban, more dispensaries have opened up in the city ... If we don't play defense and come up with our own ordinance this can also get out of control," Tinajero said.

Through joint enforcement efforts with the Drug Enforcement Administration, the city has shut down 177 collectives and fined illegal shops more than $138,000 since enforcement began in 2010.

STATE SENATE BILL

A measure from Sen. Lou Correa, D-Santa Ana, that would set up a system for regulating how medical cannabis is sold in the California, recently cleared the state senate. The bill would require medical marijuana dispensaries to get a state license and approval from local officials in order to see patients.

The conflicting rules surrounding the industry have put a strain on cities and local law enforcement officials, Correa said, adding that his bill would create a "much-needed" regulatory framework. "We cannot continue to be blind to this issue," he said during the floor debate. "This does not legalize marijuana, but rather it says that if we're going to have medical marijuana in our society, let's regulate it properly."

Under SB1262, dispensary owners would have to get a license from the state Department of Consumer Affairs. They would have to show approval from local officials before a state license could be issued.

Register reporters Laura Olson and Scott Martindale contributed to this report.

11-10-09

R-10

MEMORANDUM

TO: Councilwoman Rae Gabelich
FROM: James B. Devine, Attorney for David Zink
DATE: November 9, 2009
RE: P -10

Please recall that on or about October 23, 2009, I wrote to you a letter on behalf of David Zink responding to comments made by City Attorney Reeves regarding the legality of medical marijuana dispensaries in Long Beach. On November 6, 2009, I was presented with Draft Ordinance R-10 from the Long Beach City Attorney's Office regarding the establishment of a local ordinance to regulate medical cannabis/marijuana collectives in Long Beach. Mr. Zink asked me to provide you with my proposed revisions to the draft ordinance and my reasoning for the proposed revisions.

Proposed revision to 5.87.105, subdivision (I)

"Medical Marijuana Collective" ("Collective") means an incorporated or unincorporated association, composed of four (4) or more Qualified Patients and their designated Primary Caregivers who associate at a particular location or Property to collectively or cooperatively cultivate Marijuana for medical purposes, in accordance with California Health and Safety Code Sections 11362.5, et seq. For purposes of this Chapter, the term Medical Marijuana "cooperative" shall have the same meaning as Medical Marijuana Collective, provided that the collective has incorporated under California law as either a consumer cooperative or agricultural cooperative.

My proposed language is underlined. I suggest adding this language to clarify the corporate structure of the collective. Only corporations that are incorporated as actual cooperatives may use that term in their name. In addition, because consumer cooperatives do not operate to make a profit, the consumer cooperative form is one frequently chosen by dispensary operators.

Proposed revision to 5.87.020

No Medical Marijuana Collective ~~or member~~ shall carry on, maintain or conduct any Medical Marijuana related operations in the City without first obtaining a Medical Marijuana Collective permit from the Department of Financial Management.

My proposal is to delete the words "or member." That is because an entity cannot be responsible for the conduct of each and every one if its members. No other California entity is directly responsible for the conduct of each and every one of its shareholders, members or partners. There is no reason to interpose such liability on medical cannabis patients. In addition, there are numerous "Medical Marijuana related operations" which are personal to the patients and are protected by California state law independent of local Long Beach ordinances. These include possession of their own medicine, cultivation of their own medicine, and transportation thereof. All of these activities would fall under

the broad definition of Medical Marijuana related operations, and they will have occurred even before the ordinance is enacted. A patient can easily be a member of the collective before it is approved, engage in conduct that is Medical Marijuana related, and violate the ordinance. Thus, the words "or member" should be removed.

Proposed revision to 5.87.030, subdivision (A)(5)

The name, address and telephone number, if they have a telephone number, of each Medical Marijuana Collective member at the time of the application, whether the member is a Qualified Patient or designated Primary Caregiver, and the name of the member(s) making the designation(s);

My proposed revisions are underlined. My first proposed revision is to address the fact that some people do not have telephone numbers, even in this day and age. The second proposed revision to address the fact that collective membership is expected to grow after initial formation. A reviewing agency could determine that since the initial membership application only listed four people (the minimum number required), but the actual membership is in the thousands, the applicant misled the City and the permit should be negatively impacted.

Proposed revisions to 5.87.030, subdivisions (A)(9)(c)-(e)

~~c. Written verification of the Collective's California tax exempt status;~~

~~d. Written verification of the Collective's federal tax exempt status; and~~

~~e. Written verification that the Collective is registered with the California Office of the Attorney General as a non profit entity~~;

My proposed revisions are to delete each one of these subdivisions. There is absolutely no requirement under California law that a medical marijuana collective achieve tax exempt status. Please recall that Health & Safety Code section 11362.765, subdivision (a) provides: "nor shall anything in this section authorize any individual or group to cultivate or distribute marijuana for profit." (Health & Saf., Code, §11362.765, subd.(a)). The actual text of the statute does not include the words "tax exempt" or "non-profit," which are adjectives used to describe an otherwise profit driven business who achieves certain tax benefits. Rather, the actual text of the statute focuses on the action verbs "cultivate or distribute…for profit." Courts and other administrative bodies are not empowered to insert words into or amend a statute to conform to a presumed intent that is not expressed in the statute. (See, e.g., *American Civil Rights Foundation v. Berkeley Unified School Dist.* (200) 90 Cal.Rptr.3d 789; *Troyk v. Farmers Group, Inc.* (2009) 90 Cal.Rptr.3d 589.) The Attorney General makes no mention of collectives achieving tax-exempt status in his August 2008 *Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use*. Thus, the current draft imports a requirement of tax-exempt and non-profit status when none is found in the underlying statute. The

importation of the extraneous requirement is unconstitutional and violates California rules of statutory interpretation.

Furthermore, since 1996, the Internal Revenue Service has not granted IRC section 501(c)(3) status to any California entity whose primary business involves medical cannabis due to the fact that the federal government still finds marijuana possession, etc. illegal. With the current draft of the ordinance, the City would merely be setting people up to fail because the federal government will not grant tax exempt status. Frankly, it seems that this is one way that those opposed to medical marijuana (despite its legality and their own employment being a result of California law only) are trying to quash an otherwise valid law. Please also recall that Health & Safety Code section 11362.83 requires cities to enact ordinances "consistent with" the Compassionate Use Act and the Medical Marijuana Program Act. By enacting an ordinance which would require the impossible, the City could hardly be considered to be "consistent with" California medical marijuana laws.

Proposed revisions to 5.87.040, subdivision (I)

The location and property is monitored at all times by web-based closed-circuit television for security purposes. The camera and recording system must be of adequate quality, color rendition and resolution to allow the ready identification of any individual committing a crime anywhere on or adjacent to the property. The recordings shall be maintained for a period of not less than ten (10) ~~thirty (30)~~ days and shall be made available by the Collective to the Long Beach Police ~~Department upon request. Consent is given by the collective under this Chapter to the provision of said recordings to the Police Department without requirement for a~~ upon presentation of a valid, legal, and lawfully obtained search warrant, subpoena or court order;

My proposed revisions include underlined new language and stricken through deleted language. My first revision is to address a technological issue. Please recall that the proposed hours of operation are between 10:00 a.m. and 8:00 p.m. which is 10 hours per day. Some data storage units can hold up to 120 hours of video recording, which is approximately 12 days. To keep 30 days of recording would require the collectives to purchase extremely expensive equipment, which is an unfair burden. Jewelry, convenience, and liquor are just, if not more, ripe for crime than a dispensary. However, they are not required to maintain this level of data storage.

My second revision is to address the Fourth Amendment of the United States Constitution, which protects against unreasonable searches and seizures. There are tomes of legal text on the sanctity of the Fourth Amendment and why it is one of the last bastions of personal freedom and protection. Rather than have me explain why the Police Department should obtain a warrant, I think it would better to ask the City Attorney why the citizens and tax payers of Long Beach should be deprived of their constitutional protections. If these provisions are kept in the ordinance, the City will undoubtedly have groups like the ACLU, NORML, and ASA lining up to file lawsuits the first time a Long Beach Police Officer attempts to enforce this statute.

Proposed revision to 5.87.050

A Medical Marijuana Collective permit issued pursuant to this Chapter shall become null and void upon the cessation of the Collective, upon the relocation of the Collective to a different Property, or upon a violation by the Collective ~~or any of its members~~ of a provision of this Chapter.

As with an earlier revision, this ordinance impermissibly allocates the conduct of a member to an entity. There is only so much control that an entity has over its members. Furthermore, a dispensary could have one rogue member out of hundreds. Why should the rest of the members be punished for the conduct of another member? This is akin to having one member of the City Attorney's office or an officer of the Police Department violating a statute and the rest of the office/department having to resign. I am sure that is not a situation the City Attorney would want for his own office or for the Department.

Proposed revision to 5.87.060, subdivision (A)(4)

~~**The full name, address, and telephone number(s) of each member to whom the Collective provides medical marijuana;**~~

My proposed revision is to delete this subdivision because it violates the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164. Medical information is private. There is no restriction on the use of the information collected under the ordinance. Absent a notice to each member that the City wants their information, a signed waiver of HIPAA rights by the patient, and controls over the City's use of the information, this statute is also grounds for litigation.

Proposed revision to 5.87.060, subdivision (B)(4)

These records shall be maintained by the Medical Marijuana Collective for a period of five (5) years and shall be made available by the Collective to the City upon ~~request. Consent is given by the Medical Marijuana Collective and its members pursuant to this Chapter to provide said records to the City without requirement for a~~ presentation of a valid, legal, and lawfully obtained search warrant, subpoena or court order.

This proposed revision is made for the same reasons as with section 5.87.040, subdivision (I).

Proposed revision to 5.87.090, subdivision (K)

~~No Medical Marijuana Collective shall possess more than five (5) pounds of dried marijuana or more than one hundred (100) plants of any size at the Property.~~

My proposed revision is to delete this subdivision. The case *People v. Kelly* was argued on November 3, 2009. In this case, the constitutionality of the limitations of 8 dry ounces, 6 mature plants, and 12 immature plants found in Health & Safety Code section

1162.77. During oral argument, the Attorney General noted that its position in the case had evolved since the case was filed. Now, the Attorney General agrees that the numerical limitations are unconstitutional. The balance of the statute, i.e., that the patient may "possess an amount of marijuana consistent with the patient's needs" was to remain intact, a position with which the defense agreed. It is expected that within 90 days, the numerical limitations will be deemed unconstitutional. Similarly, here, the imposition of numerical limitations will be unconstitutional. Accordingly, the City should not adopt any limitations and instead rely on the existing state law requiring the amount to be reasonably necessary for the patient's medical needs. This can easily be applied to the collective because the number of patients will be easy to identify and their needs can be extrapolated from there.

Conclusion

If there is any additional information you need or any questions you may have, please do not hesitate to contact me directly at 805-654-0200, extension 23.

**Because we recognize the need of patient volunteers/workers to medicate during the course of the day, we (The Medical Marijuana Task Force) propose the following change to our proposed ordinance:

5.91.090

N. Except by Qualified Patient workers, volunteers or Managing Members for medical reasons and pursuant to a valid recommendation by an Attending Physician, Medical Marijuana may not be inhaled, smoked, eaten, ingested, or otherwise consumed on the Property. Medical Marijuana may not be inhaled, smoked, eaten, ingested, or otherwise consumed in the parking areas of the Property, or in those areas restricted under the provisions of California Health and Safety Code Section 11362.79, which include:

1. Any place where smoking is prohibited by law;
2. Within one thousand feet (1,000') of the grounds of a school, recreation center, or youth center;
3. While on a school bus; or
4. While in a motor vehicle that is being operated.

Shannon

City Council Meeting Statement

Hello, Council Members ~ Thank you for this opportunity to speak to you. My name is: ______________________________ I am a resident of Long Beach and am very concerned regarding matters that are affecting our city financially and from a community standpoint.

Specifically, I am concerned about the legal matter that attorney Matthew Pappas has filed in the Superior Court – Pack vs. Long Beach – against the City in regard to whether or not the Ordinance 10-0007 is in compliance with the Federal Law.

I would like to read from a transcript of the January 19, 2010 City Council meeting where City Attorney Shannon stated:

"Additionally although this really hasn't come up till now, we've had a number of complaints relative to referencing federal law and I will tell you that of course it will be your decision but I have no problem with eliminating the word federal from page two and wherever else it might appear, uh it may be on other pages. I'm told it is on some other pages. But we will eliminate the word federal and basically what we're saying is nothing in this chapter purports to permit activities otherwise illegal under state or local law;"

" but I want to emphasize one thing, there's no way we can enact an ordinance that will trump federal law, we can not nullify federal law. So the fact that we are not mentioning the word federal does not mean we're indicating that we can ignore federal law".

If the City Attorney did not feel that the Ordinance was in compliance with Federal Law before it was passed, is the Ordinance now in compliance with Federal Law? Is it valid? Basically, I just want to make sure that the Ordinance is in compliance with Federal Law. I would put that question to Mr. Shannon: Is the Long Beach Ordinance 10-0007 in compliance with Federal Law or is Mr. Pappas' lawsuit correct that it is not?

Mr. Shannon, may we please have your response – and ASSURANCE that the City that the Ordinance is in complete compliance with Federal Law.
I am seriously afraid that the pending lawsuit will end up costing Long Beach a huge sum of money if our attorney did not even make sure that the Ordinance is correct. Thank you. . . . . Mr. Shannon

Heidi Eidson

From: diana lejins <dianalejins@yahoo.com>
Sent: Thursday, July 10, 2014 1:17 PM
To: Heidi Eidson; Jeffrey Winklepleck; Amy Bodek
Cc: Michael Mais; Charles Parkin; Kendra Carney; Diana Lejins
Subject: OC Register Editorial re Santa Ana Collectives

Hi
I'm working at a public computer and couldn't seem to save this so am sending it in text to you.....

Opinion Editorial: Pondering pot in Santa Ana ORANGE COUNTY REGISTER Published: June 27, 2014 The Santa Ana City Council will resume discussions Tuesday on a proposed medical marijuana ordinance that could make the November ballot. But the city seems to be rushing its measure to ensure it is available to compete with a citizen-proposed measure already on the ballot.
Marijuana collectives have been banned in Santa Ana since 2007, but reports say more than 50 dispensaries still operate illegally in the city. As outlined by Proposition 215, patients should have reasonable access to their prescribed medicine. The council should be commended for seeking to allow the legal operation of medical marijuana shops, but it should take its time to ensure that it crafts a practical and effective measure.
An ideal ordinance would create an environment that would promote legal activity through readily available access to legal medicinal marijuana, and shouldn't conflict with existing state laws and legal precedent. That being said, the list of questionable stipulations in the current ordinance is long, and council members can start by adjusting the most pertinent provisions of the law.
At the top of the list is a restriction that caps the number of dispensaries at 12 and a zoning requirement that relegates dispensaries to certain industrial zones covering a very small part of the city. This approach is far too restrictive. Instead, the council should remove the arbitrary cap and allow dispensary locations within reasonable boundaries, like far from schools and parks, throughout the city.
While the council might think pushing dispensaries to the city's outskirts promotes safety, a 2012 UCLA study found no evidence that dispensaries in neighborhoods led to more crime, and subsequent reports from other cities mirrored this discovery. If anything, relegating collectives to industrialized zones is already pigeonholing them as unscrupulous before they even open for business.
Once the council adjusts the location restrictions, it should establish an improved permitting process. The draft currently creates a lottery system to determine which collectives are awarded the limited number of medical marijuana business licenses. A similar process in Long Beach was deemed unconstitutional, as courts found the city positively promoted marijuana distribution, a violation of federal law. The council should make sure it inoculates itself against such legal challenges.
After the council has made these adjustments, it should continue to develop its draft to ensure it presents an ordinance with good policies to voters.
Accommodating medical marijuana cooperatives will be much fairer – and safer – to patients and the public at large than heavy-handed regulations that drive businesses underground and leave them at the mercy of black markets.

Working to make the World a better place, diana

Heidi Eidson

From: Amy Bodek
Sent: Thursday, July 10, 2014 2:14 PM
To: Heidi Eidson
Subject: FW: Deja Vu - MMj 2009

If you haven't mailed the packets yet, please include this. If you have, just email this to the PC members. Thanks, Amy

-----Original Message-----
From: diana lejins [mailto:dianalejins@yahoo.com]
Sent: Monday, July 07, 2014 4:03 PM
To: Diana Lejins
Cc: Jeffrey Winklepleck; Amy Bodek
Subject: Deja Vu - MMj 2009

fyi -

Random Lengths News by Greggory Moore Can Long Beach Finally Get Out of Its Own Way in Regards to Medpot?

The medical-marijuana movement is here, and it's something we have to deal with and accept.
–Long Beach City Council member Robert Garcia, 2009-Aug-04

Despite those seemingly auspicious words, a review of the last four years reveals that Long Beach city government has been anything but accepting of medical marijuana. From extracting a proverbial pound of flesh from dispensaries that wanted to be part of the system to dispatching police with assault rifles against the ones that didn't, then finally banning dispensaries entirely despite representing a populace that in 2010 voted in favor of the legalization of even recreational marijuana use, medpot patients and providers have been left wondering when Long Beach's leadership will catch up with its populace.
Now, with the city council taking another bite of the brownie by instructing the city attorney to begin drafting a new medpot ordinance, it's a fine time to review Long Beach's long, strange trip.
In fall of 2008 the City of Long Beach was taking what Assistant City Attorney Mike Mais called a "wait and see" approach on the question of medical-marijuana collectives, with the Long Beach Police Department and other City departments choosing not to expend any of their resources against the 50+ medpot dispensaries operating within city limits at that time.

Whether or not the status quo was well enough, less than a year later the City decided not to leave it alone, with the city council instructing then-City Attorney Robert Shannon to craft an ordinance officially sanctioning dispensaries.
It didn't start off well. Among the initial proposed requirements that the dispensaries furnish the City with the names of all patients, and for required 24/7 interior/exterior video surveillance with a 30-day memory be accessible by police even absent any suspicion that a crime had been committed.
It got worse. For example...

- In September 2009 then-City Prosecutor Tom Reeves penned an unsolicited op-ed for the Long Beach Post in which he declared, "It is still a felony to grow [marijuana]"—despite SB 420's notation that "[t]he [Compassionate Use Act] prohibits the provisions of law making unlawful the possession or cultivation of marijuana from applying to a patient, or to a patient's primary caregiver"—and likened Long Beach medpot collectives to street-corner drug dealers.
- In November 2009, Shannon submitted a first draft of ordinance that included a provision that any violation of "state or federal regulations or laws shall be ground for permit suspension or revocation" (emphasis added)—seemingly a

back-door attempt to give the City free rein to target dispensaries at will, since federal law prohibits even medicinal use of marijuana.

- In January 2010, Shannon's second draft included a provision disallowing sales of any kind, despite CUA co-author Sen. Mark Leno's statement to the Los Angeles Times that "the intent [of the CUA] was not to prohibit dispensaries from engaging in sales of this medicine [but] to clarify the allowance of it."
- A month later, Shannon unilaterally disregarded a 5-4 council vote in favor of a draft ordinance lacking a requirement that cannabis be cultivated within city limits, arguing that such an ordinance could not be legally enacted because doing so would mean that marijuana distributed by collectives "could come from out of the country"—a complete fiction, since state law provides immunity only for qualified individuals "who associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes."

A week later, in an effort to persuade the council to mandate that cultivation take place within city limits, Shannon brought to council representatives from outspoken medpot opponent L.A. County District Attorney Steve Cooley's office to speak on the question. Sixth District Councilmember Dee Andrews, a swing vote on the issue, was persuaded, and.....

**in March the council passed a medpot ordinance so restrictive that then-7th District Councilmember Tonia Reyes Uranga was prompted to speak against it. "Let's be clear," she told her cohort and the public in open session, "the purpose of this ordinance is to put [collectives] out of business."

First, though, collectives that wanted in had to pony up a non-refundable fee of $14,792 just to get into a lottery so ill-fated that the gods arranged it so that the winners' balls had to be drawn by hand out of a plastic recycling bin when the machine set up for the purpose failed to perform.

Ultimately, neither did the lottery, as an appeals court eventually ruled that the City's entire permitting scheme was illegal. But during the interim the City aggressively targeted what LBPD Chief Jim McDonnell liked to call "rogue operators," so aggressively that Judge Patrick T. Madden expressing concern over the LBPD's "strong-arm tactics." Battering rams were used to break in the doors of collectives. Police often entered pointing assault rifles. Security cameras were routinely smashed, even when a deputy city attorney had tagged along for the ride. Allegations of excessive force were not uncommon, with one instances of an officer stepping on the neck of a facedown, fully compliant suspect caught on video (an act that led to the filing of a million-dollar lawsuit against the City).

With the Pack decision finding much of the City's ordinance to be illegal, the city council seemingly had no choice but to rescind the ordinance. But the council went a step further on February 14, 2012, banning collectives entirely. The motion put forward by Vice-Mayor (and current mayoral candidate) Robert Garcia included six-month exemptions for 18 collectives that the council judged to been in compliance with the ordinance, with Garcia indicating that after six months the council would consider extending the exemptions for collectives that had continued to voluntarily comply with the terms of the former ordinance.

But then-8th District Councilmember Rae Gabelich, who had pushed for one-year exemptions, proved prescient in her skepticism of the intent behind the exemptions. "If the objective of the council is to ban them all," she said at the time, "then this [...] six months is really just saying, you know, 'Goodbye. You've got six months to close the door. We don't want you anymore.' So it's really putting them out of business—it's just giving them the opportunity to take six months to close down."

Garcia later confirmed that this was, in fact, his intent. "Yes, that was the purpose of the six months," Garcia told the Long Beach Post five months later: "to allow them to phase out [...] to recoup some of their investment, and to give patients time to find new sources for medicine."

A month later, however, Garcia voted with three other councilmembers (Gabelich, Suja Lowenthal, and Steven Neal) to extend the exemptions another six months or until the State Supreme Court decided the City's appeal of the Pack decision (which it would ultimately dismiss). But the other five councilmembers—including James Johnson, currently a candidate of city attorney; and mayoral candidate Gerrie Schipske, who floated the idea of a complete ban on collectives within three months of the enactment of the City's medpot ordinance—won the day.

The council was prompted not to extend the exemptions in part by two pieces of false information provided to them by City staff. The first came by way of City Manager Pat West, who, in a May 18, 2012, memorandum sent to Mayor Bob Foster and the council, claimed that "the District Attorney has indicated that they will not file felony drug charges against any dispensary operator in the City as long as the partial exemption from the ban exists." However, the District

Attorney's office flatly denied the claim. ("It is not true," said a D.A. spokesperson.) Approximately one month later, Chief McDonnell claimed that the federal government would not work with the City to close dispensaries while any exemptions were in place. "If we were able to get the ban, we then are allowed to get on the list to be able to work with the U.S. Attorney and the DEA to be able to do asset forfeiture, to be able to seize the assets of those that are selling within the city," he told the council on June 19. "We can't do that as long as we have the two-tiered system where the City has somewhat sanctioned the 18 [dispensaries] and not the rest." But both the Drug Enforcement Administration (DEA) and the U.S. Attorney's Office denied McDonnell's claim. "There's no 'list' that we have," said a DEA spokesperson in response to McDonnell's quote. A U.S. Attorney's Office said virtually the same thing: "There is no specific 'list.' As we have said [...] the marijuana industry is illegal and subject to federal enforcement wherever it is found."

The City's false moves and flip-flopping when it comes to medpot loosely mirrors the federal government's inconsistency under President Barack Obama. In October 2009, Deputy Attorney General David Ogden issued a memorandum signaling that the federal government would decrease its focus on medpot prosecutions in states allowing for the use of medical cannabis, then spent the next three years surpassing all the anti-medpot efforts undertaken by the federal government during the entire eight years of the George W. Bush administration.

Prompted by Colorado and Washington legalizing the recreational use of marijuana, in August 2013 the Department of Justice issued a memo once again signaling to states that the federal government will not be prioritizing pot prosecutions. And seemingly on cue, last month the City of Long Beach directed Acting City Attorney Charles Parkin to draft an(other) ordinance allowing for dispensaries.

As quoted in the Long Beach Business Journal, Councilmember Lowenthal says that, while the long-term solution to the medpot situation lies with the federal government allowing medpot to be "approved by the FDA and prescriptions picked up at our local pharmacies, just like any other prescribed drug, [...] the journey to achieving that status begins with smaller, legal, legislative and elected struggles. It includes missteps and overreach. That's the beauty of public policy. It's a working document, and sometimes we misstep and sometimes we overreach. Most importantly, it includes leadership and resolve."

To this point the City's leadership thus far on the medpot issue has been neither beautiful nor representative of the will of Long Beach residents. Perhaps now, finally, city officials will display the resolve to minimize their missteps and overreaching, finally taking a pragmatic path "to ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes," as Californians voted into law 17 years ago.

Because Vice-Mayor Garcia was right in 2009: the medical-marijuana movement is here. And while the City has yet to properly accept and deal with the issue, better late than never.

Working to make the World a better place, diana