2-14-12 2B-7

MMj Pack decision analysis
diana lejins
to:
Suja Lowenthal, Patrick ODonnell, Gerrie Schipske, Dee Andrews, James Johnson, Rae Gabelich, Steve Neal, Gary DeLong, Robert Garcia
02/09/2012 06:38 PM
Cc:
Bob Foster, Nancy Muth
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This is imperative reading for the MMj issue Tues.....

Working to make the World a better place,

diana

--- On **Mon, 1/16/12, Matthew Pappas** ***<matt.s.pappas@gmail.com>*** wrote:

> From: Matthew Pappas <matt.s.pappas@gmail.com>
> Subject: Fwd: Try this one
> To:
> Date: Monday, January 16, 2012, 9:32 PM
>
> ---------- Forwarded message ----------
> From: **Matthew Pappas** <matt.s.pappas@gmail.com>
> Date: Mon, Jan 16, 2012 at 9:30 PM
> Subject: Try this one
> To: Katherine Aldrich <katherinealdrich@hotmail.com>
>
> Try this
>
> --
> **Matt Pappas**
> Law Offices of Matthew Pappas
> Mission Viejo, CA
> (949) 371-7881
>
> --
> **Matt Pappas**
> Law Offices of Matthew Pappas
> Mission Viejo, CA
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ANALYSIS OF PROPOSED LONG BEACH MEDICAL CANNABIS COLLECTIVE BAN

ISSUE	ANSWER/SUPPORTING LAW/FACTS	EXHIBIT
Does the *Pack* case hold that the City of Long Beach must ban all medical marijuana collectives? Does the *Pack* case *effectively* mean that Long Beach must ban collectives?	**No.** The *Pack* case held that: 1) the Long Beach permit, permit fee, and permit lottery were **invalid**; 2) almost **all** of the *regulatory* provisions of LBMC Chapter 5.87 are **valid**; and 3) those parts of the *regulatory* provisions that are tied to the invalid permit scheme can be separated and survive. Moreover, the *Pack* court **granted** the *writ petition* which asked that enforcement of 5.87 be **enjoined** to **ensure** the plaintiff patients could access medication through their collectives. A ban **contravenes** the order of the court.	***#1:*** *HIGHLIGHTED PARTS OF THE PACK OPINION;* ***#2:*** *HIGHLIGHTED PARTS OF DEC. 21 2011 LETTER FROM ATTY GEN. HARRIS;* ***#3:*** *MEMO RE: THE RELIEF REQUESTED;*
Can the City of Long Beach implement medical marijuana collective regulations that protect the health, safety, and welfare of Long Beach citizens?	**Yes.** According to the *Pack* court**,** the City **can** implement almost **all** of the regulatory provisions of 5.87. This **includes** the valid **distance** provisions of that law (i.e. distances from schools). The **permit** provisions were designed to generate **revenue** and have **nothing** to do with regulating for the health, safety, and welfare of Long Beach citizens.	***#4:*** *LEAGUE OF CAL. CITIES MEMO ON PACK;* ***#5:*** *PROVISIONS OF 5.87 THAT CAN BE ENFORCED;*
Will a full ban of medical marijuana collectives, as proposed by the Long Beach City Attorney's office, expose Long Beach taxpayers to substantial potential pecuniary liability?	**Yes.** Title 2 of the *Americans with Disabilities Act*, 42 U.S.C. §§ 12101, *et seq.*, ("*ADA*") prohibits city zoning ordinances, practices, or procedures that facially or by operation discriminate against qualified disabled individuals. The *ADA* is applicable in California in-part through Ca. Civil Code § 54(c), which provides "[a] violation of the right of an individual under the *Americans with Disabilities Act* of 1990 (Public Law 101-336) also constitutes a violation of this section." Cities are subject to damages for violation of Title 2 of the *ADA* & Civ. Code § 54.	***#6:*** *MORRISON AND FORRESTER ANALYSIS OF BAY AREA RES. V. CITY OF ANTIOCH, CA. CASE;* ***#7:*** *CIVIL CODE § 54;* ***#8:*** *APPLICABLE PARTS OF GOV'T CODE §§ 65008 AND 12296.1;* ***#9:*** *SELECTED PARTS OF CASES SHOWING CITIES ARE LIABLE FOR TITLE 2 VIOLATION RELATED DAMAGES;*

Is the motivation of City Attorney Robert Shannon (who is insisting on a ban) based on: 1) perceived harm from stereotypes and generalized fears; 2) retaliation after losing *Pack*; or 3) on the holding in the *Pack* case?	The motivation of City Attorney Robert Shannon is either: A) perceived harm from **generalized fears and stereotypes**; or B) retaliation after losing *Pack*. Since, as an attorney, Mr. Shannon knows that: 1) the *Pack* court provided the City of Long Beach can regulate; and 2) that any **ban** would **violate** the *ADA*, Civil Code § 54, Gov't Code § 65008, as well as the appellate court's order in *Pack*, it is clear he is suggesting a ban because of stereotypes and perceived fears or to retaliate against the patients for striking down his law.	***#10:*** *PARTS OF THE NOV. 2, 2010 ORDER OF SUPERIOR COURT IN PACK FINDING LBMC 5.87 WAS MOTIVATED BY SENTIMENTS CONTRARY TO AND INCONSISENT WITH STATE LAW;*
Whether the secondary effects of medical marijuana patient collectives, if any, cause severe harm so as to justify a ban of all collectives? Whether crime **increases** when collectives are closed by cities?	**No.** The trial judge in the *Pack* case found the city had produced **no** evidence of any negative secondary effects from patient collectives. Furthermore, in a recent article, L.E.A.P. (Law Enforcement Against Prohibition) provided evidence that prohibition itself causes crime to increase while medical marijuana patient collectives do not. Finally, although retracted because of political pressure, the RAND Corporation produced a report in or around November, 2011 showing crime increases when collectives are closed.	***#11:*** *PARTS OF NOV. 2 2010 COURT ORDER FINDING LONG BEACH HAD PRODUCED **NO** EVIDENCE OF NEGATIVE IMPACT FROM COLLECTIVES;* ***#12:*** *N.Y. TIMES EDITORIAL (12/2011);* ***#13:*** *RAND REPORT (11/2011);*
Do seriously ill patients depend on medical marijuana collectives similar to patients who depend on traditional pharmacies for more dangerous drugs like Oxycontin and Vicodin?	**Yes.** Patients with cancer, AIDS, suffering from serious disability and/or permanent injuries must contend with the symptoms and effects of their respective conditions. Marijuana cultivation requires expertise, time, and skill. Also, different strains work for different illnesses and disabilities. We don't **require** patients with these same diseases to make their own Vicodin or Oxycontin.	***#14:*** *MEMO RE: HISTORY OF MARIJUANA, CUA, AND MMPA;* ***#15:*** *CASES SHOWING TAKING MEDICATION ACCESS AWAY FROM A PATIENT IS "ULTIMATE HARM;"*
Can **all** medical marijuana patients with renal failure or cancer or AIDS realistically grow medical marijuana on their own or are collectives necessary for these patients? Did the *CUA* provide for these patients?	**No.** Although some patients may be able to grow medical cannabis on their own, those patients suffering severe symptoms and effects from cancer, AIDS, serious disability, or permanent injury often cannot grow medication effectively. The *Compassionate Use Act*, at Ca. Health and Safety Code § 11362.5(A)(1)(c) provided the state should enact legislation to ensure these patients can obtain medication through the collective process.	***#16:*** *PARTS OF HEALTH AND SAFETY CODE § 11362.5 (CUA) AND 11362.775 (MMPA);* ***#17:*** *NATIONAL CANCER INSTITUTE WEBSITE ON MAR. 25, 2011;*

Does the medical cannabis provided to patient members by their Long Beach patient collective groups come from illegal drug cartels?	**No.** Illegal marijuana is generally a "low" quality street drug. Cannabis cultivated for medical purpose by patient collectives must work to help patients suffering from a variety of medical conditions. Patients will **not** accept the low quality medication from illegal drug cartels when collectives are available because the illegal street marijuana is: 1) more expensive; and 2) is poor quality and often contains improper additives and impurities.	***#18:*** *ARTICLE ON ILLEGAL STREET MARIJUANA VERSUS PATIENT CULTIVATED MEDICATION;*
If a patient collective group is taking in medication from illegal sources (i.e. drug cartels) do the police have any recourse absent a complete **ban** of collectives?	**Yes.** Under the *MMPA* (Ca. Health and Safety Code § 11362.775) and Section IV(B)(4) of the 2008 Attorney General *Guidelines for the Security an Non-Diversion of Marijuana Grown for Medical Use*, collectives and cooperatives can **only acquire marijuana from their constituent members**. Hence, the criminal liability exceptions provided by the *MMPA* are **inapplicable** if a collective obtains medication otherwise. It follows that, if the Long Beach Police Department has evidence that collectives are obtaining marijuana from illegal drug cartels, it can take immediate action and prosecute the individuals involved in such illegal activities.	***#19:*** *PARTS OF SECTION IV OF THE CA. ATTORNEY GENERAL 2008 MEDICAL MARIJUANA GUIDELINES;*
Should government agencies claim crime is increasing when it is really decreasing in order to garner much needed funding for programs and personnel?	**No.** Governmental agencies have a duty to act properly regardless of difficult economic conditions. While safety is important, crime has been **decreasing** and it is inappropriate for departments to contrive statistics in an effort to save jobs or maintain pre-recession budget levels.	***#20:*** *CRIME STATISTICS REPORTS AND INFORMATION (EXCERPTS) (2012);*
Have Long Beach police officers and city employees exposed city taxpayers to significant potential financial liability by engaging in illegal raids of collectives? Did the illegal raids result in **any** arrests under state law?	**Yes.** The trial judge found an LBPD raid of a patient collective was unconstitutional. He suggested the federal *Civil Rights Act of 1871* (42 U.S.C. § 1983) as a potential damages remedy. **No.** None of the almost twenty (20) similar illegal raids resulted in state law charges. Had the collectives been operating outside the protections of the *CUA* and *MMPA*, state charges would have been brought. These properly operating groups of patients were attacked without proper basis by city officers and officials thereby subjecting taxpayers to liability.	***#21:*** *EXCERPTS FROM TRANSCRIPT OF SUPERIOR COURT FINDING LBPD RAIDS UNCONSTITUTIONAL;*

HIGHLIGHTED PARTS OF PACK SHOWING CITY MAY REGULATE AND GRANTING WRIT PETITION

Filed 10/4/11

CERTIFIED FOR PUBLICATION

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

RYAN PACK et al., Petitioners, v. THE SUPERIOR COURT OF LOS ANGELES COUNTY, Respondent; CITY OF LONG BEACH, Real Party in Interest.	B228781 (Los Angeles County Super. Ct. Nos. NC055010/NC055053

ORIGINAL PROCEEDINGS in mandate. Patrick T. Madden, Judge. Petition granted and remanded with directions.

Matthew S. Pappas for Petitioners.

Scott Michelman, Michael T. Risher and M. Allen Hopper (N. California), Peter Bibring (S. California), and David Blair-Loy (San Diego & Imperial Counties) for American Civil Liberties Union as Amici Curiae on behalf of Petitioners.

EXHIBIT "1"

those without permits may not. The City's permit is nothing less than an *authorization* to collectively cultivate.

Second, the City charges substantial application and renewal fees, and has chosen to hold a lottery among all qualified collective applicants (who pay the application fee) in order to determine those lucky few who will be granted permits. The City has created a system by which: (1) of all collectives which follow its rules, only those which pay a substantial fee may be considered for a permit; and (2) of all those which follow its rules and pay the substantial fee, only a randomly selected few will be granted the right to operate. The conclusion is inescapable: the City's permits are more than simply an easy way to identify those collectives against whom the City has chosen not to enforce its prohibition against collectives; the permits instead authorize the operation of collectives by those which hold them. As such, the permit provisions, including the substantial application fees and renewal fees, and the lottery system, are federally preempted.

THE PERMITTING, LOTTERY, AND FEE PARTS ARE INVALID -- NOT THE REGULATORY PARTS

c. *Severability*

Having concluded that the permit provisions of the City's ordinance are federally preempted, we turn to the issue of severability. The City's ordinance provides, "If any provision of this Chapter, or the application thereof to any person or circumstance, is held invalid, that invalidity shall not affect any other provision or application of this Chapter that can be given effect without the invalid provision or application; and to this end, the provisions or applications of this Chapter are severable." (Long Beach Mun. Code, ch. 5.87, § 5.87.130.)

EXAMPLES OF PROVISIONS THAT ARE VALID NOW - WITHOUT CHANGE

This case is before us on a writ petition from the denial of a preliminary injunction. As we have concluded the permit provisions of the City's ordinance are preempted under federal law, the operation of those provisions should have been enjoined. The parties did not brief the issue of which, if any, of the other provisions of the ordinance must also be enjoined, and which can be severed and given independent effect.[32] Under the circumstances, we believe it is appropriate for the trial court to consider this issue in the first instance. However, we make the following observations: Several provisions of the City's ordinance simply identify prohibited conduct without regard to the issuance of permits. For example, the ordinance includes provisions (1) prohibiting a medical marijuana collective from providing medical marijuana to its members between the hours of 8:00 p.m. and 10:00 a.m. (Long Beach Mun. Code, ch. 5.87, § 5.87.090 at subd. H); (2) prohibiting a person under the age of 18 from being on the premises of a medical marijuana collective unless that person is a qualified patient accompanied by his or her physician, parent or guardian (*id.* at subd. I); and (3) prohibiting the collective from permitting the consumption of alcohol on the property or in its parking area (*id.* at subd. K). These provisions impose further limitations on medical marijuana collectives beyond those imposed under the MMPA, and do not, in any way, permit or authorize activity prohibited by the federal CSA. As such, they cannot be federally preempted, and appear to be easily severable.

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[32] In their reply brief, petitioners argue that, as the entire ordinance is designed to regulate and permit medical marijuana collectives, the federally preempted provisions cannot be severed from other provisions. The City did not brief the severability issue at all.

PROVISIONS THAT WITH SMALL CHANGE (REMOVE FROM PERMIT REQ.) THAT WOULD BE VALID.

Other provisions of the ordinance could be interpreted to simply impose further limitations, although they are found in sections relating to the issuance of permits. For example, in order to obtain a medical marijuana collective permit, an applicant must establish that the property is not located in an exclusive residential zone (Long Beach Mun. Code, ch. 5.87, § 5.87.040, subd. A), and not within a 1,500 foot radius of a high school or 1,000 foot radius of a kindergarten, elementary, middle, or junior high school (*id.* at subd. B). These restrictions, if imposed strictly as a limitation on the operation of medical marijuana collectives in the City, would not be federally preempted. However, the restrictions, as currently phrased, appear to be a part of the preempted permit process. We leave it to the trial court to determine, in the first instance, whether these and other restrictions can be interpreted to stand alone in the absence of the City's permit system, and therefore not conflict with the federal CSA.[33] It is also for the trial court to consider whether any provisions of the City's ordinance that are not federally preempted impermissibly conflict with state law, to the extent plaintiffs have appropriately pleaded (or can so plead) the issue.

THE PARTS OF 5.87 REFERENCED BY THE COURT ARE EXAMPLES - THERE ARE MANY OTHER PARTS -- MOST OF THE REGULATORY CONTROLS -- THAT CLEARLY AND ABSOLUTELY WOULD BE VALID AND ENFORCEABLE

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[33] The ordinance also includes record-keeping provisions as a condition of obtaining a permit. (Long Beach Mun. Code, ch. 5.87, § 5.87.040, subd. S.) Other record-keeping provisions appear unconnected to the permit requirement. (Long Beach Mun. Code, ch. 5.87, § 5.87.060.) Although we requested briefing on the issue of whether the record-keeping provisions violated the Fifth Amendment privilege against self-incrimination, the trial court will first have to determine, as a preliminary matter, whether each of the comprehensive record-keeping provisions can stand in the absence of the permit provisions.

DISPOSITION

The petition for writ of mandate is granted. The matter is remanded to the trial court for further proceedings consistent with the views expressed in this opinion. The petitioners shall recover their costs in this proceeding.

CERTIFIED FOR PUBLICATION

THE PATIENTS PETITIONED FOR AN ORDER TO STOP THE CITY FROM CLOSING COLLECTIVES UNDER 5.87. ACCORDINGLY, A BAN THAT CLOSES COLLECTIVES, VIOLATES THE COURT'S ORDER.

CROSKEY, J.

WE CONCUR:

KLEIN, P. J.

ALDRICH, J.

STATE OF CALIFORNIA

OFFICE OF THE ATTORNEY GENERAL

KAMALA D. HARRIS
ATTORNEY GENERAL

December 21, 2011

The Honorable Darrell Steinberg
President Pro-Tempore
State Capitol, Room 205
Sacramento, CA 95814

The Honorable John A. Perez
Speaker of the Assembly
State Capitol
P.O. Box 942849
Sacramento, CA 94249-0046

Re: Medical Marijuana Legislation

Dear President Pro-Tempore Steinberg and Speaker Perez:

As the state's chief law enforcement official, I am troubled by the exploitation of California's medical marijuana laws by gangs, criminal enterprises and others. My Office recently concluded a long series of meetings with representatives across the state from law enforcement, cities, counties, and the patient and civil rights communities. The primary purpose of the meetings was to assess whether we could clarify the medical marijuana guidelines that my predecessor published in 2008 in order to stop the abuses. These conversations, and the recent unilateral federal enforcement actions, reaffirmed that the facts today are far more complicated than was the case in 2008. I have come to recognize that non-binding guidelines will not solve our problems – state law itself needs to be reformed, simplified, and improved to better explain to law enforcement and patients alike how, when, and where individuals may cultivate and obtain physician-recommended marijuana. In short, it is time for real solutions, not half-measures.

I am writing to identify some unsettled questions of law and policy in the areas of cultivation and distribution of physician-recommended marijuana that I believe are suitable for legislative treatment. Before I get into the substance, however, I want to highlight two important legal boundaries to keep in mind when drafting legislation.

A "TOTAL BAN" IS A HALF MEASURE.

EXHIBIT "2"

First, the Court of Appeal for the Second Appellate District recently ruled in *Pack v. Superior Court* (2011) 199 Cal.App.4th 1070 that state and local laws which license the large-scale cultivation and manufacture of marijuana stand as an obstacle to federal enforcement efforts and are therefore preempted by the federal Controlled Substances Act. Although the parties involved in that case have sought review of the decision in the California Supreme Court, for now it is binding law. As mentioned below, the decision in *Pack* may limit the ways in which the State can regulate dispensaries and related activities.

Second, because the Compassionate Use Act (Proposition 215) was adopted as an initiative statute, legislative efforts to address some of the issues surrounding medical marijuana might be limited by article II, section 10(c) of the Constitution, which generally prohibits the Legislature from amending initiatives, or changing their scope or effect, without voter approval. In simple terms, this means that the core right of qualified patients to cultivate and possess marijuana cannot be abridged. But, as long as new laws do not "undo what the people have done" through Proposition 215, we believe that the Legislature remains free to address many issues, including dispensaries, collective cultivation, zoning, and other issues of concern to cities and counties unrelated to the core rights created in the Compassionate Use Act.

With this context, the following are significant issues that I believe require clarification in statute in order to provide certainty in the law:

(1) Defining the contours of the right to collective and cooperative cultivation

Section 11362.775 of the Health and Safety Code recognized a group cultivation right and is the source of what have come to be known as "dispensaries." It provides, in full:

> Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients and persons with identification cards, who associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions under Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570.

There are significant unresolved legal questions regarding the meaning of this statute. Strict constructionists argue that the plain wording of the law only provides immunity to prosecution for those who "associate" in order to "collectively or cooperatively . . . cultivate" marijuana, and that any interpretation under which group members are not involved in physical cultivation is too broad. Others read section 11362.775 expansively to permit large-scale cultivation and transportation of marijuana, memberships in multiple collectives, and the sale of marijuana through dispensaries. These divergent viewpoints highlight the statute's ambiguity. Without a substantive change to existing law, these irreconcilable interpretations of the law, and the resulting uncertainty for law enforcement and seriously ill patients, will persist. By articulating the scope of the collective and cooperative cultivation right, the Legislature will help law enforcement and others ensure lawful, consistent and safe access to medical marijuana.

THE UNCERTAINTY IS FOR LAW ENFORCEMENT AND SERIOUSLY ILL PATIENTS. BOTH SHOULD BE WORKING TOGETHER

(2) Dispensaries

The term "dispensary" is not found in Proposition 215 and is not defined in the Medical Marijuana Program Act. It generally refers to any group that is "dispensing," or distributing, medical marijuana grown by one or more of its members to other members of the enterprise through a commercial storefront.

Many city, county, and law enforcement leaders have told us they are concerned about the proliferation of dispensaries, both storefront and mobile, and the impact they can have on public safety and quality of life. Rather than confront these difficult issues, many cities are opting to simply ban dispensaries, which has obvious impacts on the availability of medicine to patients in those communities. Here, the Legislature could weigh in with rules about hours, locations, audits, security, employee background checks, zoning, compensation, and whether sales of marijuana are permissible.

As noted, however, the *Pack* decision suggests that if the State goes too far in regulating medical marijuana enterprises (by permitting them, requiring license or registration fees, or calling for mandatory testing of marijuana), the law might be preempted by the Controlled Substances Act. We also cannot predict how the federal government will react to legislation regulating (and thus allowing) large scale medical marijuana cultivation and distribution. However, the California-based United States Attorneys have stated (paraphrase Cole memo re: hands off approach to those clearly complying with relevant state medical marijuana laws).

(3) Non-Profit Operation

Nothing in Proposition 215 or the Medical Marijuana Program Act authorizes any individual or group to cultivate or distribute marijuana for profit. Thus, distribution and sales for profit of marijuana – medical or otherwise – are criminal under California law. It would be helpful if the Legislature could clarify what it means for a collective or cooperative to operate as a "non-profit."

The issues here are defining the term "profit" and determining what costs are reasonable for a collective or cooperative to incur. This is linked to the issue of what compensation paid by a collective or cooperative to members who perform work for the enterprise is reasonable.

(4) Edible medical marijuana products

Many medical marijuana collectives, cooperatives, and dispensaries offer food products to their members that contain marijuana or marijuana derivatives such as cannabis oils or THC. These edible cannabis products, which include cookies, brownies, butter, candy, ice cream, and cupcakes, are not monitored or regulated by state and local health authorities like commercially-distributed food products or pharmaceuticals, nor can they be given their drug content. Likewise, there presently are no standards for THC dosage in edible products.

ELECTED OFFICIALS HAVE AN OBLIGATION TO TACKLE DIFFICULT ISSUES, NOT SIMPLY TO LOOK THE OTHER WAY WHEN PATIENTS, INCLUDING PEOPLE WITH TERMINAL ILLNESSES, ARE IMPACTED BY "HALF MEASURES" (BANS).

Commercial enterprises that manufacture and distribute marijuana edibles and candy do not fit any recognized model of collective or cooperative cultivation and under current law may be engaged in the illegal sale and distribution of marijuana. Clarity must be brought to the law in order to protect the health and safety of patients who presently cannot be sure whether the edibles they are consuming were manufactured in a safe manner.

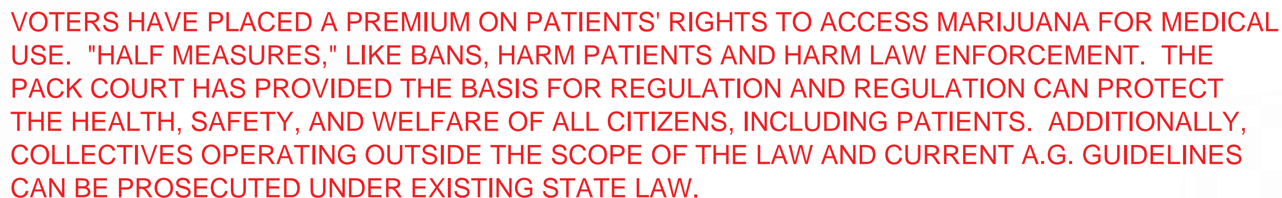
I hope that the foregoing suggestions are helpful to you in crafting legislation. California law places a premium on patients' rights to access marijuana for medical use. In any legislative action that is taken, the voters' decision to allow physicians to recommend marijuana to treat seriously ill individuals must be respected.

Please do not hesitate to contact me if you have questions or concerns.

Sincerely,

KAMALA D. HARRIS
Attorney General

cc: The Honorable Mark Leno
The Honorable Tom Ammiano



<u>Analysis of the relief granted by the appellate court in</u>
<u>*Ryan Pack, et al. v. Superior Court of Los Angeles County* (2011)</u>
<u>199 Cal.App.4th 1070</u>

The Petition in *Pack* involved the denial of a preliminary injunction by the trial court. To obtain a preliminary injunction, a party must show: 1) a likelihood of success on the merits, 2) irreparable injury if the preliminary relief is not granted, 3) a balance of hardships, if any, favoring the moving party, and 4) in certain cases, the advancement of the public interest. (*Earth Island Institute v. U.S. Forest Service* (9th Cir. 2003) 351 F.3rd 1291; *Mattel v. Greiner & Hausser* (9th Cir. 2003) 354 F.3rd 857.) Preliminary injunctive relief requires a finding that: (1) the plaintiff is likely to prevail on the merits at trial; and (2) the **<u>interim harm the plaintiff is likely to sustain</u>** in the absence of an injunction is greater than the harm the defendant will probably suffer if an injunction is issued. (*Vo v. City of Garden Grove* (2004) 115 Cal.App.4th 425, 433 [*Vo*].) A consideration of interim harm includes the inadequacy of other remedies, including damages, and the degree of irreparable injury the denial of the injunction would cause. (*Id.* at p. 435; *Intel Corp. v. Hamidi* (2003) 30 Cal.4th 1342, 1352; 5 Witkin, Cal. Procedure (5th ed. 2008) Provisional Remedies, § 337, p. 282.)

Similar to the court in *Vo*, the appellate court in *Pack* provided, "[T]wo interrelated factors bear on the issuance of a preliminary injunction—[t]he likelihood of the plaintiff's success on the merits at trial and the balance of harm to the parties in issuing or denying injunctive relief."

The verified Petition filed by the patients in the appellate court included:

"9. Unless an appropriate writ is granted, the Petitioners will continue to suffer irreparable harm. The city has altered the provisions of a voter passed initiative …

EXHIBIT "3"

> **The city's actions have resulted in the denial of access by the patients to their medication through the collective process.**" *See* Petition for Writ of Mandamus, *Pack, supra*, at p. 12 (*emphasis added*).

In their supporting discussion, the Petitioners provided:

> "**The pain and suffering [Petitioner Gayle] endures because the city is preventing access to medication recommended by his doctor is not "repairable."** The city cannot give him back the time nor can it take back the pain he has endured … [T]he City cannot take back the pain and suffering petitioner Pack endures. Nor can it retroactively erase the stress and worry it has caused by enforcing its unconstitutional ordinance that is targeted at its citizens who can only be, under state law, patients who have been recommended medication for serious illnesses, disabilities, or injuries." *See* Petition for Writ of Mandamus, *Pack, supra*, at p. 47 (*emphasis added*).

In its October 4, 2011 opinion granting the Petition for Writ of Mandate, the appellate court held, "[I]t is clear, in this case, that if the City's ordinance is invalid as a matter of law, plaintiffs had a 100% probability of prevailing, and a preliminary injunction therefore should have been entered." (*Pack, supra*.)

The Petitioners in *Pack* sought relief to **maintain access to medication as California citizens under California law**. Specifically, in the underlying case, the City's actions threatening closure of the medical marijuana patient collectives that Petitioners were members of and that were provided for and established under the state's *Compassionate Use Act*[1] constituted the "irreparable harm" claimed by the Petitioners.

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[1] The collective and cooperative system provided for in the state's *Medical Marijuana Program Act* are an implementation of the Ca. Health & Safety Code 11362.5(B)(1)(a) and 11362.5(B)(1)(c) provisions of the *Compassionate Use Act*, a voter-passed initiative (Prop. 215, enacted 1996). See *People v. Hochanadel* (2010) 176 Cal.App.4th 997, 1002. The *Hochanadel* court further held that the collective and cooperative provisions in § 11362.775 were "**expressly contemplated**" by the *CUA* and thus an *implementation* of that voter-passed law. *Id.* at 1014.

The City is aware of the relief requested by the Petitioners. It is aware the appellate court determined the Petitioners "sought the assistance of the California courts in order to assert their rights to use medical marijuana under the California statutes. As the CUA and MMPA decriminalize medical marijuana use in California, [Petitioners'] hands were not unclean under California law." (*Pack*, *supra*, at *fn.* 25.) The appellate court granted the writ petition. (*Pack* at holding).

IV. THE "IRREPARABLE HARM" CLAIMED AND THEN REDRESSED BY THE APPELLATE COURT (I.E. ACCESS TO MEDICATION) IS THE SAME "IRREPARABLE HARM" CAUSED BY A "BAN" OF ALL COLLECTIVES.

Whether enacted or not, proposed Chapter 5.89 thwarts the decision of the appellate court by proclaiming the City must "ban" all collectives because of the relief granted by the appellate court. Irreparable harm is an essential element in any injunctive consideration. The appellate court referenced its considerations in the *Pack* opinion noting, ""[T]wo interrelated factors bear on the issuance of a preliminary injunction—[t]he likelihood of the plaintiff's success on the merits at trial and **the balance of harm to the parties in issuing or denying injunctive relief**." (*Pack*, *supra.*) The "irreparable harm" claimed by the patient Petitioners was the action of the City that prevented them from accessing medication. Yet, in 5.89 the City claims it must "ban" all collectives **because of the appellate court's decision**. The appellate court certainly did <u>not</u> file an opinion that *required* the City to take action to *thwart* the "irreparable harm" remedy it prescribed when it granted the writ petition.

In Chapter 5.89, the City bases the reasons for the ban of all collectives on the erroneous finding that *Pack* holds "the permitting and **regulating of medical marijuana**

dispensaries and cultivation sites pursuant to Chapter 5.87 **is preempted by the CSA**." (Ex. 3, Proposed Chapter 5.89, p. 2, lines 12-16). However, despite the City's proclamation in 5.89, the appellate court did not hold that Long Beach cannot regulate medical marijuana collectives. To the contrary, under *Pack* almost all of the regulatory provisions of Chapter 5.87 designed to protect the health, safety, and welfare of Long Beach citizens by placing restrictions and limitations on medical marijuana patient collectives are severable and enforceable.

Likewise, the City's "finding" that *Pack* prevents it from managing the geographical locations of medical marijuana collectives is flawed. The appellate court specifically held that the school distance provisions, if separated from the invalid permit requirements, would not be federally preempted. Although the appellate court provided the trial court should consider state law preemption issues, nowhere did it require Long Beach to ban all patient medical marijuana patient collectives. In fact, since the appellate court's holding was based almost entirely on federal preemption, a holding requiring Long Beach to ban all patient collectives based on federal law would have directly contravened the holding in *Qualified Patients Ass'n v. City of Anaheim,* (2010) 187 Cal.App.4th 734 (holding California cities are "creatures" of the state, cannot be conscripted to enforce federal law, and may not "ban" collectives solely on the basis of federal law.)

A city ban of patient collectives by Long Beach is a direct violation of the appellate court's order and subjects the City to potential financial liability.

HIGHLIGHTED PARTS OF LEAGUE OF CA. CITIES ANALYSIS OF THE PACK CASE

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MEMORANDUM

Date: October 26, 2011
From: Ad Hoc Medical Marijuana Committee, City Attorneys' Department
Re: ***Pack v. City of Long Beach* – Analysis**

This memorandum is provided for general information only and is not offered or intended as legal advice. Readers should seek the advice of an attorney when confronted with legal issues and attorneys should perform an independent evaluation of the issues raised in this memorandum.

INTRODUCTION

The following is an analysis of *Pack v. Superior Court of Los Angeles County (City of Long Beach)*, 2011 WL 4553155 (Cal.App. 2 Dist.), prepared by the Ad Hoc Medical Marijuana Committee of the City Attorneys' Department. Questions that may be raised by the opinion are also included.

FACTS

The City of Long Beach (City) enacted a comprehensive regulatory scheme governing medical marijuana collectives. Under the ordinance, the City charged application fees, and, because the ordinance prohibited any collective from operating within 1,000 feet of another collective, held a lottery to determine which locations could potentially operate. When enacted, the ordinance expressly provided that no collective could commence or continue operations without a permit. To obtain a permit, collectives were subject to numerous operational requirements and location restrictions. To date, the City has not issued any permits.

PROCEDURAL POSTURE

Plaintiffs were members of medical marijuana collectives who sought to enjoin enforcement of the City's ordinance, arguing that the ordinance went beyond decriminalization and permitted conduct prohibited by the federal Controlled Substance Act (CSA). The trial court denied the preliminary injunction, declining to address the federal preemption argument and instead finding that plaintiffs could not request such a finding when the plaintiffs themselves were in violation of the same federal law. Plaintiffs filed a petition for writ of mandate in the Court of Appeal, Second District, Division 3. That Court granted the writ petition as to the permit provisions of

EXHIBIT "4"

the ordinance and remanded the matter to the trial court to determine whether any remaining provisions could be severed and given effect, and whether any of the remaining provisions conflict with state law.

ISSUE

The Court of Appeal framed the issue as being "whether the City's ordinance, which permits and regulates medical marijuana collectives rather than merely decriminalizing specific acts, is preempted by federal law."[1]

HELD

In a case of first impression, the Court concluded that, to the extent the City's ordinance permits collectives, it stands as an obstacle to the purposes of the CSA and is preempted by federal law. The ordinance's permit provisions, including its "substantial" application and renewal fees and lottery system, impermissibly authorize the operation of collectives. One provision, which requires permitted collectives to have samples of their marijuana analyzed by an independent laboratory, is preempted under conflict preemption principles because it requires collectives to violate the CSA by distributing marijuana for testing.

ANALYSIS

The Court reviewed the CSA, Compassionate Use Act (CUA), and Medical Marijuana Program Act (MMPA). The Court noted that the CSA contains a provision governing preemption, and relied on that provision in its analysis. The Court further noted that the CUA "simply decriminalizes" certain conduct for state law purposes, and thus is not preempted by the CSA, citing *Qualified Patients Ass'n v. City of Anaheim,* 187 Cal. 4th 734,757 (2010). The Court described the MMPA as an expansion of the immunities provided by the CUA,[2] including arrest immunity for those who participate in the voluntary identification card system. It also limited the amount of marijuana that may be possessed, and decriminalized the collective or cooperative cultivation of marijuana. The Court later relies on the distinction between decriminalization and "authorization" or "permission" in its conclusion that the City's ordinance is preempted by federal law.

In its preemption analysis, the Court reviewed the four types of federal preemption: express, conflict, obstacle and field preemption. Express and field preemption were eliminated as sources

[1] The larger issue is whether any state, county or municipality can regulate medical marijuana collectives without violating the CSA, which was enacted to prevent illicit drug diversion.

[2] The additional immunities provided under the MMPA are triggered "solely on the basis of" specified conduct by specified individuals. To the extent that the conduct goes beyond that, it is not immunized or decriminalized. *People v. Mentch*, 45 Cal. 4th 274 (2008)

of preemption because of 21 U.S.C. § 903.[3] Conflict preemption is established when it is impossible to simultaneously comply with two laws, in this case the CSA and the City's ordinance. Citing *County of San Diego v. San Diego NORML*, 165 Cal. App. 4th, 798, 823 (2008), the reviewing Court determined that "the federal CSA would preempt any state or local law which fails the test for conflict preemption." Thereafter, the Court acknowledged that other courts "concluded that the federal CSA's preemption language bars consideration of obstacle preemption" while another court "concluded that the federal CSA preempts conflicting laws under both conflict and obstacle preemption." Addressing these divergent views, the Court reasoned that "the federal CSA can preempt state and local laws under both conflict and obstacle preemption." In so doing, the Court maintained that it had "not driven a legal wedge – only a terminological one – between 'conflicts' that prevent or frustrate the accomplishment of a federal objective and 'conflicts' that make it 'impossible' for private parties to comply with both state and federal law."

That said, in the limited area of medical marijuana testing, the Court applied conflict preemption. Specifically, the Court found the City's requirement that collectives have samples of their medical marijuana tested at an independent laboratory to ensure that it is free from pesticides and contaminants was preempted by the CSA because this provision required collectives to distribute marijuana for testing. The Court was not persuaded by the argument that the ordinance did not compel any person who did not desire to possess or distribute marijuana to do so.[4]

The Court expressly disagreed with,

> their colleagues who, in two other appellate opinions, have implied that medical marijuana laws might not pose an obstacle to the accomplishment of the purposes of the federal CSA because the purpose of the federal CSA is to combat recreational drug use, not regulate a state's medical practices . . . [and] as far as Congress is concerned, there is no such thing as medical marijuana.

[3] Section 903 provides: "No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together."

[4] In a troubling footnote, and while acknowledging that the issue was not before them, the Court noted that the City's ordinance might require certain city officials to violate federal law by aiding and abetting a violation of the CSA. The Court then points to a letter written by US Attorneys for the Eastern District to the Governor of Washington, in which the U.S. Attorneys warn that state employees may not be immune from liability under the CSA for the employees' implementation of certain legislative proposals for marijuana growers and dispensaries. The Court did not engage in an analysis of aiding and abetting, which requires, *inter alia*, a specific intent to facilitate the commission of a crime by another and the requisite intent of the underlying substantive offense, both of which, arguably, would not be present in the state employee implementing a state regulatory scheme. *Conant v. Walters*, 309 F. 3d 629, 635 (9th Cir. 2002).

The Court ultimately relied on obstacle preemption to conclude that the City's permit scheme is preempted where it authorized, rather than decriminalized, the possession and cultivation of medical marijuana. In contrast, the Court, in footnote 30, acknowledged that "the MMPA sometimes speaks in the language of authorization, when it appears to mean only decriminalization . . . [and that] any preemption analysis should focus on the purposes and effects of the provisions of the MMPA, not merely the language used." The City was determining which collectives were permissible and which were not by requiring collectives to meet certain conditions and pay fees. Possession of a City permit would allow certain collectives to operate, while those without permits could not operate; thus, the Court concluded that the permit was equivalent to authorization.

The Court was also concerned with the City's application and renewal fees, and the fact a lottery was held to determine which collectives might ultimately be granted a permit. Such action, the Court concluded, authorized operation and was preempted. In light of this reasoning, the Court placed "some weight" on a February 1, 2011, letter issued by the U.S. Attorney for the Northern District of California to the Oakland City Attorney regarding that city's consideration of a licensing scheme for medical marijuana. The letter explained, "Congress placed marijuana in Schedule I of the Controlled Substance Act (CSA) and, as such, growing, distributing, and possessing marijuana in any capacity, other than as part of a federally authorized research program, is a violation of federal law regardless of state laws permitting such activities." Still, the Court stopped short of rendering any opinion as to federal preemption of the MMPA, but instead focused on provisions of the City's ordinance.

The Court went on to observe that certain provisions of the ordinance which simply identified prohibited conduct without regard to the issuance of a permit, such as closing hours, age restrictions, and no alcohol consumption on premises, imposed limitations on collectives, and thus did not authorize activity prohibited by the CSA. Further locational restrictions, imposed as a limitation on the operation of collectives, would not be federally preempted. However, the latter restrictions appeared as part of the permit process and the Court left it to the trial court on remand to interpret whether those provisions could stand alone.

QUESTIONS

1. Can a city require a permit as a condition of operating a collective in that city?

No. The *Pack* Court viewed the issuance of a permit as authorization to operate a collective, and such authorization is an obstacle to enforcement of the CSA, and therefore preempted. The Court in two footnotes (18 and 31) points to the practical result of the City's ordinance: because of the fees, alarm and other equipment installation requirements, and locational restrictions, the only kind of collectives allowed would be "large dispensaries that require patients to complete a form summarily designating the business owner as their primary caregiver and offer marijuana in exchange for cash 'donations'-the precise type of dispensary believed by the Attorney General likely to be in violation of California law." The Court contrasts this commercial model with a

small collective "of four patients and/or caregivers growing a few dozen plants," suggesting that such an enterprise is more keeping with state law. The Court notes that the large-scale dispensary is disapproved both in the Attorney General Guidelines and the U.S. Attorney Letters. However, given the Court's conclusion that it is the City's authorization that triggers federal preemption, it is unclear how a city could "permit" even a small collective, even though this Court seemed inclined to view small collectives differently.

2. Can a city impose a business tax on collectives?

Taxes were not at issue in *Pack*. However, cities that impose a higher tax rate specifically on medical marijuana collectives may want to evaluate that practice in light of *Pack*. The Court references the Attorney General Guidelines' confirmation of the state's taxation of medical marijuana transactions and requirement that those engaging in such transactions obtain a seller's permit. This, according to the Guidelines, does not allow "unlawful sales" but rather merely "provides a way to remit" any taxes due. (Footnote 11.) To the extent that a local tax on collectives is part of a permitting scheme, it would appear to be preempted under *Pack*. Also, to the extent that such taxation could be viewed as encouraging large-scale commercial operations, *Pack*'s analysis suggests that obstacle preemption may be found.

3. Can a city impose zoning restrictions?

Maybe. The Court does not address zoning separately, nor does it analyze any cases which discuss the traditional power of cities to zone. In providing the background for the case, the Court says "The city's ordinance not only restricts the location of medical marijuana collectives, (citations omitted), but also regulates their operation by means of a permit system (citations omitted)." The Court notes that there is a distinction between not making an activity unlawful, and making the activity lawful. Further, the Court remanded the locational restrictions to the trial court to determine whether they could be interpreted to stand apart from the permit process. "These restrictions, imposed strictly as a limitation on the operation of medical marijuana collectives in the City, would not be federally preempted." It appears that cities can tell collectives where they can't be, but not where they can be.

4. Can a city include collectives and dispensaries as an "allowed" or "enumerated" land use in its code?

Probably not. Although *Pack* does not directly address this issue, its analysis logically seems to disfavor any authorization or allowance of collectives, even if not in the form of permits. If city action "goes beyond decriminalization into authorization" of conduct prohibited by the CSA, it likely runs afoul of *Pack*.

Nowhere in the opinion does the Court address the Tenth Amendment to the U.S. Constitution, which provides that all powers not delegated by the U.S. Constitution to the United States nor prohibited by it to the states are reserved to the states or the people; the authority to make land use regulations is based on this reservation of power. 9 Miller & Starr, Cal Real Estate section

25.2 (3d ed. 2009). In California, zoning is a local matter exercised by the cities pursuant to the police powers set forth in article XI, section 7 of the California Constitution. *Id.*

Pack also did not address California Government Code section 37100, which provides: "The legislative body [of a city] may pass ordinances not in conflict with the Constitution and laws of the State or the United States." This statute is clearly consistent with the Court's decision and appears to reinforce that an ordinance which permits conduct in violation of either federal or state law cannot stand.

5. Can a city impose public safety-related restrictions or prohibitions?

Probably. The Court noted that there are provisions of the City's ordinance that identified prohibited conduct without regard to the issuance of permits. Thus, it appears that making certain conduct unlawful is probably not preempted by the federal CSA.

6. Is there a true split in authority with the Fourth District Court of Appeal such that a city could cautiously ignore *Pack*?

When opinions of the Court of Appeal conflict, the trial court must apply its own wisdom to the matter and choose between the opinions. *McCallum v. McCallum*, 190 Cal. App. 3d 308, 315, fn. 4, (1987).

> As a practical matter, a superior court ordinarily will follow an appellate opinion emanating from its own district even though it is not bound to do so. Superior courts in other appellate districts may pick and choose between conflicting lines of authority. This dilemma will endure until the Supreme Court resolves the conflict, or the Legislature clears up the uncertainty by legislation.

Ibid.

The *Pack* Court disagrees with what the Fourth District Court "implied" with respect to obstacle preemption in *Qualified Patients Ass'n v. City of Anaheim*, 187 Cal. App. 4th 734 (2010) and *County of San Diego v. San Diego NORML*, 165 Cal. App. 4th 798 (2008). In *Qualified Patients*, the Fourth District said:

> . . . a city's compliance with state law in the exercise of its regulatory, licensing, zoning, or other power with respect to the operation of medical marijuana dispensaries that meet state law requirements would not violate conflicting federal law. . . . [T]he fact that some individuals or collectives or cooperatives might choose to act in the absence of state criminal law in a way that violates federal law does not implicate the city in any such violation . . . governmental entities do not incur aider and abettor

> or direct liability by complying with their obligations under the state medical marijuana laws.

Id. at 759-760. This statement is at odds with the *Pack* Court at footnote 27, wherein the Court states that there may be an issue of city officials aiding, abetting or facilitating a violation of federal law when approving and issuing a permit. Further, the Fourth District rejected the argument that the MMPA, specifically Health and Safety Code section 11362.775 (providing immunity from certain drug related offenses for qualified patients, ID card holders, and primary caregivers who collectively and cooperatively associate to cultivate marijuana for medical purposes), is preempted under a theory of obstacle preemption.

Finally, the Fourth District in *County of San Diego* concluded that the state's identification card program was not preempted as an obstacle to the CSA because the CSA combats recreational drug use, and does not regulate a state's medical practices. *County* at 826-827. Although the Second and Fourth Districts analyzed the issue of obstacle preemption differently, the Fourth District was not confronted with a permitting scheme in either *County of San Diego* or *Qualified Patients*. Thus, it appears that no conflict presently exists with respect to whether cities may permit collectives.

7. If a city has already permitted collectives, what should it do?

Pack says the permit scheme is preempted. One view is that such ordinances are preempted, and thus no longer enforceable, in the same way that a city could not enforce, for example, an illegal lodging ordinance if a court ruled that ordinance unconstitutional. To the extent that, under this view, a permitting ordinance is "null and void" as a matter of law, there is case law which suggests otherwise. In *Travis v. County of Santa Cruz*, 33 Cal. 4th 757, 775-776 (2004), the state Supreme Court stated:

> Plaintiffs suggest that preemption by state law renders a local ordinance not only unenforceable but also 'null and void,' and that consequently in this case 'there is no applicable limitations period because there is essentially no ordinance.' Plaintiffs' claims would thus be timely whenever brought. Plaintiffs cite no authority for this approach, and we have discovered none. Nor does it appeal as a matter of logic. A preempted ordinance, while it may lack any legal effect or force, does not cease to exist; if it did cease to exist, any challenge to it would have no object.

Though *Travis* involved state preemption and the applicable statute of limitations, the Court's analysis is germane. Following its logic, a city council may decide to formally repeal an ordinance which permits or otherwise authorizes collectives or dispensaries based on preemption by federal law, rather than deem it null and void by operation of law. Such an ordinance could expressly provide that any permits issued under the repealed ordinance are void and without legal force or effect.

Another view is that each individual issued permit must be revoked, with notice, so that the permitee is provided due process. Usually this involves some type of appeal hearing. A possibility to consider under this scenario, however, is: What if the hearing body or officer restores the permit to the collective? While such a decision would be inconsistent with *Pack*, collectives would likely argue that, under state law, they have a "right" to exist under the CUA and MMPA. In fact, such arguments are likely to be made regardless of the mechanism a city uses to "disallow" permitted collectives based on the *Pack* ruling. While a court would probably reject such arguments, based on abundant case law finding that state law does not require cities to allow collectives or dispensaries, cities should certainly anticipate them. *See City of Claremont v. Kruse*, 177 Cal. App. 4th 1153 (2009), *City of Corona v. Naulls*, 166 Cal. App. 4th 418 (2008), *County of Los Angeles v. Hill*, 192 Cal. App. 4th 861 (2011).

8. What should a city do with existing zoning provisions?

The city should review the language used to create the zoning restrictions. It appears under *Pack* that if the restrictions operate as a limitation, those restrictions are not preempted. If the zoning provisions are written in a manner that authorizes or allows or permits collectives, they are likely preempted. The main body of the Court's opinion focuses on limitation versus authorization, and seems to imply that the drafting of the right "prohibitory" language will save such ordinances from a preemption problem. However, the Court also says, in footnote 30, that any preemption analysis should focus on the purposes and effect of the provisions, not merely the language used. In that footnote, the Court is discussing the MMPA and how the MMPA sometimes speaks in authorization language when it appears to mean only decriminalization. If the language in your city's ordinance really means only decriminalization, you may be able to use this footnote. However, a similar argument was made as to the "permit" in the *Pack* case, and that argument was rejected by the Court, as the only way one could operate was with a permit. Therefore, it was, again, authorization and not decriminalization.

9. Does *Pack* apply to Charter cities?

Pack says "yes" (footnote 24). *Pack* comes to this conclusion by noting that regulation of medical marijuana is a matter of state and national interest.

10. If a city is contemplating regulation or has started the process of considering an ordinance to permit collectives, what should it do?

The city should re-evaluate its position and not move forward. The city should consider limitations, rather than a permitting scheme. (But see question and answer number six.)

Opinion: http://www.courtinfo.ca.gov/opinions/documents/B228781.PDF
Long Beach Ordinance:http://www.longbeach.gov/civica/filebank/blobdload.asp?BlobID=30310

Selected Parts of LBMC Chapter 5.87 Revised to Comply with the *Pack* Decision)

Section	Text (Revised Provisions Highlighted in Yellow)
5.87.010(A)	It is the purpose and intent of this Chapter **to regulate the collective cultivation of medical marijuana** in order to ensure the health, safety and welfare of the residents of the City of Long Beach.
5.87.040(A)	The Property is not located in an area zoned in the City for exclusive residential use.
5.87.040(B)	The Medical Marijuana Collective is not located within a one thousand five hundred foot (1,500') radius of a public or private high school or within a one thousand foot (1,000') radius of a public or private kindergarten, elementary, middle or junior high school. The distances specified in this subdivision shall be determined by the horizontal distance measured in a straight line from the property line of the school to the closest property line of the lot on which the Medical Marijuana Collective is located, without regard to intervening structures.
5.87.040(D)	A Medical Marijuana Collective <u>not</u> in compliance with all applicable provisions of this Code, including but not limited to Title 21 of this Code, the building, lighting, and general business provisions of this Code, are **prohibited.**
5.87.040(E)	Exterior or interior signs visible from the exterior of the Property are **prohibited**.
5.87.040(F)	Medical Marijuana Collectives that fail to secure windows and roof hatches so as to prevent unauthorized entry using latches that may be released quickly from the inside to allow exit in the event of emergency or that are in compliance with all applicable LBMC building code provisions are **prohibited.**
5.87.040(G)	Medical Marijuana Collectives that fail to provide sufficient sound absorbing insulation so that noise generated inside the premises is not audible anywhere on the adjacent property or public rights-of-way, or within any other building or other separate unit within the same building are **prohibited.**
5.87.040(H)	Medical Marijuana Collectives that fail to provide sufficient odor absorbing ventilation and exhaust system so that odor generated inside the Property is not detected outside the Property, anywhere on adjacent property or public rights-of-way, or within any other unit located within the same building are **prohibited.**
5.87.040(K)	Medical Marijuana Collectives that do <u>not</u> provide the following interior signs readily viewable by a person or persons entering the Property: 1. "The diversion of marijuana for non-medical purposes is a violation of State law. 2. The use of marijuana may impair a person's ability to drive a motor vehicle or operate heavy machinery.

EXHIBIT "5"

	3. Loitering at the location of a Medical Marijuana Collective for an illegal purpose is prohibited by California Penal Code Section 647(h). 4. The sale of marijuana and the diversion of marijuana for non-medical purposes are violations of State Law" are **prohibited.**
5.87.040(M)	To ensure the protection of the health, safety and welfare of the community, Medical Marijuana Collectives that do not comply with or that are not eligible for civil and criminal liability exceptions provided under state law are **prohibited**.
5.87.040(N)	No Collective shall operate for profit.
5.87.040(O)	**Cultivation of Medical Marijuana** by persons who are not Management Members or members of the Medical Marijuana Collective is prohibited.
5.87.080	Any existing Medical Marijuana Collective, dispensary, operator, establishment, or provider that does not comply with the requirements of this Chapter must immediately cease operation**.**
5.87.090(D)	No Medical Marijuana Collective, Management Member or member shall cause or permit the sale, distribution or exchange of Medical Marijuana or of any Edible Medical Marijuana product to any non-Collective Management Member or member.
5.87.090(E)	No Medical Marijuana Collective, Management Member or member shall allow or permit the commercial sale of any product, good or service, including but not limited to drug paraphernalia identified in Health and Safety Code Section 11364, on the Property or in the Property's parking area.
5.87.090(F)	Medication shall not be visible with the naked eye from any public or other private property, **nor shall cultivated Medical Marijuana or dried Medical Marijuana be visible** from the building exterior. Cultivation of medication may not occur in an area that is not devoted to the cultivation is secured from public access by means of a locked gate and any other security measures necessary to prevent unauthorized entry.
5.87.090(G)	Manufacture of Concentrated Cannabis in violation of California Health and Safety Code Section 11379.6 is **prohibited**.
5.87.090(H)	No Medical Marijuana Collective shall be open to or **provide Medical Marijuana** to its members or Management Members between the hours of eight o'clock (8:00) P.M. and ten o'clock (10:00) A.M.
5.87.090(I)	No person under the age of eighteen (18) that is not a Qualified Patient accompanied by his or her licensed Attending Physician, parent(s) or documented legal guardian shall be allowed at the Property.
5.87.090(J)	No Medical Marijuana Collective shall **possess Medical Marijuana that was not collectively cultivated by its Management Members** or members.
5.87.090(L)	No dried Medical Marijuana shall be stored at the Property in structures **that are not completely enclosed, in an unlocked vault or safe, in any other unsecured storage structure**, or in a safe or

	vault that is not bolted to the floor of the Property.
5.87.090(M)	Medical Marijuana may not be inhaled, smoked, eaten, ingested, or otherwise consumed on the Property, in the parking areas of the Property, or in those areas restricted under the provisions of California Health and Safety Code Section 11362.79.

Suggested Additions to Chapter 5.87 Permissible Under *Pack*

Business License	Medical Marijuana Collectives that have <u>not</u> met the inspection and general requirements for a city business license, including but not limited to building department and fire department requirements, under this Code are **prohibited.**
	Requirements for issuance of and the fees for a general business license issued to a Medical Marijuana Collective shall be the same as the requirements for issuance and fees for a general retail business establishment business license in the City of Long Beach. Issuance of a general business license to a Medical Marijuana Collective does <u>not</u> authorize or permit the use, possession, cultivation, storage, transportation, or distribution of marijuana and establishes only that the subject Medical Marijuana Collective has met the general building, safety, and inspection requirements and paid the general business license fees for a retail business establishment operating in the City of Long Beach.
Inspection	Medical Marijuana Collectives that deny reasonable entry and access to the Property by city inspectors, officials, fire department employees, or police officers for purposes of enforcing the building code, safety code, or state law are **prohibited.**
	Other than a police officer enforcing alleged violations of state law, no city inspector, official, fire department employee, or contractor shall have contact with, touch, remove, or in any way access marijuana on or in the Property while acting in his or her official capacity.

Permits	No provision of this Code in any way authorizes or permits the use, possession, cultivation, storage, transportation, or distribution of marijuana.
	No provision of this Code imposes criminal sanctions for activities related to medical marijuana that are protected under Ca. Health and Safety code sections 11362.5 and 11362.775.
	Nothing in this Chapter prohibits the Long Beach Police Department from enforcing violations of state marijuana laws that are not protected under Ca. Health and Safety code sections 11362.5 and 11362.775 or any other valid provision of state law.
Enforcement	The first violation of any part of this Chapter shall be an infraction subjecting the violator to a fine of up to $500.00. Any subsequent violation of this Chapter by the same person or person(s) shall be a misdemeanor subjecting the violator to up to six-months in jail or a fine of up to $1,000.00 or both.

Land Use and Environmental Law Briefing: New Limits On Local Government Zoning Authority: Ninth Circuit Holds ADA Applies To Zoning

By Morrison & Foerster LLP

In *Bay Area Addiction Research and Treatment, Inc. v. City of Antioch*, 99 C.D.O.S. 4223 (9th Cir. 1999), the Ninth Circuit Court of Appeals held that the Americans with Disabilities Act ("ADA") and the Rehabilitation Act (the "Acts") apply to local zoning ordinances. The case is noteworthy for two reasons. First, it is the first time the Ninth Circuit has held that the Acts apply to zoning. Second, the Court explained the showing required under the Acts to obtain a preliminary injunction barring enforcement of a facially-discriminatory ordinance.

Bay Area Addiction was a class action brought by named plaintiffs Bay Area Addiction Research and Treatment, Inc. and California Detoxification Programs, Inc. (collectively, "BAART"). BAART appealed the district court's denial of its motion for a preliminary injunction barring the City of Antioch from enforcing an ordinance prohibiting the operation of methadone clinics within 500 feet of residential areas. The district court denied the motion because, among other things, BAART had not shown that it was likely to prevail on the merits at trial. Relying on *Crowder v. Kitagawa*, 81 F.3d 1480 (9th Cir. 1996), the district court found that a public entity may avoid violating the ADA by making "reasonable modifications" to its challenged policies or practices. Because the ordinance did not entirely exclude BAART's clinic from the City, the district court found that the City could make a reasonable accommodation for BAART. As a result, BAART had not shown that it was likely to prevail on the merits.

The Ninth Circuit reversed and remanded, holding that: (1) both Acts apply to zoning; and (2) the district court incorrectly held that BAART did not demonstrate a likelihood of success on the merits. In holding that the Acts apply to zoning, the Court found that both the ADA and the Rehabilitation Act apply to "all the operations" of a local government. The Court also held that because the City's ordinance discriminates on its face, BAART was not required to show that the City failed to provide a reasonable modification.

Finally, the Court held that the "significant risk" test should be applied to determine whether the proposed clinic's methadone patients were qualified for protection under the ADA. An individual who poses a significant risk to the health or safety of others that cannot be ameliorated by reasonable accommodations or modifications by the agency charged with discrimination does not qualify for the ADA's protection. According to the Court, the district court should have first determined whether clinic patients posed such a risk because, if they do, they are not covered by the Act. Here, the Ninth Circuit explained, the district court erred by proceeding to assess BART's likelihood of success on the merits without first determining whether BART's patients were covered by the Act.

The *Bay Area Addiction* case provides some guidance to courts (and local governments) considering whether a given individual poses a "significant risk" under the Act. The Court stated that the relevant factors include "the nature, duration, and severity of the risk," and "the probability that the potential injury will actually occur." It further noted that the terms "health and safety" were broad enough to include "severe and likely harms to the community that are directly associated with the operation of the methadone clinic." The Court cautioned, however, that, "[a]lthough a city may consider legitimate safety concerns in its zoning decisions, it may not base its decisions on the perceived harm from . . . stereotypes and generalized fears."

EXHIBIT "6"

Ca. Civil Code § 54

(a) Individuals with disabilities or medical conditions have the same right as the general public to the full and free use of the streets, highways, sidewalks, walkways, public buildings, medical facilities, including hospitals, clinics, and physicians' offices, public facilities, and other public places.

(b) For purposes of this section:

(1) "Disability" means any mental or physical disability as defined in Section 12926 of the Government Code.

(2) "Medical condition" has the same meaning as defined in subdivision (h) of Section 12926 of the Government Code.

(c) A violation of the right of an individual under the Americans with Disabilities Act of 1990 (Public Law 101-336) also constitutes a violation of this section.

EXHIBIT "7"

(Selected Parts of) Ca. Gov't Code § 65008

(a) **Any action pursuant to this title by any city, county, city and county, or other local governmental agency in this state is null and void** if it denies to any individual or group of individuals the enjoyment of residence, landownership, tenancy, **or any other land use in this state** because of any of the following reasons: (1)(A) The lawful occupation, age, or any characteristic of the individual or group of individuals listed in subdivision (a) or (d) of Section 12955, as those bases are defined in Sections 12926, **12926.1**, subdivision (m) and paragraph (1) of subdivision (p) of Section 12955 and Section 12955.2.

(Selected Parts of) Ca. Gov't Code § 12926.1(c)

(c) Physical and mental disabilities include, but are not limited to, chronic or episodic conditions such as HIV/AIDS, hepatitis, epilepsy, seizure disorder, diabetes, clinical depression, bipolar disorder, multiple sclerosis, and heart disease. In addition, the Legislature has determined that the definitions of "physical disability" and "mental disability" under the law of this state require a "limitation" upon a major life activity, but do not require, as does the *Americans with Disabilities Act of 1990*, a "substantial limitation." **This distinction is intended to result in broader coverage under the law of this state than under that federal act**. Under the law of this state, whether a condition limits a major life activity shall be determined without respect to any mitigating measures, unless the mitigating measure itself limits a major life activity, regardless of federal law under the Americans with Disabilities Act of 1990.

EXHIBIT "8"

Money Damages Under Title 2 of the *Americans with Disabilities Act* (42 U.S.C. §§ 12101, *et seq.*)

1. No Eleventh Amendment Immunity for Cities

"[T]he Eleventh Amendment does not extend its immunity to units of local government." (Board of the Trustees of the University of Alabama v. Garrett, 531 U.S. 356 (2001) at 369. As announced by the Supreme Court in United States v. Georgia, 546 U.S. 151, 153 (2006), "[T]itle II of the ADA provides that 'no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.'" Id. (citing 42 U.S.C. § 12132). Moreover, Title II "provides that '[a] State shall not be immune under the eleventh amendment to the Constitution of the United States from an action in [a] Federal or State court of competent jurisdiction for a violation of this chapter.'" Id. at 154 (citing 42 U.S.C. § 12202).

2. Damages and Attorney's Fees Under Ca. Civil Code § 54.3

Civil Code 54.3(a) provides:

"Any person or persons, firm or corporation who denies or interferes with admittance to or enjoyment of the public facilities as specified in Sections 54 and 54.1 or otherwise interferes with the rights of an individual with a disability under Sections 54, 54.1 and 54.2 is liable for each offense for the actual damages and any amount as may be determined by a jury, or the court sitting without a jury, up to a maximum of three times the amount of actual damages but in no case less than seven hundred fifty dollars ($ 750), and such attorney's fees as may be determined by the court in addition thereto, suffered by any person denied any of the rights provided in Sections 54, 54.1, and 54.2. "Interfere," for purposes of this section,

EXHIBIT "9"

includes, but is not limited to, preventing or causing the prevention of a guide, signal, or service dog from carrying out its functions in assisting a disabled person."

3. Nonexclusive Remedy

"(b) The remedies in this section are nonexclusive and are in addition to any other remedy provided by law, including, but not limited to, any action for injunctive or other equitable relief available to the aggrieved party or brought in the name of the people of this state or of the United States."

4. Recent Verdict

1. **Sept. 16, 2011 - $680,000.00 (*ADA* case):**
   Mickel Hoback v. City of Chattanooga, 10-CV-00074 (09-16-2011);

TRIAL COURT FINDING 5.87
MOTIVATED BY SENTIMENTS
CONTRARY TO STATE LAW

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OF ORIGINAL FILED
Los Angeles Superior Court
NOV 02 2010
John A. Clarke, Clerk
By ________, Deputy

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES SOUTH DISTRICT

SJ NON PROFIT COLLECTIVE, INC., a CALIFORNIA nonprofit, etc.,
Plaintiff,

v.

CITY OF LONG BEACH, etc.,

Defendant.

CASE NO. NC055053

ORDER ON OSC RE: PRELIMINARY INJUNCTION

1. BACKGROUND

On October 6, 2010, the court held a hearing on two Orders to Show Cause re: Preliminary Injunction ("OSC") in two cases, Ryan Pack and Anthony Gayle v. City of Long Beach , Case No. NC055010 and SJ Non-Profit Collective, Inc., v. City of Long Beach, Case No. NC055053. Even though the above cases are separate and have not been consolidated or deemed related, these OSCs involve many similar issues, and for purposes of consistency and judicial economy, the court addresses them in a single ruling. Distinctions between the two cases will be noted when relevant. Identical orders are filed in each case.

Case No. NC055010 is brought by Ryan Pack and Anthony Gayle (collectively, the "Patients"), who allege they are members of medical

EXHIBIT "10"

being used for any non-medical purpose. Nor has the City presented any evidence of such things. Indeed, the Ordinance, taken as a whole, conveys an impression of simply being motivated by sentiments contrary to the stated purposes of the CUA and MMPA.

The CUA provides that its purposes include:

- ensuring "that seriously ill Californians have the right to obtain and use marijuana for medical purposes" (H&S Code § 11362.5(b)(1)(A));
- ensuring "that patients and their primary caregivers who obtain and use marijuana for medical purposes . . . *are not subject to criminal prosecution or sanction*" (H&S Code § 11362.5(b)(1)(B) (emphasis supplied)); and
- encouraging "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".

H&S Code § 11362.5(b)(1)(C))

The CUA goes on to provides that the statutes criminalizing possession and cultivation of marijuana "shall not apply to a patient, or a patient's primary caregiver, who possesses or cultivates marijuana for . . . medical purposes[.]" H&S Code § 11362.5(d). In other words, the CUA declares that it is not a crime under California law for patients and caregivers to possess or grow medical marijuana.

The MMPA was enacted seven years after passage of the CUA in order to clarify its requirements and implement it. The Legislature's intent in enacting the MMPA is stated as follows:

- "reports from across the state have revealed problems

TRIAL COURT FINDING CITY HAD PRESENTED NO EVIDENCE OF NEGATIVE COLLECTIVE

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES SOUTH DISTRICT

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Case No. NC055010 is brought by Ryan Pack and Anthony Gayle (collectively, the "Patients"), who allege they are members of medical

EXHIBIT "11"

entity subject to the local regulations." City's Opposition to Patients' OSC at 4:1-2. And at oral argument, the City contended that because the Collective was no longer operating as a result of the Ordinance, the Collective also lacked standing. However, the Patients' undisputed evidence plainly states that they are members of medical marijuana collectives within the City. MP Patients' Schaffer Declaration ¶ 8; Pack Declaration ¶ 5; and Gayle Declaration ¶ 4. Hence, it appears that both of the Patients are (1) members of collectives subject to the Ordinance, and (2) themselves subject to the Ordinance. The Patients have standing. So does the Collective. The Collective's having been shut down under the Ordinance, if anything, strengthens its claim as to standing.

(e) City's "Unclean Hands" Argument

The court does not agree with the City's contention that Plaintiffs' hands are unclean simply because they dispute the constitutionality of the Ordinance with which they have been unable or unwilling to comply. The City's argument ignores Plaintiffs' evidence that at least the 1 AM Collective was issued a City business license or business permit and the clear implication that the collective opened before the Ordinance went into effect. Hence, the City's contention that Plaintiffs claims are barred because they have acted unlawfully is unsupported.

(f) The Overall Sense of the Ordinance is Inconsistent with the Purposes of the CUA and MMPA, but That Alone Does Not Make the Ordinance Unconstitutional

The Ordinance itself makes no mention of any ill effects from the operation of medical marijuana collectives (it only remarks about their increasing number), and does not suggest that collectives are

being used for any non-medical purpose. Nor has the City presented any evidence of such things. Indeed, the Ordinance, taken as a whole, conveys an impression of simply being motivated by sentiments contrary to the stated purposes of the CUA and MMPA.

The CUA provides that its purposes include:

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  H&S Code § 11362.5(b)(1)(C))

The CUA goes on to provides that the statutes criminalizing possession and cultivation of marijuana "shall not apply to a patient, or a patient's primary caregiver, who possesses or cultivates marijuana for . . . medical purposes[.]" H&S Code § 11362.5(d). In other words, the CUA declares that it is not a crime under California law for patients and caregivers to possess or grow medical marijuana.

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- "reports from across the state have revealed problems

The New York Times

The Law Adds to the Harm

Joseph D. McNamara, retired police chief of San Jose, Calif., is a research fellow at the Hoover Institution at Stanford University.

Updated December 19, 2011, 8:22 PM

The appearance of any new study indicating an increase in marijuana use by youth is always a prelude to a renewed government surge in America's war on drugs. But let's be realistic about our options. It's not as though tough enforcement keeps kids away from marijuana. Usage goes up and down no matter what we do. By keeping marijuana illegal, we nudge youngsters into contact with real criminals engaged in the drug trade. Then we bust kids, giving them a criminal record.

We should be asking: Is the drug war worth fighting? Is there such a thing as victory? We shouldn't, of course, recommend to kids that they get high on pot instead of drunk on booze or blasted on coke, but recognizing that they may not be the perfect children that we were, the following facts speak for themselves: No one ever died from using marijuana, unlike alcohol or cocaine. Marijuana tends to mellow people, but we know alcohol and cocaine excites some into violence. Driving under any of these drugs is a no-no, but cocaine and alcohol are more likely to produce speeding and reckless driving than marijuana is. Both the law and common sense clearly show that a designated driver is the way to travel.

The scare tactics — raising alarms about youngsters falling under the evil spell of marijuana and tumbling down the slippery slope to a lifetime of degradation and crime — are used to ward off hard questions. The real policy question is not how to save kids from the bogeyman scare scenes depicted in "Reefer Madness," the government's ludicrous 1930s film advocating a ban on marijuana. Instead we should be asking: Is the drug war worth fighting? Is there such a thing as victory? Are the methods we employ worse than the supposed evils they are meant to prevent?

Alcohol prohibition from 1920 to 1933 taught the federal government that it pays to emphasize the "protect our youth" angle. This intimidates many from daring to question some of the corruption and unnecessary deaths and injuries resulting from violent drug enforcement. Even I, a former anti-drug warrior, am hesitant to risk being attacked as encouraging kids to think any drug use is harmless and cool. Yet I have joined thousands of former hard-charging cops, prosecutors and judges in an organization called Law Enforcement Against Prohibition, which unequivocally states that people can cure past drug excess, but can never cure the damage of a conviction and a youthful trip into the world of crime and the criminal justice system.

Topics: Health, alcohol, drugs, teenagers

EXHIBIT "12"

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Safety and Justice

A RAND INFRASTRUCTURE, SAFETY, AND ENVIRONMENT PROGRAM

TECHNICAL REPORT

Regulating Medical Marijuana Dispensaries

An Overview with Preliminary Evidence of Their Impact on Crime

Mireille Jacobson, Tom Chang, James M. Anderson, John MacDonald, Ricky N. Bluthenthal, Scott C. Ashwood

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Sixteen states and the District of Columbia have passed laws that allow certain individuals to use marijuana for medical purposes. Each year another state takes up this issue, either at the polls or in the legislature: At present, legislatures in more than half a dozen states are set to debate whether to adopt medical marijuana laws.

In this report, we provide an overview of state medical marijuana laws. We discuss current approaches to regulating the supply of medical marijuana, including capping the number of medical marijuana dispensaries, the retail shops that provide marijuana to individuals with a physician's recommendation for the drug, and banning them outright. We then take a closer look at the controversy over retail medical marijuana sales and crime.

To empirically evaluate the connection between medical marijuana dispensaries and crime, we report results from an ongoing analysis in the City of Los Angeles. Since 2005, the number of medical marijuana dispensaries in the city has grown rapidly. At its peak, the number of dispensaries in the city was estimated at 800 and was said to exceed the number of CVS pharmacies or Starbucks locations. In an effort to rein in this growth, Los Angeles ordered the closure of over 70 percent of the 638 dispensaries operating in the city in June 2010. We collected data on the number of crimes (overall and by type) reported per block in the City of Los Angeles and surrounding communities, such as Hollywood, Beverly Hills, and unincorporated areas of Los Angeles County. For this preliminary analysis, we analyzed data for the ten days prior to and ten days following the June 7, 2010, dispensary closures. We combined this with data from the Los Angeles City Attorney's Office on the exact location of dispensaries that were either subject to closure or allowed to remain open.

Together these data allowed us to analyze crime reports within a few blocks around dispensaries that closed relative to those that remained open. Comparing changes in daily crime reports within areas around dispensaries that closed relative to those that remained open, we found that crime increased in the vicinity of closed dispensaries compared with those allowed to remain open. These results occur within both a 0.3- and 0.6-mile radius of dispensaries but diminish with increasing distance. At 1.5 miles out, there is no perceptible change in crime. The effects are concentrated on crimes, such as breaking and entering and assault, that may be particularly sensitive to the presence of security.

We provide several hypotheses for what might drive these results, including the loss of on-site security and surveillance, a reduction in foot traffic, a resurgence in outdoor drug activity, and a change in police efforts. We consider the merits of each of these hypotheses and describe ways these might be tested in the future. In ongoing analysis, we are studying crimes for a longer period before and after the 2010 closures and assessing whether these effects vary according to characteristics of the neighborhoods surrounding dispensaries. We will also analyze closures leading up to a pending (but as of yet unscheduled) dispensary license lottery in the City of Los Angeles. Finally, we will analyze the closures directly determined by the lottery.

Recent events promise to bolster the importance of decentralized but locally regulated medical marijuana dispensaries. U.S. Attorneys have sent letters to officials in at least ten states that have been trying to implement centrally regulated supply systems. These letters urge caution, reminding the governors and their legislatures that the federal government will "vigorously" prosecute those involved in the manufacturing and distribution of marijuana, even if they are in compliance with state law. An implication of this federal action is that small-scale privately run

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dispensaries, operating in the shadow of federal law, will continue to be the most viable source of medical marijuana. Our work aims to inform the debate on local approaches to regulating this market.

Introduction

In 1996, California voters approved Proposition 215, the Compassionate Use Act, ushering in an era of state medical marijuana laws. Since then, a total of 16 states and the District of Columbia have passed laws allowing marijuana use for medical purposes.[1] In nearly every election cycle, another state contemplates the issue, either at the ballot box or in the legislature. The latest law (passed by Delaware's legislature) became effective on July 1, 2011 (Delaware Code, 2011). In addition, legislatures in ten other states are currently debating whether to join the others.

Medical marijuana laws present states with several unique challenges: (1) how to regulate the supply of marijuana for patients who cannot cultivate the drug themselves, while maintaining its criminal status for nonmedical purposes, and (2) how to reconcile state-sanctioned supply channels (and, to a lesser extent, individual use) with federal prohibition. Until quite recently the dominant approach, particularly in large cities and at the state level, has been benign neglect. Medical marijuana dispensaries, sometimes called pot shops or cannabis clubs, have sprung up through the cracks. Dispensaries typically sell marijuana and edible marijuana products to qualified patients. In some cases, customers/patients consume the marijuana on the premises. The strictness with which the sales of marijuana are limited to those with a bona fide medical need—and how that need is defined—varies widely by state. The enforcement of bona fide medical need also varies by local jurisdiction.

The proliferation of medical marijuana dispensaries in such places as Los Angeles, San Francisco, and Denver has raised the ire of some residents and public officials who believe that the dispensaries attract crime or, at the very least, create a public nuisance (McDonald and Pelisek, 2009; National Public Radio, 2009; Reuteman, 2010). Jurisdictions have responded in a myriad of ways, including capping the number of dispensaries, banning them outright, or, at the other extreme, proposing state-run or regulated dispensaries.

On its face, the claim that dispensaries are associated with crime seems plausible. Illegal drugs have long been associated with crime in the public's consciousness. Many remember the crack cocaine epidemic of the 1980s, when drug dealers battled to control local distribution—often with deadly consequences. In the current setting, the relationship between marijuana sales and crime could occur through several possible causal mechanisms. First, marijuana consumption, which is presumably higher at or near dispensaries, may have direct criminogenic effects on users. These effects are cited in the context of alcohol outlets, where openings (Teh, 2008) and availability (Scribner, MacKinnon, and Dwyer, 1995) in Los Angeles and other jurisdictions (Gorman et al., 1998; Scribner et al., 1999) are associated with increases in crime. While superficially plausible in this setting, some research suggests that marijuana use does not increase crime commission per se (Pacula and Kilmer, 2003) and may even inhibit aggressive behavior (Myerscough and Taylor, 1985; Hoaken and Stewart, 2003).

Second, crime could increase near dispensaries as users try to finance their drug use by theft or other crime. Third, the quasi-legal status of dispensaries could engender crime if customers, employees, or owners resort to violence to resolve disputes (Miron, 1999; Resignato, 2000). Finally, dispensaries, which are a direct source of drugs and cash, may offer opportunities to and thus attract criminals. Anecdotal evidence suggests that dispensaries have been subject to break-ins and robberies (e.g., see McDonald and Pelisek, 2009). However, it is unclear whether other types of businesses in the same locations would engender the same kind of crime.

The argument that marijuana use (medical or otherwise) increases crime has proven influential with policymakers: New York City's special narcotics prosecutor used it to prevent the passage of a medical marijuana bill in the state senate (Campanile, 2010), and law enforcement in Oregon raised it to oppose the recent initiative to create a state-run supply system (Measure 74), which was defeated in the November 2010 elections (Burke, 2010). However, the claim that marijuana dispensaries per se attract crime has not been rigorously empirically evaluated. Our work is the first systematic, independent analysis of this claim.[2]

[1] The states are Alaska, Arizona, California, Colorado, Delaware, Hawaii, Maine, Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington. While many states have laws that are broadly supportive of medical use—e.g., protecting patients from jail time, as in Maryland—only these 16 remove state penalties for the cultivation, possession, and use of marijuana for approved medical purposes (Marijuana Policy Project, 2008). Pacula et al. (2002) provide an overview of the myriad of state laws on medical marijuana.

[2] The Denver Police Department (Ingold, 2010) and the Colorado Springs Police Department (Rodgers, 2010) each analyzed the number of crimes around dispensaries and compared them with the numbers around banks, pharmacies, and other businesses. Neither found evidence that dispensaries attracted crime.

In this report we provide a brief overview of the history of state medical marijuana laws and current approaches to regulating medical marijuana supply. We then provide a case study of the City of Los Angeles, dubbed "the Wild West of Weed" (Philips, 2009), which has experienced rapid growth in medical marijuana dispensaries since 2005. We clarify the evolving regulatory landscape in the city and use its recent experience ordering the closure of over 70 percent of the 638 dispensaries operating within the city to evaluate the claim that marijuana dispensaries attract or cause crime. Surprisingly, we find that crime increased in the vicinity of the closed dispensaries relative to the vicinity of dispensaries allowed to remain open.

The Los Angeles experience continues to evolve. In January 2011, the city's dispensary closures were invalidated as the result of a legal challenge. In response, the city plans to allocate 100 dispensary licenses by lottery (Hoeffel, 2011c). However, these plans face ongoing legal challenge (Hoeffel, 2011d).

As Los Angeles and other jurisdictions around the nation consider ways to regulate marijuana dispensaries, this study should provide some empirical evidence to guide policymakers. Ultimately any sustained approach to supplying medical marijuana will have to balance a complex mix of legal, regulatory, political, and public safety concerns. Although more work remains to be done, our initial investi-gation suggests that the latter concern—namely, public safety—may not be as important as commonly believed.

The Control of Medical Marijuana: A Brief Overview

Like heroin and LSD, marijuana is classified under federal law as a Schedule I drug, meaning that it has high abuse potential and no accepted medical use (Grinspoon and Bakalar, 1993). It is illegal under federal law to cultivate, possess, or distribute marijuana for any purpose (Mikos, 2009).

Despite this status, the federal government makes marijuana available for medical purposes in a very limited way: through a "Compassionate Use" Investigational New Drug program that once allowed physicians to provide marijuana to approved patients on an experimental basis and through larger-scale research studies that require approvals from the Food and Drug Administration, a special Public Health Service panel, and the Drug Enforcement Administration (Harris, 2010). The Compassionate Use program, which was closed to new patients in 1992, never reached more than 36 patients total (Grinspoon and Bakalar, 1993), and federal approval to study marijuana is notoriously difficult to obtain (Harris, 2010). In both cases, marijuana must be acquired from the University of Mississippi, which runs the only federally approved grow site in the United States (Mikos, 2009).

Like the federal government, all states outlaw marijuana cultivation, possession, and distribution for nonmedical purposes, although some treat minor offenses as a civil rather than a criminal offense (Mikos, 2009). But an increasing number of states—16 and the District of Columbia as of July 2011—make an exception to allow cultivation, possession, and use for approved medical purposes. Most of these laws were passed through voter-approved initiatives (see Table 1).

Medical marijuana use has wide support in principle. Recent polls indicate that over 70 percent of Americans favor state laws allowing marijuana use for prescribed medical purposes (Pew Research Center, 2010). However, 44 percent would be somewhat or very concerned if a "store that sold medical marijuana" opened in their area (Pew Research Center, 2010). Perhaps as a consequence, medical marijuana laws have been remarkably ambiguous about key supply issues, until quite recently. While all allow registered patients to grow their own marijuana or designate somebody as their grower, none provides a mechanism for legally obtaining seeds or cuttings (Harrison, 2010).

Physicians can generally discuss marijuana's benefits and recommend its use to patients, though this practice is controversial in some states (Hoffmann and Weber, 2010).[3] They still cannot legally prescribe, dispense, or even advise patients on how to obtain the drug without violating federal law (Hoffmann and Weber, 2010). Moreover, although the anti-commandeering doctrine prohibits Congress from requiring states to prohibit medical marijuana (Mikos, 2009), a 2005 Supreme Court decision (*Gonzales v Raich*) reaffirmed that individuals who cultivate or possess marijuana legally under state law may be prosecuted under federal law (Hoffmann and Weber, 2010).[4]

[3] In *Conant v Walters*, 309 F.3d 629 (9th Cir. 2002), cert. denied, 540 U.S. 946 (2003), the United States Court of Appeals for the Ninth Circuit ruled that physicians had a First Amendment right to advise patients about marijuana. Judge Kosinski, concurring, argued that the federal government prohibiting doctors from discussing medical marijuana also violated the "commandeering" doctrine of *New York v United States*, 505 U.S. 144 (1992), and *Printz v United States*, 521 U.S. 898 (1997). While the Court of Appeals ruling is technically only binding on the states within the Ninth Circuit (California, Nevada, Washington, Oregon, Montana, Idaho, Arizona, Alaska, and Hawaii), it may prove influential in other jurisdictions.

[4] The U.S. Department of Justice (DOJ), which brought *Gonzales v Raich* to the Supreme Court, exercised this power regularly; it has raided 30 to 40 medical marijuana dispensaries in California since 2005 (Blum, 2009; Alex Johnson, 2009).

Table 1
Summary of State Medical Marijuana Laws

State	Year Passed	Date Effective	Voter Approved?	Maximum Patients per Caregiver	Dispensary Regulations
Alaska	1998	March 4, 1999	Yes	1	
Arizona	2010	November 29, 2010[a]	Yes	5[c]	State regulated
California	1996	November 6, 1996	Yes	None	Licensed through city or county business ordinances
Colorado	2000	June 1, 2001	Yes	5[c]	Authority given to localities
Delaware	2011	July 1, 2011[a]	No	5	State regulated
District of Columbia	2010	July 27, 2010[a]	Yes	1[c]	Will be city regulated
Hawaii	2000	December 28, 2000	No	None	
Maine	1999	December 22, 1999	Yes	5[c]	State regulated
Michigan	2008	December 4, 2008	Yes	5	
Montana	2004	November 2, 2004	Yes	None	Not allowed, but dispensaries are proliferating. The legislature is expected to pass regulations in 2011.
Nevada	2000	October 1, 2001	Yes	1	Not allowed, but several dispensaries are operating
New Jersey	2010	January 2011[a]	No	1	Will be state regulated
New Mexico	2007	July 1, 2007	No	4[c]	State regulated
Oregon	1998	December 3, 1998[b]	Yes	None	
Rhode Island	2006	January 3, 2006	No	5[c]	State regulated; program is on hold as of July 2011
Vermont	2004	July 1, 2004	No	1	
Washington	1998	November 3, 1998	Yes	1	State indicates that dispensaries are "not allowed"

[a] These programs are not yet active, as of August 2011.
[b] Oregonians defeated Measure 74 on the November 2010 ballot, which would have established a state-regulated supply system (Oregon Ballot Measure 74, 2010; "November 2, 2010, General Election Abstracts of Votes, State Measure No. 74," undated).
[c] Limits do not apply to dispensaries.
SOURCES: Arizona Medical Marijuana Act (2009), Council of the District of Columbia (2010), Delaware State Senate (2011), Harrison (2010), Johnson (2010), Maine State Law and Reference Library (2011), Malinowski (2011), O'Connell (2010), ProCon.org (2011a), Southall (2010), Washington State Department of Health (2011), and Whited (2009).

The Emerging Regulatory Framework: California and Beyond

Faced with these legal obstacles to purchasing medical marijuana, patients and buyers banded together to form cooperatives or buyer's clubs, later known as dispensaries. In California, the first cooperatives actually predate the state's medical marijuana law (Cohen, 2000). In October 1996, a month before Proposition 215 passed, the *Los Angeles Times* reported that six dispensaries were operating in the Bay Area and several others were open in Southern California (Curtis and Yates, 1996).[5] These dispensaries, like the first medical marijuana laws themselves, emerged, at least in part, out of AIDS activism (Reiman, 2010); AIDS wasting syndrome is one of the conditions for which the benefits of marijuana are least controversial (Watson, Benson, and Joy, 2000).

[5] The San Francisco Cannabis Buyers Club, which was founded in 1991 by Dennis Peron, a coauthor of Proposition 215, was likely the first dispensary (McCabe, 1996).

More dispensaries opened after Proposition 215 took effect. Their numbers increased rapidly after 2004, when California Senate Bill 420 (2003) established a (voluntary) patient identification card program and recognized a patient's right to cultivate marijuana through nonprofit collectives and cooperatives—i.e., dispensaries.[6] In accordance with Senate Bill 420, the California State Attorney General, Jerry Brown, later issued guidelines to prevent the diversion of medical marijuana (Brown, 2008). Among other things, these guidelines indicated that local jurisdictions had the right to further regulate dispensary operations, which seems to have set in motion a wave of city and county regulations.

As of May 2011, 42 cities and nine counties in California have ordinances regulating dispensary operations (Americans for Safe Access, 2011). While approaches vary, most dispensary regulations deal with the following core issues: licensure, zoning (including district and distance requirements), security systems, storage, on-site consumption, and signage (Salkin and Kansler, 2010). San Francisco, which in 2005 was one of the earliest cities to craft comprehensive dispensary regulations, established zoning and proximity restrictions, as well as ventilation requirements for dispensaries that obtained approval for on-site smoking.[7] Another "early adopter," West Hollywood, caps the number of dispensaries at four, limits business hours, prohibits on-site consumption, and sets zoning and proximity restrictions. It also requires each dispensary to have a neighborhood guard patrol within a two-block radius of a dispensary during business hours and to distribute the name and phone number of a staff person responsible for handling problems to neighbors within 100 feet of a dispensary (City Council of the City of West Hollywood, 2007). Many, primarily smaller, jurisdictions have moratoria on new dispensaries or outlaw them altogether (Americans for Safe Access, 2011).[8] City bans are currently being challenged in the ongoing case of *Qualified Patients Association v City of Anaheim* (see Hoeffel, 2010b; Carpenter, 2011).

While California allows counties and cities to regulate dispensaries, eight states—Arizona, Colorado, Delaware, Maine, New Mexico, New Jersey, Rhode Island, and Vermont—and the District of Columbia regulate medical marijuana dispensaries directly (see Table 2). Many passed regulations in an effort to avoid California's experience—the massive growth in dispensaries (Maas, 2009) and the patchwork of local ordinances that emerged in their wake.

In addition, they reacted to what had until recently been viewed as a softer federal stance on dispensaries. In March 2009, Attorney General Eric Holder announced that federal raids of dispensaries would be restricted to those involved in drug trafficking (Johnston and Lewis, 2009). Holder's announcement was seen as a dramatic change of policy from the Drug Enforcement Administration's dispensary raids during the George W. Bush administration. Headlines such as "A Federal About-Face on Medical Marijuana" (Meyer, 2009) and "Obama Administration to Stop Raids on Medical Marijuana Dispensers" (Johnston and Lewis, 2009) promoted the impression that dispensaries would be allowed to grow unimpeded by federal law enforcement, although DOJ later released a memorandum clarifying that the policy was not a green light for dispensaries (United States Department of Justice, 2009).

Recent efforts to regulate the supply of medical marijuana centralize the licensing and oversight of dispensaries, primarily at the state level. New Mexico, which in 2007 was the first to establish a state system to regulate medical marijuana production and distribution, licenses nonprofit providers and sets limits on the amount of marijuana they can grow and dispense (Holmes, 2010). Rather than capping the number of dispensaries, as is done in most state systems, New Mexico limits the number of patients any dispensary can serve to a total of four. Maine's regulatory system, which was created by a 2009 voter amendment to its 1999 medical marijuana law, licenses and regulates dispensaries as well, but caps their total number at eight.[9]

The specific caps chosen tend to be driven by geography. For example, New Jersey's law establishes six "alternative treatment centers" for medical marijuana, two in each of the northern, central, and southern parts of the state. At the very high end of caps, Arizona limits the number of dispensaries to 124 at the outset, "proportionate to the number of pharmacies in the state" (Lee, 2010). In 2013, Delaware will grant licenses to one state-regulated "compassion center" in each of its three counties based on a scoring system for safety, security, diversion prevention, and record-keeping plans. Three additional licenses will be granted in 2014. With the exception

[6] This right was affirmed in *People v Urziceanu* (2005), which reversed the conviction of a collective owner, Michael Urziceanu, for conspiracy to sell marijuana.

[7] The ordinance specifies, for example, the types of neighborhoods where dispensaries can operate and places a 1,000-foot buffer around schools and recreational facilities. For more detail, see City and County of San Francisco Planning Department (undated).

[8] As of May 2011, 152 cities and 13 counties ban dispensaries, and 96 cities and 15 counties have moratoria in effect.

[9] See Maine State Law and Reference Library (2011).

Table 2
Summary of State Dispensary Regulations

State	Enacted	Nonprofit?	Cap on Numbers?	Zoning Requirements	Quantity Limits?	Security
Arizona	November 29, 2010[a]	Yes	Yes—not to exceed 10% of pharmacies; will start at 124	Devolves to local jurisdictions	Yes	Security alarm system
Colorado	June 7, 2010	No	No, but caps are enacted at the local level	At least 1,000 feet from a school, alcohol or drug treatment facility, or child care facility	Yes	Video and alarm systems
Delaware	May 13, 2011[a]	Yes	1 in each of 3 counties, with 3 more in year 2	500 feet from a school	Yes	Alarm system
District of Columbia	July 27, 2010[a]	No	5	At least 1,000 feet from a school or youth center	Yes	Plan required
Maine	November 3, 2009	Yes	8	At least 500 feet from a school	Yes	Must demonstrate adequate security
New Jersey	January 2011[a]	Yes	6	Devolves to local jurisdictions; cannot be within 1,000 feet of a school	Yes	Plan required
New Mexico	December 15, 2008	Yes	No caps, but suppliers are limited to 4 patients	At least 300 feet from any school, church, or day care center	Yes	Not specified
Rhode Island	June 16, 2009[b]	Yes	3	At least 500 feet from a school	Yes	Security alarm system
Vermont	June 6, 2011[b]	Yes	4	At least 1,000 feet from a school or child care facility	Yes	Security alarm system

[a] These programs are not yet active in their entirety, as of August 2011.
[b] The dispensary system is not yet active, as of August 2011.
SOURCES: Arizona Medical Marijuana Act (2009), California Senate Bill 420 (2003), Delaware State Senate (2011), General Assembly of the State of Colorado (2010), General Assembly of the State of Vermont (2011), Maine Department of Health and Human Services, Division of Licensing and Regulatory Services (2010), New Jersey Register (2010), New Mexico Department of Health (undated), ProCon.org (2011b), and Rhode Island General Assembly (2009).

of Colorado, Maine, and New Mexico, the other state-regulated supply systems exist only on paper and have not yet issued licenses.[10] More states, such as Hawaii and Montana, have been actively contemplating the establishment of systems to regulate the supply of medical marijuana.

Many efforts to plan or implement central supply systems have slowed or ceased in recent months, after U.S. Attorneys in ten states sent letters to governors and other elected officials restating the conflict between state and federal law. The letters warned that those involved in the manufacture or distribution of marijuana risk civil or criminal penalties (see Table 3). In some cases, these letters responded to requests for guidance (seven states), but several others were sent on DOJ's own initiative (three states). Vermont and Hawaii appear to be pressing ahead despite these letters, but the response among other recipients and the likely chilling effect in states considering similar systems suggest that the regulation of medical marijuana supply may remain a local issue.[11]

[10] Colorado's system is in an interim phase. Colorado will not issue licenses until July 1, 2012 (originally 2011), but dispensaries that had filed an application by the August 1, 2010, deadline can continue to operate until that time. See Wyatt (2011) for discussion of the extension.

[11] One letter was sent to the City of Oakland, which had plans to establish four industrial-scale marijuana production facilities (Wholsen, 2010). It has since abandoned this plan. Although it is the rare jurisdiction that contemplates such an approach, local regulations will likely involve far less centralization.

Table 3
Summary of 2011 U.S. Attorney Letters Regarding Medical Marijuana

When	U.S. Attorney	District	To Whom	Letter Solicited?	Comments and Outcome
February 1	Melinda Haag	Northern California	Oakland City Attorney	Yes—guidance on Oakland ordinance	Warns that city's plans to license 4 industrial-scale production facilities could result in civil and criminal penalties. City suspended plans after receipt of letter.
April 12	Florence Nakakuni	Hawaii	Director, Public Safety	Yes—guidance on law to establish at least 1 dispensary	States that disruption and prosecution of drug trafficking is a core priority
April 14	Jenny Durkan, Michael Ormsby	Western and Eastern Washington	Governor	Yes—guidance on program to license growers and dispensaries	States that disruption and prosecution of drug trafficking is a core priority. Governor vetoes bill.
April 20	Michael Cotter	Montana	Several state legislators	Yes—guidance on proposal to license and regulate production and distribution	States that disruption and prosecution of drug trafficking is a core priority. New legislation passed will likely shut down hundreds of dispensaries.
April 26	John Walsh	Colorado	Colorado Attorney General	Yes—guidance on bill to clarify law that licenses marijuana dispensaries	DOJ will consider "appropriate civil and criminal" remedies. Law passes despite letter; extends moratorium on new dispensaries through 2012.
April 29	Peter Neronha	Rhode Island	Governor	No—responds to licensing of 3 "Compassion Centers"	States that prosecution of businesses that "market and sell marijuana" is a "core priority." Governor suspends program to license dispensaries.
May 2	Dennis Burke	Arizona	Director, Department of Health Services	No—responds to rules filed for dispensary licensing and other aspects of program	Governor filed suit against Burke and Attorney General Holder seeking clarification on the legal protections their law affords voters
May 4	Tristram Coffin	Vermont	Information not available	Yes—guidance on bill sought after Rhode Island received an unsolicited letter about proposed compassion centers	Bill passes and receives governor's signature
May 16	Thomas Delahanty II	Maine	Health and Human Services Committee	Yes—guidance on changes to law, such as making patient registration voluntary	DOJ will act "vigorously against individuals and organizations" involved in unlawful manufacturing and distribution
June 3	Dwight Holton	Oregon	Dispensary owners, operators, landlords	No—responds to dispensary growth	Letter signed by many Oregon DAs, sheriffs, and police chiefs. Warns of risk of prosecution, civil action, and asset seizure.

NOTE: DA = district attorney.
SOURCES: For letters from Rhode Island, Colorado, California, Hawaii, Washington, and Montana, see *Reason* (2011). For the Arizona letter, see Burke (2011). For the Oregon letter, see Holton (2011) and Richardson (2011). For details of the Vermont letter, see Hallenbeck (2011).

The Los Angeles Experience

The movement to regulate medical marijuana supply, and in particular to limit and tightly manage dispensary systems, has been fueled in part by the experience in Los Angeles. In this section, we study Los Angeles in order to put the current debate in proper historical context and to shed light on what remains an important issue for local regulations moving forward—the relationship between dispensaries and public safety.

The effort to regulate dispensaries in Los Angeles began in May 2005, when City Council member Dennis Zine requested a study of the city's dispensaries. His goal was to set the stage for drafting comprehensive land use regulations (Doherty, 2010).[12] In its report in July 2005, the Los Angeles Police Department (LAPD) identified four known dispensaries

[12] A description of the motion can be found at LACityClerk Connect (undated[a]).

within city limits, suggested that several others were operating at mobile sites, and claimed that dispensaries generated crime.[13] To substantiate these claims, the LAPD cited several felony narcotics arrests made at these dispensaries. They noted that "no reported non-narcotics related crimes can be attributed to these locations" but indicated that it was highly likely that "crimes such as theft, robbery and assault have occurred and will occur along with the sale of marijuana from these locations" (Bratton, 2005).

To address these concerns, the LAPD report called for restricting dispensaries to commercial areas, if the city chose not to ban them altogether. It further suggested prohibiting dispensaries from residential areas, near schools and colleges, and near both public and private recreational areas and recommended a set of regulations for those already in operation. In 2006, the City Attorney's Office issued its own report laying out various options for regulating dispensaries, including an outright ban based on federal law, an interim moratorium until state law is "further clarified," and a land use ordinance establishing zoning requirements.[14]

As detailed in Table 4, the city opted for an Interim Control Ordinance (ICO), which took effect almost a full year later in September 2007. The ICO placed a temporary moratorium on new dispensaries and required existing dispensaries to register with the city by November 13, 2007. To register, dispensaries had to present a City of Los Angeles Tax Registration Certificate, a State Board of Equalization seller's permit, a lease, proof of insurance, and dispensary membership forms. The broad goal of the ICO was to address concerns of neighborhood activists about the growth of dispensaries while buying the city some time to draft permanent legislation.

The ICO was also a response to the LAPD's fact sheet documenting a massive increase in dispensaries (from four to 98) between July 2005 and November 2006 and attempting to tie these dispensaries to an increase in crime in their reporting districts.[15] This link was summarized in the fact sheet's table of areas with dispensaries, the number of dispensaries, and the percentage change in crimes (robberies, burglaries, aggravated assaults, and burglary from auto) in these areas from July 30, 2005, to October 29, 2005, and from July 30, 2006, to October 28, 2006. No effort was made to isolate the change in crime near dispensaries from broader neighborhood-specific crime patterns or to compare them with the change around other neighborhood establishments, such as liquor stores, coffee shops, or banks.

Although the ICO was intended to halt the growth in dispensaries, it actually had the opposite effect. Hundreds of dispensaries opened subsequent to the moratorium after filing applications for "hardship exemption," requests that were allowed under the ICO (McDonald and Pelisek, 2009).[16] Many entrepreneurs quickly realized that the city would not prosecute these dispensaries until their hardship applications had been reviewed, and the City Council seemed in no hurry to review these applications. Indeed, the City Council did not rule on any applications before June 2009, after more than 500 applications had been submitted (Hoeffel, 2009a). To close this loophole, the city passed an ordinance on June 19, 2009, that amended the ICO to eliminate the hardship exemption.[17]

It was not until January 26, 2010, that the City Council approved final regulations. The new ordinance set the number of dispensaries in the city at 70.[18] Dispensaries that registered and had been operating legally in the city since the ICO were grandfathered, meaning that the number of legal dispensaries could exceed 70 in the short run. However, all dispensaries were subject to new zoning rules, including a 1,000-foot buffer between dispensaries and between dispensaries and "sensitive use" sites, such as schools, parks, and libraries. The ordinance also established a set of operating conditions. Dispensaries were required to have web-based closed-circuit television security systems, maintain security recordings for a minimum of 90 days, and make those recordings available to the police on request. The ordinance prohibited on-site consumption of marijuana, dispensary operation between the hours of 8:00 p.m. and 10:00 a.m., the sale of alcoholic beverages, and the entry of persons under the age of 18 without proof of patient qualification and the presence of a parent, legal guardian, or licensed attending physician.

On June 7, 2010, dispensaries that were not operating legally were to cease operations. The city sent "courtesy notices" to the 439 dispensaries that were being ordered to shut their doors.[19] Early reports indicated that most dispensaries ordered to close did so; the City Attorney's Office estimated that 20 to 30 stores were

[13] See Bratton (2005).
[14] See Delgadillo (2006).
[15] See Los Angeles Police Department, Narcotics Division (2006).

[16] The first set of hardship applications requested exemptions because of delays beyond the dispensaries' control, such as receiving a city business tax registration certificate, which prevented them from meeting the November 13, 2007, registration deadline. Later applicants provided a much wider range of justifications, such as that they provided a community service or that they could not officially register in 2007 because of the fear imposed by federal authorities (Hoeffel, 2009a).
[17] See Council of the City of Los Angeles (2009).
[18] See Council of the City of Los Angeles (2010a).
[19] See Romero (2010a) for a sample letter.

Table 4
Timeline of Events Impacting Medical Marijuana Dispensaries in Los Angeles and Beyond

Date	Law/Event	Key Details
November 5, 1996	Proposition 215: The Compassionate Use Act of 1996	California voters approve medical use of marijuana by 56%. Law took effect on November 6, 1996.
September 11, 2003	Senate Bill 420: Medical Marijuana Program Act of 2003	Law took effect on January 1, 2004. Establishes a voluntary ID program for qualified patients and provides some legal cover for medical marijuana dispensaries by validating access through "cooperatives and collectives." Authorizes localities to adopt and enforce laws consistent with the act. Also set possession limits, but they were struck down at the Appeals Court and State Supreme Court levels in 2008 and 2010, respectively.
May 23, 2006	L.A. County Ordinance No. 2006-0032	Law took effect on June 22, 2006. Allows medical marijuana dispensaries to operate in Los Angeles County with a conditional use permit. Limits hours, establishes distance requirements and other rules as part of Title 22.56 of the county's planning and zoning code. The law was replaced in 2010 by a ban on dispensaries.
December 14, 2006	LAPD fact sheet released	Fact sheet details the explosion of medical marijuana dispensaries in the City of Los Angeles, shows statistics to support the view that the dispensaries increase crime, and recommends a moratorium on new dispensaries and detailed regulations for existing dispensaries
September 14, 2007	ICO: L.A. Ordinance 179027	Placed a temporary moratorium on the opening of new medical marijuana dispensaries in the City of Los Angeles. Allows for a hardship exemption.
November 13, 2007	ICO registration deadline	Deadline for dispensary registration under the ICO
August 25, 2008	Brown guidelines released	California State Attorney General Jerry Brown issues guidelines to clarify details of Senate Bill 420
March 18, 2009	Holder announcement	U.S. Attorney General Eric Holder outlines new federal policy on medical marijuana dispensary raids
June 24, 2009	ICO amended via L.A. Ordinance 180749	Eliminates hardship exemption
October 19, 2009	Ogden memo	U.S. Deputy Attorney General David Ogden issues a memo clarifying federal policy on "investigations and prosecutions" in states that allow medical marijuana
January 26, 2010	L.A. Ordinance 181069 to regulate medical marijuana collectives passes	Caps the number of dispensaries in the city at 70. Allows existing dispensaries in excess of 70 to remain operational provided that they comply with the ICO and abide by new requirements. Dispensaries must be geographically distributed across L.A. community plan areas in proportion to the population; must be at least 1,000 feet from "sensitive use" buildings, such as schools and parks; and must not be located on a lot "abutting, across the street or alley from, or having a common corner with a residentially zoned area."
March 14, 2010	L.A. Ordinance 181069 takes effect	Dispensaries that are legally operating have 180 days to meet zoning requirements.
June 7, 2010	L.A. Ordinance 181069, Chapter IV, Article 5.1, takes effect	As part of the ordinance, the city shuts down the more than 400 dispensaries that had not registered by November 13, 2007. Offenders face civil penalties of $2,500 per day and may receive up to six months in jail. The remaining dispensaries have 180 days to comply with the new zoning requirements, which, in many cases, means moving.
August 25, 2010	Villaraigosa memo	City states that 128 of the remaining 169 dispensaries must shut down because they had changes in management, which were precluded under the ICO. City allows these dispensaries to remain open until the courts can rule on the decision's legality.
November 23, 2010	Los Angeles County and Orange County approve bans	Both the Los Angeles County Board of Supervisors and the Orange County Board of Supervisors vote to ban dispensaries in unincorporated parts of their counties.
November 24, 2010	Koretz-Hahn and other amendments to L.A. Ordinance 181069	City Council adopts amendments that clarify and effectively loosen the "same ownership and management" requirements and extend the timeline for full compliance for "qualifying" dispensaries. Mayor has until December 6, 2010, to decide on the amendments.
December 10, 2010	Mohr injunction	Los Angeles County Superior Court Judge Anthony J. Mohr grants an injunction that bars the city from enforcing key aspects of L.A. Ordinance 181069, including closures based on the moratorium
January 25, 2011	L.A. Ordinance 181530 takes effect	Amends L.A. Ordinance 181069 to cap the number of dispensaries at 100 among those continuously operating since September 14, 2007. Allocates permits by lottery.

SOURCES: Brown (2008), California Senate Bill 420 (2003), Compassionate Use Act of 1996, Council of the City of Los Angeles (2007), Council of the City of Los Angeles (2009), Council of the City of Los Angeles (2010a), Council of the City of Los Angeles (2010b), Council of the City of Los Angeles (2011), Hoeffel (2010a), Hoeffel (2011b), Hoeffel (2010d), Hoeffel (2010e), Johnston and Lewis (2009), LACityClerk Connect (undated[b]), Lagmay (2010), Los Angeles County Department of Regional Planning (2009), Los Angeles Police Department, Narcotics Division (2006), and United States Department of Justice (2009).

still open illegally, and the LAPD conducted raids on at least four defiant stores (Rubin and Hoeffel, 2010).[20] Another 186 were deemed in compliance and could apply for permits to remain operational. Of these, 170 dispensaries notified the City Clerk of their intention to register, even though many would have to move to meet the new zoning requirements (Guerrero, 2010). Only 41 were in full compliance with the eligibility requirements of the new ordinance (Hoeffel, 2010c).[21]

Most of the other dispensaries failed to meet a requirement that they have the same ownership and management as identified in their ICO registration (Banks, 2010). The City Attorney's Office released the list of the dispensaries deemed eligible and ineligible but said that it would not close any dispensaries until the many legal challenges to the ordinance were resolved (Hoeffel, 2010c; Lagmay, 2010). Efforts were under way to abolish the continuous management requirement, which would have allowed a total of 180 dispensaries to remain in operation (Romero, 2010b). However, in January 2011, a Los Angeles County Superior Court judge issued an injunction barring the city from enforcing many aspects of the medical marijuana ordinance, including dispensary closures based on registration (or lack thereof) at the time of the moratorium (Hoeffel, 2010c). The judge suggested that alternative approaches, including allowing dispensaries to remain open if they could prove they were in operation on the date the moratorium took effect, would be permissible.

To that end, on January 22, 2011, the L.A. City Council amended its ordinance. It now caps the number of dispensaries at 100 among those that can demonstrate continuous operation since September 14, 2007 (Hoeffel, 2011b); 100 permits will be distributed by lottery. According to the City Clerk's Office, 228 dispensaries have applied to participate in the lottery (Hoeffel, 2011c). The date of the lottery has not yet been determined, as of August 2011. The city has begun notifying dispensaries that did not apply to participate in the lottery or cannot demonstrate continuous operation that they must shut down (Hoeffel, 2011c). However, the legality of the lottery is already being challenged (Hoeffel, 2011d).

Evaluating the Dispensary–Crime Connection

One of the principal reasons behind the city's effort (and similar efforts in other jurisdictions) to limit dispensaries is the presumed connection to crime. Residents neighboring dispensaries complain about crime and other quality of life concerns (Romero, 2010c). In Los Angeles, increased crime around dispensaries was explicitly cited as a reason that the City Council decided to restrict dispensaries.[22] Los Angeles County Sheriff Lee Baca has publically stated that dispensaries have been "hijacked" by criminals and have become crime targets (Winton, 2010). Countless media outlets have reported this claim.[23] But despite its plausibility, we know of no systematic evaluation of the claim that dispensaries themselves attract or cause crime.

To fill the gap in our knowledge, we use the first round of dispensary closures in the City of Los Angeles to assess the impact of dispensaries on crime. Figure 1 shows the geographic distribution of medical marijuana dispensaries by closure status. For each dispensary, we collected data on the number of crimes (overall and by type) reported per block in the City of Los Angeles and surrounding communities, such as Hollywood, Beverly Hills, and unincorporated areas of Los Angeles County. Data were extracted from CrimeReports (undated), an online software mapping tool that allows law enforcement agencies to spatially analyze their crime data and share these data with the public.

According to CrimeReports, its software is used by more than 700 law enforcement agencies across North America. During our study period, the LAPD subscribed to this service, allowing us to extract data on crimes by type, day, and city block. The LAPD no longer uses CrimeReports, possibly because it is launching its own mapping system.[24] During our time period, we compared the data from CrimeReports with those publically available through the LAPD's website. The data correspond very closely. However, the data provided by the LAPD are only available for four crime categories (versus 13 categories from CrimeReports) and are not available for jurisdictions that neighbor the City of Los Angeles.

Importantly, the CrimeReports data capture reported offenses or incidents rather than arrests. This distinction is important for several reasons. First, arrests typically undercount crime, since many incidents, even those in which an offender is apprehended, do not result in processed arrests. Second,

[20] Some stores simply removed their inventory, awaiting legal challenges. See Guerrero (2010) for details.

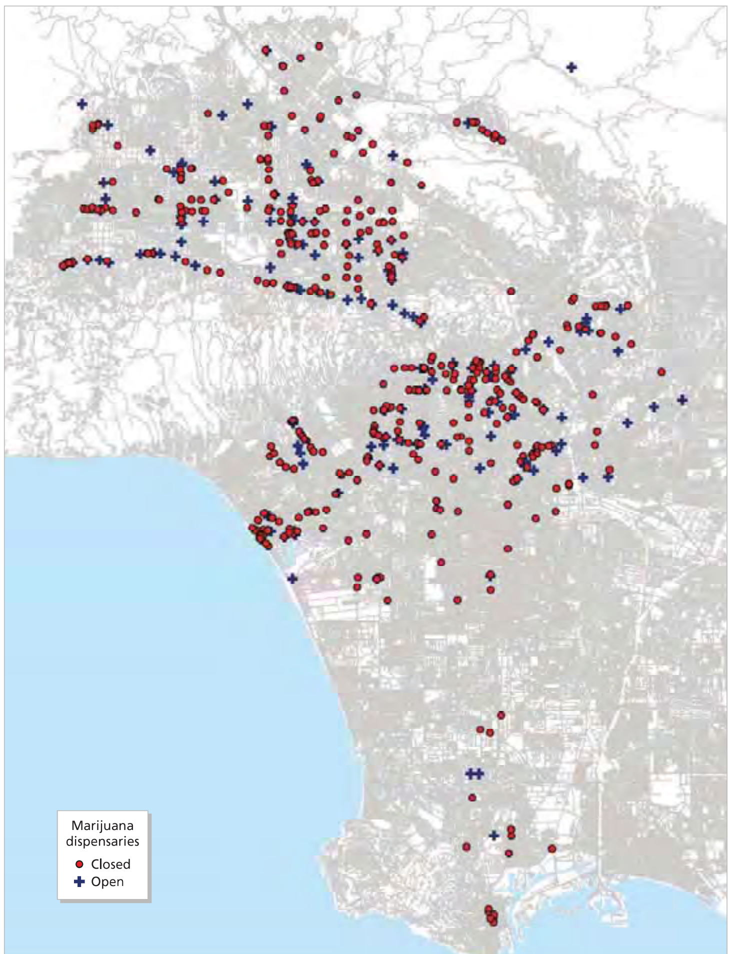
[21] See Los Angeles Municipal Code Section 45.19.6.2.B.2 for the full set of requirements (available at Council of the City of Los Angeles [2010a]).

[22] See the fifth paragraph of Ordinance 181069 (Council of the City of Los Angeles, 2010a).

[23] Examples abound. See Del Barco (2010), which asserts that "[s]ome of the city's marijuana dispensaries have become magnets for criminals wanting cash and pot, and even the site of murders, including a recent triple homicide."

[24] See Los Angeles Police Department (2011).

Figure 1
Geographic Distribution of Medical Marijuana Dispensaries in Los Angeles as of June 7, 2010



the potential lag between the commission of a crime and an arrest means that a long time horizon is required to link arrests back to the period around the closures. Third, arrest data typically do not contain precise-enough geographic information to link an incident to an exact city block.

For this preliminary analysis, we used crime data for the ten days prior to and ten days following the June 7, 2010, closures of dispensaries. We combined these data with information from the Los Angeles City Attorney's Office on the exact locations of dispensaries that were either subject to closure or allowed to remain open. We analyzed crime reports within 0.3, 0.6, 1.5, and 3 miles of dispensaries that closed relative to those that remained open.[25] In total, our dataset includes 21 days of crime reports for 600 dispensaries; 170 of these dispensaries were allowed to remain open, and 430 were ordered to close.

Table 5 presents basic summary statistics on our main outcomes: total daily crimes reported, as well as thefts, breaking and entering incidents, and assaults. We chose these categories of crimes because they are the most common. In Table A.1 we show the difference in pre-closure crime counts for dispensaries allowed to remain open relative to those ordered to close. In general, with a few exceptions, the differences are small and not statistically distinguishable

Table 5
Summary Statistics: Average Number of Crimes Surrounding Dispensaries per 100 Days

	Radius Around Dispensary			
Crime Type	0.3 Miles	0.6 Miles	1.5 Miles	3 Miles
Total crimes	2.2	7.0	43.5	133
Theft	1.3	3.9	21.9	62.2
Breaking and entering	0.4	1.2	7.5	20.8
Assault	0.2	0.9	6.9	23.7
Observations	12,600	12,600	12,600	12,600

NOTES: Data are from CrimeReports (undated) for May 28, 2010, through June 17, 2010. Data for these 21 days cover the areas surrounding 600 dispensaries, 430 that were subject to closure on June 7, 2010, and 170 that were allowed to remain open. A few (nine) dispensaries are not included because of a lack of coverage by CrimeReports. Theft includes general theft, theft from a vehicle, and theft of a vehicle. Assault includes assault with a deadly weapon. Other crime categories include homicide, robbery, sexual offense, "other," quality of life, and traffic.

from zero. This suggests that open dispensaries may serve as a reasonable control group for those ordered to close, although our empirical analysis will rely on comparability in crime trends rather than levels.

We estimated the effect of dispensaries on crime in a simple difference-in-differences framework, comparing changes in daily crime reports within the specified areas around dispensaries that closed relative to those that remained open. More specifically, we run an Ordinary Least Squares (OLS) regression of the following basic form (Equation 1):

$$Crime_{dt} = \alpha_d + \beta 1(date > june7) * 1(closed) + \delta_t + \varepsilon_{dt}, \quad (1)$$

where *Crime* is the number of crimes within a given radius of dispensary d on day t, α_d is a dispensary fixed effect, and δ_t are fixed effects for the exact date. We include an interaction between 1(*date* > *june 7*), an indicator for dates after the June 7, 2010, closures, and 1(*closed*), an indicator for dispensary closure status, as determined by city orders. The main post–June 7, 2010, and closure indicators are subsumed in the dispensary and date fixed effects. All standard errors allow for serial correlation of an arbitrary structure (i.e., they are clustered) at the dispensary level. Our main coefficient of interest is β, which captures the change in crime around dispensaries that closed relative to those that remained open.[26]

The identifying assumption in the difference-in-differences framework is that crime in the areas around dispensaries subject to closure is similar to that in the areas around dispensaries allowed to remain open. Because we are focusing on such a small time window around the city's closure deadline, this assumption may not be unreasonable. However, the narrow window comes with the drawback that we cannot make any claims about the long-term changes associated with dispensary closures.

Our primary results are presented in Table 6. The difference-in-differences estimates indicate that crime actually *increases* in the neighborhood (0.3 to 0.6 of a mile) around dispensaries that closed compared with those that remained open.[27] Specifically, we find that total crime increases by about 60 percent

[25] The radii calculations used here are not corrected for the curvature of the earth. Chang and Jacobson (2011) find very similar results when this correction is made.

[26] Since dispensaries tend to cluster (see Figure 1 and also Figure 2, which zooms into the neighborhood of Venice), a given radius may capture crime around both closed and open dispensaries. This is problematic for the empirical strategy only if the clustering is by closure status. Chang and Jacobson (2011) show that clustering is independent of closure status, meaning that the likelihood that a closed dispensary is near another closed dispensary is the same as the likelihood that an open dispensary is near a closed dispensary. In this case, clustering may reduce power and decrease the precision of our estimates. Assuming that the effect of closure clustering does not have multiplicative effects, it will generate a lower bound estimate of the true effect of closures on crime. This type of power issue should diminish with distance around the dispensary, since the contribution of any cluster to the radius will be reduced.

[27] Table 7 reports the results of Table 5 (including confidence intervals) in percentage terms.

Table 6
Average Increase in Daily Crime Reports Associated with Closures, with Confidence Intervals

	Radius Around Dispensary			
Crime Type	0.3 Miles	0.6 Miles	1.5 Miles	3 Miles
Total crimes	0.013 (0.006) 59% [5.4%, 114%]	0.017 (0.008) 24% [0.4%, 47%]	0.005 (0.020) 1.1% [–8%, 10%]	0.012 (0.034) 0.9% [–4.2%, 6%]
Theft	0.006 (0.006) 46% [–0.01%, 77%]	0.006 (0.006) 15% [–13%, 46%]	0.015 (0.016) 6.8% [–7.7%, 21%]	–0.017 (0.026) –2.7% [–10.7%, 5.4%]
Breaking and entering	0.006 (0.003) 150% [–5%, 275%]	0.007 (0.004) 58% [–5%, 125%]	–0.003 (0.009) –4% [–27%, 18.6%]	0.001 (0.013) 0.4% [–12%, 13%]
Assault	0.003 (0.002) 150% [–7.5%, 400%]	0.008 (0.003) 89% [13%, 166%]	0.004 (0.010) 5.8% [–22%, 34.7%]	0.0001 (0.019) 0.042% [–15%, 16%]
Observations	12,600	12,600	12,600	12,600

NOTES: Data are from CrimeReports (undated) for May 28, 2010, through June 17, 2010, for areas of the specified distance surrounding dispensaries. We have 21 days of data for 600 dispensaries; 430 were ordered to close, and 170 were allowed to remain open. Each cell represents a separate regression. The first entry in each cell is the coefficient on β from Equation 1 and represents the change in crimes post-closure. All regressions include date fixed effects and dispensary fixed effects. Standard errors are clustered at the dispensary level and given in parentheses. We also present the percentage change in crime that this estimate represents, relative to the mean crime count, and the 95-percent confidence intervals expressed as a percentage in brackets.

within 0.3 miles of a closure relative to 0.3 miles around an open dispensary.[28] The effect diminishes with distance: Within 0.6 miles the increase is about 25 percent, and by 1.5 miles out there is no perceptible change in crime. The effects are concentrated on crimes, such as assault and breaking and entering, that may be particularly sensitive to the presence of security. Incidents of breaking and entering increase by about 50 percent within four blocks, and assaults increase by about 90 percent after the dispensaries are closed. While these results are statistically significant and imply very large increases in crime, our confidence intervals are quite wide, so the estimated increase should be interpreted with some caution.[29]

We performed several sensitivity analyses and robustness checks (shown in the appendix). First, to test the sensitivity of our results to specifying crime in levels, we estimated models that analyze the log of crime plus 0.1; we add 0.1 because in small-enough areas or categories, there are no crimes, and thus the log is not defined. Results from this specification (in Table A.2) are qualitatively similar, though they suggest small percentage increases.[30] Second, because neighborhoods around dispensaries that remain open and those that close may differ even prior to the closures, we replicated our analysis on the sample of dispensaries from zip codes in which some dispensaries were allowed to remain open and others were subject to closure. Results from this "matched" sample (provided in Table A.3) are qualitatively similar, although they are slightly larger and more precisely estimated for both total crime counts and breaking and entering. Finally, we replicated our analysis on the main sample but recode as open those dispensaries that, according to reports from the *Los Angeles Times* and *LA Weekly*, remained open even though they were ordered to close.[31] Accounting for these defiant dispensaries yields results (provided in Table A.4) that are again qualitatively similar, although they are slightly larger and/or more precisely estimated for total crime counts, theft, and breaking and entering.

[28] The 60 percent figure is calculated by dividing the mean change in total crimes post-closure, 0.013, from Table 5 by the mean of 0.022 total daily crimes within 0.3 miles reported in Table 4.

[29] Although these effects seem large, work on the effects of drug enforcement on crime often finds very large effects. For example, Miron (1999) finds that a 1-percent increase in drug enforcement expenditures or projected expenditures is associated with increases in the homicide rate on the order of 25 to 50 percent, relative to the maximum value of the homicide rate in the sample (rather than the mean, as we use here).

[30] A preferred model for crime counts might be a Poisson or negative binomial regression. However, because of the sparseness of the data at small distances (e.g., 0.3 or 0.6 miles), these models often cannot be solved (i.e., they do not converge). Where they do converge, the percentage change in crime is quite similar to the implied effects from our main specification in Table 6.

[31] Defiant dispensaries were identified based on the following reports: Rubin and Hoeffel (2010) and Wei and Romero (2010).

We note that these findings are based on data collected around a relatively small window (ten days) before and after the closing of the dispensaries.

Discussion: Why Would Crime Decrease After Dispensary Closings?

In the previous section, we demonstrated that the closing of marijuana dispensaries in Los Angeles was associated with a rather immediate and sharp increase in total crime and in theft, breaking and entering, and assault. Given the conventional association between drug markets and crime, these findings are surprising. Here we offer a handful of possible explanations and suggestions for future research.

First, marijuana dispensaries in operation may have reduced crime by providing additional on-site security. California regulations require that dispensaries ensure adequate security. As a result of the value of marijuana and the cash necessary to run a dispensary, many dispensaries employ security services, in some cases around the clock. These security services may reduce crime in the immediate neighborhood, particularly such crimes as breaking and entering and robbery, which may respond more to formal and informal observation. Such an effect has been observed in studies of business improvement districts that pay for security services in neighborhoods in Los Angeles (Brooks, 2008; Cook and MacDonald, 2011). Future research might test this hypothesis by determining the extent of security that the various dispensaries employed to see if that had an effect on the reduction.

Second, operating marijuana dispensaries may reduce crime by increasing local foot traffic and "eyes on the street." Many of the marijuana dispensaries operated with extended hours. These extended hours may have brought more foot traffic to the neighborhood, which may, in turn, have deterred the "dark alley" crimes that were associated with a closing of the dispensaries. This may have interacted with the security explanation, if the dispensaries provided guards visible on the street to protect their customers. This hypothesis might be tested by comparing the effect of the dispensary closures with some other category of store closure—perhaps pharmacies, which have somewhat similar issues, or other retail operations. Such a comparison might test whether there is an effect specific to marijuana dispensaries or whether closing any retail establishment increases local crime. On the other hand, such comparisons are imperfect because closures in these cases might result from a declining neighborhood or bad economy—factors that would have an independent effect on crime. An alternative approach we are currently pursuing is to assess whether closure effects differ according to the population or retail density around a dispensary. If the increase in crime is due primarily to reduced traffic, then these effects should be larger in less-trafficked areas.

Third, the effect may be tied to the drug trade. Closing dispensaries does not eliminate the demand for marijuana. To the extent that illicit suppliers try to move in to fill the new void, this could generate other crime. Our data cover reported crimes and not arrests, and, since drug crimes are vastly underreported, we cannot observe a change in illicit drug sales in our data. However, this hypothesis may be testable with data on drug arrests or on the source of drug purchases.

Fourth, the effect may be explained by police presence. If police anticipated higher crime connected with marijuana dispensaries, they may have patrolled the areas around dispensaries more intensively, thereby reducing street crime. Once the dispensaries were closed, they may have reduced police presence, and crime may have returned to pre-dispensary levels. In this case, the real causal factor is the effect that dispensaries have on police practices, rather than any effect of the dispensaries per se. One could test this hypothesis by obtaining data about LAPD service allocation and arrest records to see if areas with dispensaries were targeted more intensively.

Fifth, the effect might be explained by some other police-related efforts in connection with the efforts to close the clinics. Perhaps the police stepped up local enforcement efforts in order to encourage dispensaries to close. Once the clinics closed, police went elsewhere and crime surged. To test this hypothesis, one could examine crime data during a larger window around the closing of the clinics. This would allow us to see if the estimated effect persists over a longer period. In ongoing work, we are extending the window around the closures to include several weeks before and after June 7, 2010.

Conclusion

The vast majority of Americans favor legalizing marijuana for medical purposes. Activists have harnessed this support to pass medical marijuana laws in 16 states and the District of Columbia, and more states are likely to follow.

Since the first medical marijuana law was passed by California in 1996, states have focused increasingly on how to regulate the supply side of this market. These efforts respond in part to thriving retail medical marijuana dispensaries in such cities as Los

Figure 2
Geographic Distribution of Medical Marijuana Dispensaries in Venice, California, as of June 7, 2010

Angeles and the presumed crime and quality of life problems they bring with them.

However, state efforts to regulate and, in some cases, institutionalize medical marijuana manufacturing and distribution have met with warnings from DOJ. Many have scaled back their efforts or abandoned their efforts altogether.

This recent turn of events suggests that local approaches to regulating marijuana may proliferate nationwide, as they do in California. Localities will consider whether to ban dispensaries and, if not, whether and how to control their numbers. This project provides some empirical evidence to guide policymakers by presenting a case study of the City of Los Angeles and its effort to control the distribution of medical marijuana.

As part of the case study, we use Los Angeles's experience ordering the close of hundreds of dispensaries to test the commonly held belief that medical marijuana dispensaries increase local crime. Contrary to conventional wisdom, press accounts, and some statements by law enforcement, our analysis suggests that the closing of the medical marijuana dispensaries is associated with an increase—rather than the expected decrease—in local crime in a short-term ten-day period. Overall crime increased almost 60 percent in the blocks surrounding closed clinics in the ten days following their closing. We offer a variety of plausible hypotheses to explain this finding. Further research is necessary to determine whether the effect is truly the result of marijuana dispensaries preventing crime in the local neighborhood. Although the current study cannot offer a definitive answer as to why crime increased around closed dispensaries, it should give jurisdictions reason to question the commonly held view that dispensaries attract and even cause crime in their neighborhoods. ■

Appendix

Table A.1
Pre-Closure Difference in Crime Counts Around Dispensaries Allowed to Remain Open and Ordered to Close

	Radius Around Dispensary			
Ln(Crime Type)	**0.3 Miles**	**0.6 Miles**	**1.5 Miles**	**3 Miles**
Total crimes	0.004 (0.005) [0.026]	−0.005 (0.011) [0.068]	−0.088 (0.032) [0.371]	−0.017 (0.074) [1.35]
Theft	0.001 (0.004) [0.013]	0.001 (0.008) [0.042]	0.021 (0.017) [0.198]	0.035 (0.032) [0.648]
Breaking and entering	0.004 (0.002) [0.08]	0.0001 (0.003) [0.013]	−0.016 (0.008) [0.065]	−0.005 (0.016) [0.220]
Assault	0.0016 (0.0014) [0.004]	−0.002 (0.003) [0.008]	0.016 (0.009) [0.056]	0.021 (0.018) [0.253]
Observations	6,600	6,600	6,600	6,600

NOTES: Data are from CrimeReports (undated) for May 28, 2010, through June 6, 2010, for areas of the specified distance surrounding dispensaries. Each cell represents a separate regression. The first number in each cell is the mean difference for open dispensaries minus closed dispensaries. The standard error on the difference is in parentheses. The mean crime count for dispensaries allowed to remain open is given in brackets.

Table A.2
Sensitivity Analysis: Log Crime Specification and Average Percentage Increase in Daily Crime Reports Associated with Closures

	Radius Around Dispensary			
Ln(Crime Type)	**0.3 Miles**	**0.6 Miles**	**1.5 Miles**	**3 Miles**
Total crimes	2.14 (1.12) [−0.075, 4.35]	2.51 (1.46) [−0.36, 5.39]	1.16 (2.64) [−4.03, 6.35]	0.25 (2.97) [−6.09, 5.58]
Theft	0.32 (0.61) [−0.87, 1.51]	0.41 (0.99) [−1.54, 2.36]	0.49 (2.13) [−3.70, 4.68]	−1.12 (2.60) [−6.23, 3.98]
Breaking and entering	1.19 (0.60) [0.01, 2.36]	1.50 (0.82) [−0.11,0.31]	−0.36 (1.56) [−3.42, 2.71]	3.73 (2.29) [−0.78, 8.24]
Assault	0.82 (0.58) [−0.33, 1.96]	1.11 (0.69) [−0.23, 2.45]	−0.29 (1.50) [−3.23, 2.65]	1.83 (2.23) [−2.56, 6.21]
Observations	12,600	12,600	12,600	12,600

NOTES: Data are from CrimeReports (undated) for May 28, 2010, through June 17, 2010, for areas of the specified distance surrounding dispensaries. Each cell represents a separate regression. The first entry in each cell is the coefficient on β from Equation 1 with log(*crime* + 0.1) as the dependent variable and represents the change in crimes post-closure. All regressions include date fixed effects and dispensary fixed effects. Standard errors are clustered at the dispensary level and given in parentheses; 95-percent confidence intervals are given in brackets.

Table A.3
Sensitivity Analysis of the Average Increase in Daily Crime Associated with Closures: Restricting to Areas with Both Open and Closed Dispensaries

	Radius Around Dispensary			
Crime Type	**0.3 Miles**	**0.6 Miles**	**1.5 Miles**	**3 Miles**
Total crimes	0.015 (0.006) [0.0029, 0.028]	0.020 (0.009) [0.003, 0.037]	0.014 (0.019) [−0.024, 0.052]	0.016 (0.030) [−0.044, 0.076]
Theft	0.005 (0.004) [−0.002, 0.011]	0.009 (0.006) [−0.003, 0.021]	0.014 (0.016) [−0.019, 0.046]	−0.016 (0.026) [−0.067, 0.035]
Breaking and entering	0.007 (0.003) [0.0007, 0.013]	0.011 (0.004) [0.003, 0.019]	0.007 (0.008) [−0.009, 0.024]	0.020 (0.013) [−0.0047, 0.045]
Assault	0.004 (0.003) [−0.0012, 0.0089]	0.003 (0.003) [−0.002, 0.009]	0.011 (0.009) [−0.008, 0.029]	0.005 (0.019) [−0.033, 0.042]
Ln(Total crimes)	2.56 (1.15) [0.30, 4.82]	3.06 (1.45) [0.20, 5.91]	3.27 (2.45) [−1.16, 8.61]	1.98 (3.06) [−4.03, 7.99]
Ln(Theft)	0.32 (0.61) [−0.87, 1.52]	0.98 (1.01) [−1.00, 2.96]	1.00 (1.90) [−2.73, 4.73]	−0.86 (2.63) [−6.01, 4.29]
Ln(Breaking and entering)	1.47 (0.63) [0.22, 2.71]	2.29 (0.85) [0.62, 3.96]	0.85 (1.48) [2.05, 3.75]	5.06 (2.16) [0.82, 9.31]
Ln(Assault)	0.92 (0.62) [−0.30, 2.13]	0.84 (0.68) [−0.50, 2.17]	1.11 (1.44) [−1.71, 3.94]	2.35 (2.20) [−1.96, 6.66]
Observations	11,046	11,046	11,046	11,046

NOTES: Sample is restricted to 526 dispensaries located in zip codes that have both dispensaries that were subject to closure and dispensaries that were allowed to remain open. Data are from CrimeReports (undated) for May 28, 2010, through June 17, 2010, for areas of the specified distance surrounding dispensaries. Each cell represents a separate regression. The first entry in each cell is the coefficient on β from Equation 1 and represents the change in crimes post-closure. All regressions include date fixed effects and dispensary fixed effects. Standard errors are clustered at the dispensary level and given in parentheses. Confidence intervals at the 95-percent level for the estimate are provided in brackets.

Table A.4
The Average Increase in Daily Crime Reports Associated with Closures: Coding Known Defiant Dispensaries as Open

Crime Type	Radius Around Dispensary			
	0.3 Miles	0.6 Miles	1.5 Miles	3 Miles
Total crimes	0.014 (0.006) [0.002, 0.025]	0.021 (0.008) [0.005, 0.038]	–0.001 (0.020) [–0.040, 0.038]	0.025 (0.033) [–0.040, 0.090]
Theft	0.006 (0.003) [–0.001, 0.013]	0.010 (0.006) [–0.002, 0.022]	0.016 (0.016) [–0.015, 0.047]	–0.006 (0.026) [–0.056, 0.043]
Breaking and entering	0.005 (0.003) [–0.0003, 0.011]	0.008 (0.004) [0.001, 0.016]	–0.004 (0.009) [–0.021, 0.012]	0.002 (0.013) [–0.023, 0.028]
Assault	0.003 (0.002) [–0.0015, 0.008]	0.008 (0.003) [0.0011, 0.014]	0.001 (0.010) [–0.018, 0.020]	0.004 (0.019) [–0.033, 0.042]
Observations	12,600	12,600	12,600	12,600

NOTES: Data are from CrimeReports (undated) for May 28, 2010, through June 17, 2010, for areas of the specified distance surrounding dispensaries. Each cell represents a separate regression. Four defiant dispensaries were identified from the *Los Angeles Times* report on LAPD raids and another four from an *LA Weekly* report—see Rubin and Hoeffel (2010) and Romero and Wei (2010). The first entry in each cell is the coefficient on β from Equation 1 and represents the change in crimes post-closure. All regressions include date fixed effects and dispensary fixed effects. Standard errors are clustered at the dispensary level and given in parentheses; 95-percent confidence intervals are given in brackets.

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About This Report

This report presents an overview of the medical marijuana landscape nationwide along with preliminary findings on the relationship between closing medical marijuana dispensaries and local crime. The empirical analysis represents a portion of ongoing work by Mireille Jacobson and Tom Chang to more thoroughly understand the relationship between medical marijuana dispensaries and crime. It is also related to a larger project by the authors to understand the relationship between land-use law, the built environment, crime, and public health, funded by the Robert Wood Johnson Foundation's Public Health Law Research program. The report should be of particular interest to agencies and policymakers who are charged with regulating medical marijuana and to those who are interested in the relationship between medical marijuana and crime.

The RAND Safety and Justice Program

This research was conducted in the Safety and Justice Program within RAND Infrastructure, Safety, and Environment (ISE). The mission of RAND Infrastructure, Safety, and Environment is to improve the development, operation, use, and protection of society's essential physical assets and natural resources and to enhance the related social assets of safety and security of individuals in transit and in their workplaces and communities. Safety and Justice Program research addresses all aspects of public safety and the criminal justice system—including violence, policing, corrections, courts and criminal law, substance abuse, occupational safety, and public integrity.

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SERIOUSLY ILL AND DISABLE PATIENTS: CULTIVATING MEDICINAL CANNABIS

1. Use of Medical Marijuana.

Marijuana was first used as a medicine in China nearly 5000 years ago. Recommended for malaria, constipation, rheumatic pains, and as a surgical analgesic[1], subsequent records show it was later used throughout Asia, the Middle East, Southern Africa and South America.

In the 19th century, marijuana became a mainstream medicine in England[2]. An Irish scientist and physician, William O'Shaughnessy, observed its use as an analgesic, anticonvulsant, antispasmodic, and antiemetic. After toxicity experiments conducted on dogs and goats, O'Shaughnessy began providing medical marijuana to patients and was impressed with its anticonvulsant and analgesic properties[3]. After O'Shaughnessy's observations were published in 1842, medicinal use of marijuana expanded rapidly. In the United States a variety of marijuana-containing remedies were developed.

2. Federal Policy on Marijuana After 1937.

In the 1930s, Harry J. Anslinger, the head of the Federal Bureau of Narcotics (FBN), reported an increase in the number of people smoking marijuana[4]. Between 1935 and 1937, Anslinger advocated for passage of the *Uniform State Narcotic Act* and *Marihuana Tax Act*. Although the marijuana tax proposal as opposed by the *American Medical Association*[5], it was eventually enacted by Congress on August 2, 1937 (P.L. 75-238, 75th Congress, 50 Stat. 551, repealed 1971).

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[4] *The Murderers, the Story of the Narcotic Gangs*, Anslinger, H., U. S. Commissioner of Narcotics, and Oursler, W. (1961), pp. 541-554.

[5] *Statement of Dr. William C. Woodward*, Hearing before the Committee on Ways and Means, U.S. House of Representatives, May 4, 1937.

EXHIBIT "14"

The *Marihuana Tax Act* effectively proscribed medical use of marijuana in the United States until California voters approved Proposition 215, the state's *Compassionate Use Act* ("*CUA*"), in 1996. In the 15-year period since California implemented its *CUA*, fifteen (15) additional states and the District of Columbia have enacted medical marijuana laws[6].

3. The Compassionate Use Act and Medical Marijuana Program Act.

The 1996 voter-passed *Compassionate Use Act* is a plain-language law that decriminalizes medical marijuana use, possession, and cultivation for patients in medical need with doctor recommendations. At the time it was enacted, the law did not include *specific* provisions for distribution to patients but rather included the general "right to obtain" for **all** seriously ill Californians with doctor recommendations. It did, however, ask that a distribution system be setup under its general provisions and so, in 2003, the Legislature, acting in-part to address the need for distribution expressed by the voters, established the *Medical Marijuana Program Act* ("*MMPA*"). The *MMPA* decriminalized storage, land use, distribution, and transportation related to medical marijuana through a collective and cooperative distribution system. Understanding the issue with the general prohibition against marijuana expressed in federal law, the Legislature designated that the state's Attorney General promulgate guidelines related to the collective and cooperative distribution, transportation, and provision system it had established under the *CUA*. The *MMPA* also included sections related to an identification card program, law enforcement, and threshold quantity limitations.

[6] States and districts with medical marijuana laws, enacting legislation, and effective year: *Alaska* (Ballot Meas. 8, 1998); *Arizona* (Prop. 203, 2010); *California* (Prop. 215, 1996); *Colorado* (Ballot Amd. 20, 2000); *District of Columbia* (Initiative 59; Amd. Act. B18-622, 2010); *Delaware* (SB 17, 2011); *Hawaii* (SB 862, 2000); *Maine* (Ballot Quest. 2, 1999); *Michigan* (Prop. 1, 2008); *Montana* (Initiative 148, 2004); *Nevada* (Ballot Quest. 9, 2000); *New Jersey* (SB 119, 2010); *New Mexico* (SB 523, 2007); *Oregon* (Ballot Meas. 67, 1998); *Rhode Island* (SB 0710, 2006); *Vermont* (SB 76, 2004); and *Wa. State* (Init. 692, 1998).

4. Modern Medical Marijuana Use.

In March, 2011, the *National Cancer Institute's* PDQ®[7] (*Physician Data Query*) information system for physicians and health professionals reported that potential benefits of medical marijuana for people with cancer include, "antiemetic effects, appetite stimulation, pain relief, and improved sleep. In the practice of integrative oncology, the health care provider may recommend medicinal Marijuana not only for symptom management but also for its possible direct antitumor effect[8]."

In the late 1990s, the director of the *White House Office of National Drug Control Policy* ("*ONDCP*") asked the *National Institutes of Science* to review the evidence for the potential benefits and risks associated with the use of medical marijuana. The *Institute of Medicine* ("*IOM*"), a non-governmental, apolitical, non-profit part of the *National Institutes*, was charged with carrying out the research and study. Completed in March, 1999, the institute's medical marijuana project was coordinated by Janet E. Joy who, along with doctors and scientists who participated in the report, co-authored a book detailing the marijuana study:

"People who use marijuana solely as a medication do so in order to relieve specific symptoms of AIDS, cancer, multiple sclerosis, and other debilitating conditions. Some do so under the advice or consent of doctors after conventional treatments have failed to help them … Surveys of marijuana buyers' clubs indicate that most of their members do, in fact, have serious medical conditions[9]."

5. Trying to grow medication when seriously ill.

The effectiveness of medical marijuana for a particular illness, disability, or condition depends on the strain used. There are approximately 2,800 strains available

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[7] *National Cancer Institute (National Institutes of Health)* Website, Mar. 25, 2011, <http:www.cancer.gov/
cancertopics/pdq/cam/cannabis/healthprofessional/page2>.

[8] *See Physician Data Query (PDQ®) Webpage, Cannabis and Cannabinoids*, (URL in fn. 10), Mar. 25, 2011.

[9] *Marijuana as Medicine?: The Science Beyond the Controversy*, Mack, A. and Joy, J. (2000). Nat. Inst. of Science, p. 10. D.C.: Nat. Academies Press.

today[10]. According to *Yahoo! Answers*[11], it takes between two (2) and six (6) months to cultivate marijuana depending on the "strain."

The *Compassionate Use Act*[12] only protects medical marijuana patients with valid doctor recommendations from state criminal liability for medical marijuana use, possession, and personal cultivation. It does **not** provide protection from state law prohibiting distribution of marijuana.

6. Deciphering the Medical Marijuana Program Act.

When they passed the *CUA* in 1996, California voters asked the state and federal governments to "implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana." Ca. H&S § 11362.5(B)(1)(c). Accordingly, as noted above, the state's *Medical Marijuana Program Act* ("*MMPA*") was established in 2004 in part to address the issue of medication availability for seriously ill and disabled patients who may be unable to cultivate on their own. The *MMPA* was also enacted to ensure that patients with cancer, AIDS, mental illness, serious disabilities, and other recognized medical conditions "who obtain and use marijuana for medical purposes upon the recommendation of a physician are **not subject to criminal prosecution or sanction**." Ca. H&S Code §§ 11362.5(B)(1)(a) and 11362.5 (B)(1)(b) (*emphasis added*).

Exceptions from state prohibitions for patients who "associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes" are provided through Ca. H&S Code § 11362.775, part of the *MMPA*[13]. The *MMPA* includes a **specific** exemption to the "*Drug Den*" provision included at section 11570 of the Health and Safety Code.

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[10] *Budtenders Help Medical Marijuana Patients Choose Strains that Fit Their Needs*, Sutter, C. (Mar. 1, 2010). Boulder, CO: Daily Camera.
[11] *Yahoo! Answers*, 9/17/2011,<http://answers.yahoo.com/question/index?qid=20080718113848AALwUJs>.
[12] Ca. Health and Safety Code § 11362.5.
[13] Ca. H&S Code § 11362.7, *et seq*.

Deprivation of medication to seriously ill, terminally ill and disabled individuals constitutes irreparable harm.

The inability to obtain necessary medical care clearly causes the type of irreparable harm that preliminary injunctions are designed to prevent. *Caldwell v. Blum*, (2nd Cir. 1981) 621 F. 2d 491 at 498-499 (finding irreparable injury where plaintiffs were "exposed to the hardship of being denied essential medical benefits"), *cert. denied*, (1981) 452 U.S. 909; *Massachusetts Ass'n of Older Americans v. Sharp*, (1st Cir. 1983) 700 F.2d 749, 753 ("[t]ermination of benefits that causes individuals to forgo ... medical care is clearly irreparable injury"); *Becker v. Toia*, (S.D.N.Y. 1977) 439 F. Supp. 324, 336 (holding that imposing co-payments on Medicaid recipients may cause them to forgo medical treatment and that is irreparable harm); *Bass v. Richardson*, (S.D.N.Y. 1971) 338 F. Supp. 478, 488 (finding the injury to Medicaid recipients of losing coverage for prescription drugs "is not merely irreparable; it is ultimate").

EXHIBIT "15"

Health and Safety Code § 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.**

Health and Safety Code § 11362.775.

Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients and persons with identification cards, who associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions under Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570.

EXHIBIT "16"

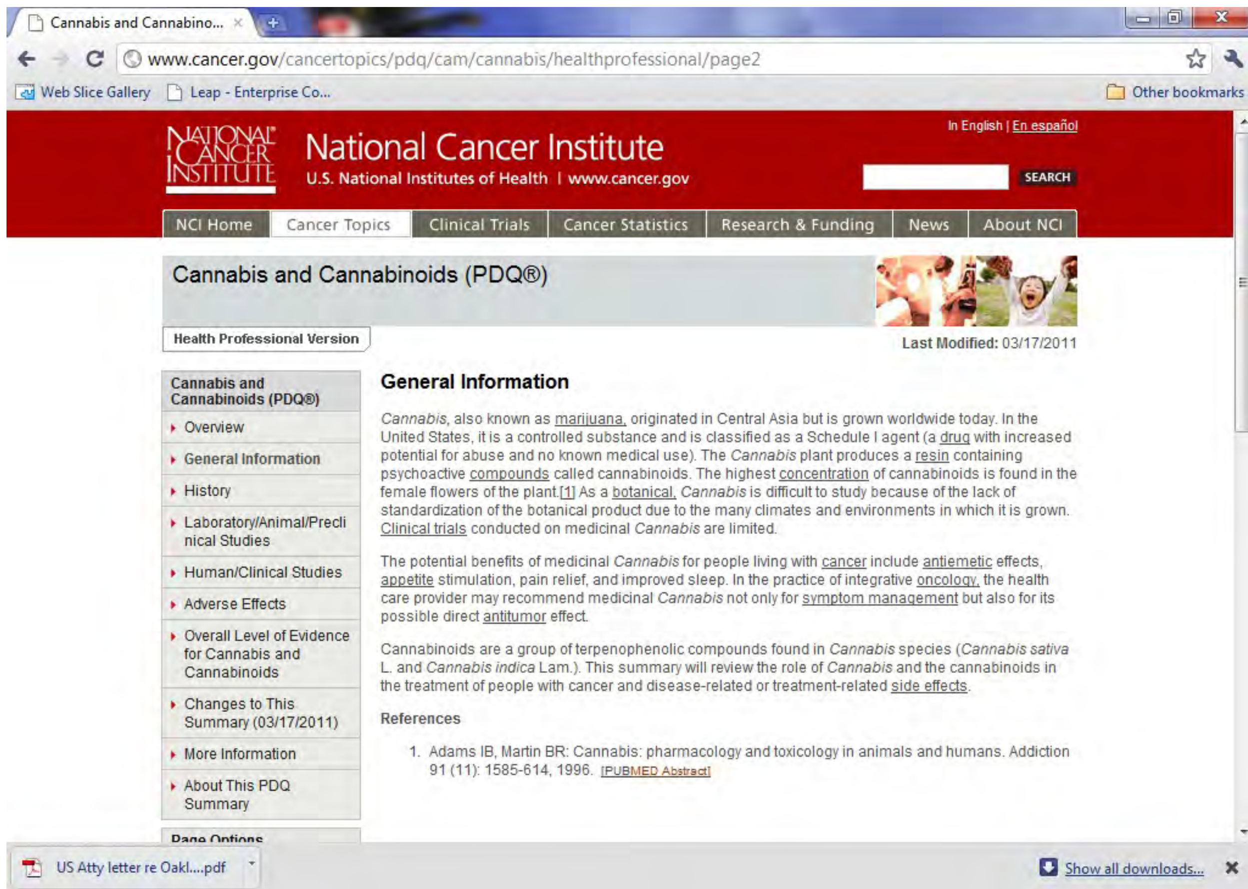

EXHIBIT "17"

THE DENVER POST

Sheriffs Lie About Medical Marijuana

Nov. 2010 - Denver, CO: You'd think the world's most active force against marijuana might actually know a little bit about it, but no, the cops are as clueless as always and continue to publish distorted facts as truth and try to link medical marijuana to the "Mexican Drug Cartel."

According to law enforcement, medical marijuana in Colorado has grown so fast in the past few months that it has outstripped the production of legal "grow" operations. Local sheriffs and agents from the U.S. Drug Enforcement Administration speculate some marijuana may be coming from illegal drug cartels. If it is, patients are not using it.

Fact: Medicinal grade marijuana is not grown in large outdoor plots of land like crappy dirt weed the Mexican cartels send to America. It is grown for the most part using highly sophisticated indoor hydroponic systems by American patient growers or caregivers. Here or in California, a medical marijuana patient would take a puff of Mexican dirt weed or "swag" and cough endlessly until they got a headache. Patients would not use this "swag" because it is not medical grade cannabis and will, in almost all cases, have the opposite impact.

Mexican Cartel Swag "weed" leads to choking and causes headaches. On the other hand, using a vaporizer with medical grade cannabis grown in California will set migraines at ease and stop nausea. The opposite happens when a patient uses illegal Mexican "weed" or cartel swag. Any medical marijuana patient can vouch for this, no matter what statistics the police contrive. The statistics are meant to garner dollars for law enforcement notwithstanding the impact on seriously ill patients.

No Colorado dispensary would buy Mexican Swag Weed grown without fertilizers, likely outdoors, improperly cured, and risking the exposure of patients to impurities and possibly dangerous additives. Personally, I know plenty of people who work in and are part of legal medical marijuana dispensaries in California and can state with 100% certainty they will not and do not buy swag weed grown illegally. It is not potent enough, is usually covered in disgusting chemicals/pesticides and is never cured properly or taken care of. In fact, any dispensary known to sell that type of illegal marijuana would be SHUNNED BY THE MEDICAL MARIJUANA PATIENTS.

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Curing is a major part of marijuana potency and guess what, Mexican Drug Cartels sell “weed” (not medical cannabis) that gives you a headache because it is never cured properly.

Police simply want federal money to fight marijuana whether it is used by seriously ill patients or sold by dangerous drug cartels. To do so, they need to keep marijuana a “bad drug.” I have dealt with many patients with cancer and other ailments yet the police treat medical marijuana as if it is the same as illegal cartel “swag.” Dispensaries would simply go out of business if they even suggested the low-quality cartel “weed” to patients.

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From the Cabinet or the Street?

How is Medical Marijuana Different from the Street Drug

Marijuana smoking has been used historically in many cultures for medical purposes. Canada was the first country to create a system for regulating the use of medical marijuana in 2001, and it is currently available for a variety of different health reasons. Smoking medical marijuana is generally thought to help relieve nausea and vomiting, and is helpful in assisting people to regain their appetite. This is most helpful for individuals suffering from AIDS/HIV and cancer. It is also thought that medical marijuana may help to reduce pain and muscle spasms.

Medical marijuana is available in several different forms. It can be smoked as marijuana cigarettes or it can be ingested in a pill form. The pill form is known as dronabinol or nabilone. It is a synthetic version of the chemical THC, which is the main chemical in cannabis or marijuana. Choosing the pill form offers an individual the opportunity to use marijuana without the health risks that come with smoking.

Health Canada has identified specific criteria for individuals who are eligible to apply for possession of medical marijuana. Individuals allowed to apply for medical marijuana are people being treated for symptoms within the context of providing end-of-life care. Individuals with severe pain and muscle spasms associated with multiple sclerosis and spinal cord injury or disease are eligible to apply for medical marijuana. In addition, people suffering from severe pain, anorexia, weight loss and nausea from cancer or HIV/AIDS, seizures from epilepsy or severe pain from arthritis are all eligible to apply for possession of medical marijuana. Individuals with any other medical conditions must be able to prove that other treatments have not worked and that those treatments failed to relieve their symptoms.

Marijuana that is used legitimately for medical purposes differs greatly from that which someone might buy on the street. One major difference between the two is where the actual drug comes from. When someone legally purchases medical marijuana, they can be assured that the quality of the marijuana is consistent, because it is coming from a company in which the production is standardized and the quality is controlled by Health Canada. When someone buys marijuana illegally on the street, they do not know where it originated, or if the quality is consistent from one batch to the next. As well, when buying marijuana on the street, there is a risk that it could be laced with other drugs such as PCP, or even cut with other products such as herbs or vegetation.

Another difference between medical marijuana and street marijuana is the outcome that the user is pursuing. People using marijuana for its medical purpose are generally not after achieving the drug's psychoactive effects. People using it for a medical purpose are trying to modify particular symptoms and generally use marijuana that is milder than recreational users. In contrast, recreational users take the drug to achieve an altered state of consciousness and perception, and generally use marijuana that is stronger and more potent.

Although medical marijuana is available for eligible, seriously ill people, it is still an illegal substance and has negative side-effects just like the marijuana available on the street. However, in the case of some terminally ill patients, the short-term benefits may outweigh the long-term effects. Research is still being conducted to provide information about whether medical marijuana is effective and appropriate in relieving symptoms of cancer and other health conditions. As well, research is still being conducted which form is the most effective way to prescribe marijuana to achieve the desired effects.

EDMUND G. BROWN JR.
Attorney General

DEPARTMENT OF JUSTICE
State of California

GUIDELINES FOR THE SECURITY AND NON-DIVERSION OF MARIJUANA GROWN FOR MEDICAL USE

August 2008

In 1996, California voters approved an initiative that exempted certain patients and their primary caregivers from criminal liability under state law for the possession and cultivation of marijuana. In 2003, the Legislature enacted additional legislation relating to medical marijuana. One of those statutes requires the Attorney General to adopt "guidelines to ensure the security and nondiversion of marijuana grown for medical use." (Health & Saf. Code, § 11362.81(d).[1]) To fulfill this mandate, this Office is issuing the following guidelines to (1) ensure that marijuana grown for medical purposes remains secure and does not find its way to non-patients or illicit markets, (2) help law enforcement agencies perform their duties effectively and in accordance with California law, and (3) help patients and primary caregivers understand how they may cultivate, transport, possess, and use medical marijuana under California law.

I. SUMMARY OF APPLICABLE LAW

A. California Penal Provisions Relating to Marijuana.

The possession, sale, cultivation, or transportation of marijuana is ordinarily a crime under California law. (See, e.g., § 11357 [possession of marijuana is a misdemeanor]; § 11358 [cultivation of marijuana is a felony]; Veh. Code, § 23222 [possession of less than 1 oz. of marijuana while driving is a misdemeanor]; § 11359 [possession with intent to sell any amount of marijuana is a felony]; § 11360 [transporting, selling, or giving away marijuana in California is a felony; under 28.5 grams is a misdemeanor]; § 11361 [selling or distributing marijuana to minors, or using a minor to transport, sell, or give away marijuana, is a felony].)

B. Proposition 215 - The Compassionate Use Act of 1996.

On November 5, 1996, California voters passed Proposition 215, which decriminalized the cultivation and use of marijuana by seriously ill individuals upon a physician's recommendation. (§ 11362.5.) Proposition 215 was enacted 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," and to "ensure that patients and their primary caregivers who obtain and use marijuana for

[1] Unless otherwise noted, all statutory references are to the Health & Safety Code.

EXHIBIT "19"

IV. GUIDELINES REGARDING COLLECTIVES AND COOPERATIVES

Under California law, medical marijuana patients and primary caregivers may "associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes." (§ 11362.775.) The following guidelines are meant to apply to qualified patients and primary caregivers who come together to collectively or cooperatively cultivate physician-recommended marijuana.

A. Business Forms: Any group that is collectively or cooperatively cultivating and distributing marijuana for medical purposes should be organized and operated in a manner that ensures the security of the crop and safeguards against diversion for non-medical purposes. The following are guidelines to help cooperatives and collectives operate within the law, and to help law enforcement determine whether they are doing so.

1. **Statutory Cooperatives:** A cooperative must file articles of incorporation with the state and conduct its business for the mutual benefit of its members. (Corp. Code, § 12201, 12300.) No business may call itself a "cooperative" (or "co-op") unless it is properly organized and registered as such a corporation under the Corporations or Food and Agricultural Code. (*Id.* at § 12311(b).) Cooperative corporations are "democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons." (*Id.* at § 12201.) The earnings and savings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash, property, credits, or services. (*Ibid.*) Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year. (See *id.* at § 12200, et seq.) Agricultural cooperatives are likewise nonprofit corporate entities "since they are not organized to make profit for themselves, as such, or for their members, as such, but only for their members as producers." (Food & Agric. Code, § 54033.) Agricultural cooperatives share many characteristics with consumer cooperatives. (See, e.g., *id.* at § 54002, et seq.) Cooperatives should not purchase marijuana from, or sell to, non-members; instead, they should only provide a means for facilitating or coordinating transactions between members.

2. **Collectives:** California law does not define collectives, but the dictionary defines them as "a business, farm, etc., jointly owned and operated by the members of a group." (*Random House Unabridged Dictionary*; Random House, Inc. © 2006.) Applying this definition, a collective should be an organization that merely facilitates the collaborative efforts of patient and caregiver members – including the allocation of costs and revenues. As such, a collective is not a statutory entity, but as a practical matter it might have to organize as some form of business to carry out its activities. The collective should not purchase marijuana from, or sell to, non-members; instead, it should only provide a means for facilitating or coordinating transactions between members.

B. **Guidelines for the Lawful Operation of a Cooperative or Collective:** Collectives and cooperatives should be organized with sufficient structure to ensure security, non-diversion of marijuana to illicit markets, and compliance with all state and local laws. The following are some suggested guidelines and practices for operating collective growing operations to help ensure lawful operation.

1. **Non-Profit Operation**: Nothing in Proposition 215 or the MMP authorizes collectives, cooperatives, or individuals to profit from the sale or distribution of marijuana. (See, e.g., § 11362.765(a) ["nothing in this section shall authorize . . . any individual or group to cultivate or distribute marijuana for profit"].

2. **Business Licenses, Sales Tax, and Seller's Permits**: The State Board of Equalization has determined that medical marijuana transactions are subject to sales tax, regardless of whether the individual or group makes a profit, and those engaging in transactions involving medical marijuana must obtain a Seller's Permit. Some cities and counties also require dispensing collectives and cooperatives to obtain business licenses.

3. **Membership Application and Verification**: When a patient or primary caregiver wishes to join a collective or cooperative, the group can help prevent the diversion of marijuana for non-medical use by having potential members complete a written membership application. The following application guidelines should be followed to help ensure that marijuana grown for medical use is not diverted to illicit markets:

a) Verify the individual's status as a qualified patient or primary caregiver. Unless he or she has a valid state medical marijuana identification card, this should involve personal contact with the recommending physician (or his or her agent), verification of the physician's identity, as well as his or her state licensing status. Verification of primary caregiver status should include contact with the qualified patient, as well as validation of the patient's recommendation. Copies should be made of the physician's recommendation or identification card, if any;

b) Have the individual agree not to distribute marijuana to non-members;

c) Have the individual agree not to use the marijuana for other than medical purposes;

d) Maintain membership records on-site or have them reasonably available;

e) Track when members' medical marijuana recommendation and/or identification cards expire; and

f) Enforce conditions of membership by excluding members whose identification card or physician recommendation are invalid or have expired, or who are caught diverting marijuana for non-medical use.

4. **Collectives Should Acquire, Possess, and Distribute Only Lawfully Cultivated Marijuana**: Collectives and cooperatives should acquire marijuana only from their constituent members, because only marijuana grown by a qualified patient or his or her primary caregiver may lawfully be transported by, or distributed to, other members of a collective or cooperative. (§§ 11362.765, 11362.775.) The collective or cooperative may then allocate it to other members of the group. Nothing allows marijuana to be purchased from outside the collective or cooperative for distribution to its members. Instead, the cycle should be a closed-circuit of marijuana cultivation and consumption with no purchases or sales to or from non-members. To help prevent diversion of medical marijuana to non-medical markets, collectives and cooperatives should document each member's contribution of labor, resources, or money to the enterprise. They also should track and record the source of their marijuana.

5. **Distribution and Sales to Non-Members are Prohibited**: State law allows primary caregivers to be reimbursed for certain services (including marijuana cultivation), but nothing allows individuals or groups to sell or distribute marijuana to non-members. Accordingly, a collective or cooperative may not distribute medical marijuana to any person who is not a member in good standing of the organization. A dispensing collective or cooperative may credit its members for marijuana they provide to the collective, which it may then allocate to other members. (§ 11362.765(c).) Members also may reimburse the collective or cooperative for marijuana that has been allocated to them. Any monetary reimbursement that members provide to the collective or cooperative should only be an amount necessary to cover overhead costs and operating expenses.

6. **Permissible Reimbursements and Allocations:** Marijuana grown at a collective or cooperative for medical purposes may be:

a) Provided free to qualified patients and primary caregivers who are members of the collective or cooperative;
b) Provided in exchange for services rendered to the entity;
c) Allocated based on fees that are reasonably calculated to cover overhead costs and operating expenses; or
d) Any combination of the above.

7. **Possession and Cultivation Guidelines**: If a person is acting as primary caregiver to more than one patient under section 11362.7(d)(2), he or she may aggregate the possession and cultivation limits for each patient. For example, applying the MMP's basic possession guidelines, if a caregiver is responsible for three patients, he or she may possess up to 24 oz. of marijuana (8 oz. per patient) and may grow 18 mature or 36 immature plants. Similarly, collectives and cooperatives may cultivate and transport marijuana in aggregate amounts tied to its membership numbers. Any patient or primary caregiver exceeding individual possession guidelines should have supporting records readily available when:

a) Operating a location for cultivation;
b) Transporting the group's medical marijuana; and
c) Operating a location for distribution to members of the collective or cooperative.

8. **Security**: Collectives and cooperatives should provide adequate security to ensure that patients are safe and that the surrounding homes or businesses are not negatively impacted by nuisance activity such as loitering or crime. Further, to maintain security, prevent fraud, and deter robberies, collectives and cooperatives should keep accurate records and follow accepted cash handling practices, including regular bank runs and cash drops, and maintain a general ledger of cash transactions.

C. **Enforcement Guidelines**: Depending upon the facts and circumstances, deviations from the guidelines outlined above, or other indicia that marijuana is not for medical use, may give rise to probable cause for arrest and seizure. The following are additional guidelines to help identify medical marijuana collectives and cooperatives that are operating outside of state law.

1. **Storefront Dispensaries:** Although medical marijuana "dispensaries" have been operating in California for years, dispensaries, as such, are not recognized under the law. As noted above, the only recognized group entities are cooperatives and collectives. (§ 11362.775.) It is the opinion of this Office that a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law, but that dispensaries that do not substantially comply with the guidelines set forth in sections IV(A) and (B), above, are likely operating outside the protections of Proposition 215 and the MMP, and that the individuals operating such entities may be subject to arrest and criminal prosecution under California law. For example, dispensaries that merely require patients to complete a form summarily designating the business owner as their primary caregiver – and then offering marijuana in exchange for cash "donations" – are likely unlawful. (*Peron*, *supra*, 59 Cal.App.4th at p. 1400 [cannabis club owner was not the primary caregiver to thousands of patients where he did not consistently assume responsibility for their housing, health, or safety].)

2. **Indicia of Unlawful Operation:** When investigating collectives or cooperatives, law enforcement officers should be alert for signs of mass production or illegal sales, including (a) excessive amounts of marijuana, (b) excessive amounts of cash, (c) failure to follow local and state laws applicable to similar businesses, such as maintenance of any required licenses and payment of any required taxes, including sales taxes, (d) weapons, (e) illicit drugs, (f) purchases from, or sales or distribution to, non-members, or (g) distribution outside of California.

Los Angeles Times

Despite weak economy, crime in Los Angeles County still declines

There were thousands fewer crimes reported in 2011 than 2010 in areas the LAPD and Sheriff's Department patrol. The trend puzzles some but reinforces a common police view that other factors are at play.

January 05, 2012|By Joel Rubin, Los Angeles Times

Even since the economy began stalling several years ago, there have been dire warnings that crime would rise.

But in Southern California, crime continues its long decline despite the weak economy. Indeed, 2011 brought new worries about a "double dip recession," yet streets in many parts of the region were the safest they've been in decades.

The trend continues to puzzle some criminologists but has reinforced the view of many in law enforcement that factors other than the economy determine the rise or fall of crime.

Los Angeles Police Chief Charlie Beck said crime rates are determined largely by how well police do their job and the "informal social standards" set by communities — that is, what kind of behavior people are willing to tolerate from others.

"The driving forces on crime," Beck said, are " 'What is the likelihood the police will catch you?' and, 'What would your mother or neighbor think if they knew what you were doing?'"

A spokesman for Sheriff Lee Baca took a similar stand. "Communities seem to be banding together to fight crime," Steve Whitmore said. "We can't take the complete credit."

The city, along with much of the rest of L.A. County, finished the year with thousands fewer serious crimes than in 2010, according to preliminary statistics gathered by the Los Angeles Police Department and the county Sheriff's Department.

Homicides, an important bellwether for violence levels in general, finished the year nearly even with the historically low rate of killing that Los Angeles reached in 2010. The LAPD tallied 298 killings in 2011, making it the second consecutive year the city experienced fewer than 300 homicides. It is a benchmark that was unimaginable amid

EXHIBIT "20"

the gang violence and crack cocaine epidemic of the 1990s, when the homicide rate was four times as high.

Throughout the rest of L.A. County, which is patrolled by the sheriff and individual cities' police departments, there were 283 homicides — a 12% decline from the previous year — according to a Times analysis of coroner's data.

Other categories of violent and property crime, meanwhile, continued the downward trend they have followed for the last several years. The number of reported robberies, aggravated assaults, burglaries and auto thefts in the city through Dec. 24, for example, was down between 3% and 9% compared with the same period the previous year, LAPD statistics showed.

The Sheriff's Department, which patrols numerous small cities and the county's unincorporated areas, also posted declines in a preliminary count through November. Serious violent crimes were down 13.5%, and property-related offenses dropped about 2%. The LAPD is scheduled to release its final crime numbers Thursday.

"It is deeply puzzling," said Richard Rosenfeld, a leading criminologist at the University of Missouri, St. Louis. "During past economic recessions, with high unemployment and stagnant incomes, we saw increases in crime. That has not been the case this time."

Since 2007, the last full year before the onset of the country's ongoing economic woes, Angelenos and others in the region have been told to brace for an anticipated surge in crime that has never come.

To the contrary, the region has watched as a downward trend in crime that began nearly a decade ago has continued largely unabated, despite high unemployment, a horrible housing market and cuts to public services. This will be the ninth consecutive year of falling crime in Los Angeles.

Not yet ready to altogether abandon the long-held belief that people's financial well-being is inexorably linked to crime rates, Rosenfeld nonetheless acknowledged that he and other researchers are running out of places to find where that link exists.

Researchers and police have long butted heads trying to make sense of what factors influence crime rates. Police argue that their work is the linchpin, while academics look for larger societal explanations.

LAPD chief: Pot clinics not plagued by crime

By Tony Castro, Staff Writer
Posted: 01/17/2010 12:00:51 AM PST

Despite neighborhood complaints, most medical marijuana clinics are not typically the magnets for crime that critics often portray, according to Los Angeles police Chief Charlie Beck.

"Banks are more likely to get robbed than medical marijuana dispensaries," Beck said at a recent meeting with editors and reporters of the Los Angeles Daily News.

Opponents of the pot clinics complain that they attract a host of criminal activity to the neighborhoods, including robberies. But a report that Beck recently had the department generate looking at citywide robberies in 2009 found that simply wasn't the case.

"I have tried to verify that because that, of course, is the mantra," said Beck. "It doesn't really bear out."

In 2009, the LAPD received reports of 71 robberies at the more than 350 banks in the city, compared to 47 robberies at medical marijuana facilities which number at least 800, the chief said in a follow up interview, in which he provided statistics from the report.

Beck said he had asked for a comparison of robberies at the two types of businesses because of the growing public outcry -- as the City Council debates tighter restrictions on clinics -- that those facilities have become an increasing target for crime.

He said he thought a comparison of banks and medical marijuana dispensaries was appropriate because of their similarities as potential targets -- both have large sums of cash and are often heavily fortified.

THE DENVER POST

Analysis: Denver pot shops' robbery rate lower than banks'

Posted: 01/27/2010 01:00:00 AM MST
Updated: 01/27/2010 05:58:13 AM MST

By John Ingold
The Denver Post

A Denver Police Department analysis estimates that medical-marijuana dispensaries in the city were robbed or burglarized at a lower rate last year than either banks or liquor stores.

The analysis — contained in a memo authored by Division Chief Tracie Keesee for Denver City Council members — finds that the projected robbery and burglary rate for storefront dispensaries in 2009 was on par with that of pharmacies.

The analysis is the first time Denver police have sought to compare crime at dispensaries with that at other businesses, and it represents a best-guess at a crime rate for the city's rapidly evolving dispensary industry. Denver police spokesman John White said he didn't want to speculate on the bigger meaning of the numbers until the department can do a more thorough analysis.

But the memo comes as welcome news to medical-marijuana advocates, who have sought to convince state and local officials that dispensaries are not crime magnets.

"It sounds anecdotally about right," said Matt Brown, with the pro-dispensary group Coloradans for Medical Marijuana Regulation. ". . . Occasionally they happen. (Dispensaries) are by no means immune to crime. But they're far more manageable than some of the public outrage would lead you to believe."

Police departments in other parts of the state — and in other states as well — have reported spikes in medical-marijuana-related crime coinciding with increases in the number of dispensaries in their communities.

Denver police statisticians arrived at the estimated crime rate for dispensaries by looking at the total number of burglaries or robberies reported at storefront dispensaries in 2009 — eight — and projecting what that number would have been had all the dispensaries operating in Denver at the end of the year been open for the full year.

The figures do not include medical-marijuana-related crimes that occurred outside storefront dispensaries — such as robberies of medical-marijuana delivery services or home-based caregivers. Previously, Denver police officials have said there were at least 25 medical-marijuana-related robberies or burglaries in the city in the last six months of 2009.

The projected 16.8 percent burglary and robbery rate for dispensaries is equal to that of pharmacies. It's below the 19.7 percent rate of liquor stores and the 33.7 percent rate for banks, the analysis found.

State Sen. Chris Romer, a Denver Democrat who has been working to create regulations for Colorado's medical-marijuana system, said the numbers show that crime at dispensaries should not be ignored.

But he said it also shows that the crime rate is not so high as to necessitate the banning of dispensaries, which one proposal floating around the state Capitol would effectively do.

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Repeal of marijuana prohibition

December 23, 2011 – 3:43 pm

A coalition of Michigan parents, teachers, attorneys, physicians, health professionals, former law enforcers and many other people from all walks of life are putting together a voter ballot initiative to repeal marijuana prohibition in Michigan. The 2012 Michigan Ballot Initiative to End Marijuana Prohibition will give Michigan citizens the opportunity to vote on the repeal of Marijuana Prohibition.

We enacted the Michigan Medical Marijuana Act (MMMA) in 2008 to protect patients from criminal prosecutions. Instead of regulating the medical marijuana industry (like Colorado did) our State Attorney General, law enforcement, activist judges and our state legislators have done everything they can think of to destroy the new law.

State registered patients and caregivers have been viciously attacked and prosecuted by the state. The voters did not intend for the state to spend millions of tax dollars to prosecute patients and caregivers and attempt to destroy the new law.

This coalition examined all the options. They thought about strengthening our current Medical Marijuana law. They discussed decriminalization and concluded that whatever they did the state would try to destroy our new effort the same way that they did with the Michigan Medical Marijuana Act.

Thanks to the current effort by AG Bill Schuette and company to destroy the MMMA, Michigan could be the first state to repeal marijuana prohibition.

Michigan prohibited alcohol in 1919. In 1933 the U.S. Government recognized the connection between high crime rates and prohibition. A state convention with one delegate from each state house district voted 99-1 to repeal alcohol prohibition. The following year Michigan had a 70 percent drop in homicides.

The violence carried out by the likes of Al Capone was minor compared to the violence that is created by marijuana prohibition. As soon as we enacted marijuana prohibition the murder rates skyrocketed the same way they did when we tried to prohibit alcohol. Crime rates will drop if we succeed in our effort to right a very serious wrong by repealing marijuana prohibition.

The repeal of marijuana prohibition in Michigan will reduce criminal gang activity, reduce access of marijuana by minors. It will promote agriculture and create jobs by creating a new hemp industry and reduce the burdens of an overpopulated prison system, increase better relations between people and law enforcement and law enforcement will have more time and resources to focus on real crime where there are actual victims.

We've spent over one trillion tax dollars and arrested over 20 million people for marijuana. Drug use with school children and adults has increased every year along with our drug war budget. Our school budgets have been gutted to the point that there is no more room to cut. Repealing marijuana prohibition will free up millions of tax dollars to help shore up our school finances.

Colorado Representative Jared Polis recently called on Congress to end the prohibition on marijuana. Rep. Polis said "We've seen the benefits across the board, as a job creation engine in Colorado". Polis predicted that national legislation was on the horizon, but said "states must lead the charge". "It's a critical and important time for advocacy at the national stage," he said. "The more states that create a regulatory structure around marijuana production and sales, the more pressure there will be on Congress nationally".

The undertaking by the coalition working to repeal marijuana prohibition will be an enormous undertaking. We need thousands of volunteers to circulate petitions in order for this to become a reality. The 30-year-old and younger crowds are being targeted in this war and they are the ones that will have to step up to the plate to help make this happen. You need to volunteer to help collect signatures and to recruit other volunteers. My generation brought an end to the Viet Nam war through peaceful demonstrations and your generation will bring an end to the war being carried out against you under the disguise of marijuana law.

Bill Schuette has many prohibition allies with very deep pockets. Bill Schuette and company will spend hundreds of thousands of dollars on negative and dishonest ads against the repeal of marijuana prohibition. We do not have financial backing to counter their ads, so we will need donations to combat the negative and false advertising that will surely come from our opponents.

Go to repealtoday.org now and volunteer to help collect signatures or to donate money for this effort, because if we fail with this effort the violent and unprovoked attacks against innocent people who choose a safer alternative (marijuana) to alcohol, will continue.

Bob Wood

June 2, 2011 [COLB v. 562 Patient Collective, et al. LASC No. NC055751]

1 THAN THIS ONE PENDING INVOLVING SIMILAR ISSUES, THE LEGALITY
2 OF THE ORDINANCE IN THE CITY OF LONG BEACH THAT DEALS WITH
3 MARIJUANA COLLECTIVES. BASED UPON TWO PRIOR CASES THAT I CAN
4 THINK OF, I FOUND THAT THE ORDINANCE IN THE CITY OF
5 LONG BEACH WAS CONSTITUTIONAL AND THE ENFORCEMENT OF THE
6 ORDINANCE COULD NOT BE ENJOINED. THAT MATTER IS NOW PENDING
7 BEFORE THE COURT OF APPEAL IN THE STATE OF CALIFORNIA, SECOND
8 APPELLATE DISTRICT.
9 AS I'VE NOTED IN THIS LAWSUIT, THE CITY HAS
10 FILED A LAWSUIT TO ABATE A NUISANCE. THE CONCERN THAT I HAVE
11 IS AS ARTICULATED BY THE DEFENDANTS, THE EVIDENCE SEEMS TO
12 SHOW THAT THE CITY THROUGH ITS POLICE HAVE USED WHAT I REFER
13 TO AS STRONG-ARM TACTICS TO KNOCK DOWN DOORS OF THE
14 COLLECTIVE WITHOUT A WARRANT AND WITHOUT EXIGENT
15 CIRCUMSTANCES.
16 PEOPLE WHO HAVE USED THE COLLECTIVE HAVE BEEN
17 ARRESTED AND BOOKED AND IT'S FURTHER ALLEGED THE CITY HAS
18 CONTACTED THE LANDLORD AND THREATENED TO WITHDRAW THE
19 BUSINESS LICENSE UNLESS THE LANDLORD EVICTS THE DEFENDANT.
20 AND THIS IS WHILE THIS CASE WHERE THE CITY IS THE PLAINTIFF
21 IS SEEKING TO ABATE WHAT IT REFERS TO THE NUISANCE WHICH IS
22 THE DEFENDANT COLLECTIVE 562 FROM OPERATING. AND SO WHAT I
23 DON'T UNDERSTAND IS WHY THE CITY WOULD USE SUCH TACTICS WHILE
24 THE CASE IS PENDING.
25 THE QUESTION THAT I HAVE IS, IF I ACCEPT THE
26 ALLEGATIONS OF THE DEFENDANT MOVING PARTY AS TRUE, WHY
27 SHOULDN'T THE COURT ENJOIN THE CITY FROM STRONG-ARM TACTICS?
28 MS. CARNEY: YOUR HONOR, IF I MAY FIRST ADDRESS THE

EXHIBIT "21"

June 10, 2011 [COLB v. 562 Patient Collective, et al. LASC No. NC055751]

1 CONNECTION WITH 3970 ATLANTIC AVENUE IN THE CITY OF
2 LONG BEACH, WHICH I BELIEVE TO BE THE LOCALE OF THE 562
3 COLLECTIVE."
4 WITH ALL DUE RESPECT, I DON'T THINK IT'S UP TO
5 OFFICER COOPER TO TELL ME WHETHER OR NOT HE'S COMPLIED. IF
6 THAT WERE THE CASE, WE WOULDN'T NEED JUDICIAL OFFICERS TO
7 DETERMINE WHETHER THERE IS PROBABLE CAUSE TO ISSUE A SEARCH
8 WARRANT, AN ARREST WARRANT, WHETHER THERE'S PROBABLE CAUSE TO
9 HOLD THE DEFENDANT TO ANSWER FOR A FELONY, ET CETERA, ET
10 CETERA, ET CETERA.
11 THERE IS NOT -- THERE'S NOT ONE FACT IN HERE
12 THAT REBUTS ANY OF THE ALLEGATIONS MADE BY THE DEFENDANTS
13 THAT IT WAS A SEARCH NOT INCIDENT TO A LAWFUL SEARCH WARRANT
14 OR ANY SEARCH WARRANT OR THAT ANY EXIGENT CIRCUMSTANCES
15 EXISTED.
16 AND, THIRDLY, THAT A BATTERING RAM DEVICE WAS
17 USED TO BREAK DOWN A DOOR AND SEIZE DOCUMENTS AS TO AN
18 OPPONENT IN A CIVIL CASE.
19 MS. CARNEY: I UNDERSTAND, YOUR HONOR. FIRST, THE
20 CITY BELIEVES THAT THE DEFENSE HAS MADE ALLEGATIONS
21 UNSUPPORTED BY EVIDENCE CONCERNING THE CIRCUMSTANCES. AND --
22 THE COURT: I'M SORRY. I JUST WANTED TO FOCUS ON THE
23 WORDS "THE PLAINTIFF BELIEVES THAT THE DEFENDANTS."
24 MS. CARNEY: DEFENDANTS HAVE MADE ALLEGATIONS NOT
25 SUPPORTED BY EVIDENCE CONCERNING THE EVENTS THAT THEY ALLEGE
26 OCCURRED AT THE 562 COLLECTIVE.
27 WHILE I'M NOT DISPUTING THE POLICE DO CONDUCT
28 REGULAR INVESTIGATIONS AND THOSE INVESTIGATIONS DID INCLUDE

1 AN INVESTIGATION OF 562, OTHER THAN STATING AT THIS TIME THAT
2 THEY COMPLIED WITH ALL THE REQUIREMENTS OF THE CONSTITUTION,
3 IF THE DEFENDANTS WOULD LIKE TO BRING A 1983 CLAIM, AS I
4 DISCUSSED IN MY FURTHER OPPOSITION, THEY'RE WELCOME TO DO SO.
5 AT THAT POINT WE MAY BE REQUIRED TO DISCLOSE SPECIFICALLY THE
6 EXIGENT CIRCUMSTANCES. BUT AS FAR AS THE MATTER THAT WE'RE
7 HERE FOR TODAY, THE CITY'S POSITION IS THAT WE DID SUPPLY
8 INFORMATION DENYING THEIR ALLEGATIONS AND THAT --
9 THE COURT: I DISAGREE WITH THAT STATEMENT. I THINK
10 YOU DENIED THE ALLEGATIONS, BUT I DON'T THINK YOU SUPPLIED
11 ANY FACTS TO REBUT THE ALLEGATIONS.
12 MS. CARNEY: I UNDERSTAND. I THINK THAT'S CORRECT.
13 THE COURT: I THINK THERE IS A DIFFERENCE WITH A
14 DISTINCTION.
15 MS. CARNEY: I AGREE.
16 THE COURT: ALL RIGHT. WELL, THE REQUEST OF THE
17 DEFENDANT IS ASKING THE COURT TO ENJOIN THE ENFORCEMENT OF
18 THE ORDINANCE IN QUESTION. AND I WILL SAY I'VE GIVEN THIS
19 MATTER A GREAT DEAL OF THOUGHT. HERE'S WHAT I -- HERE'S THE
20 BENEFIT OF MY THOUGHTS.
21 AS I'VE NOTED EARLIER, THE CITY HAS BROUGHT
22 THIS CIVIL CASE WHERE IT IS THE PLAINTIFF AND IT SEEKS TO
23 ABATE WHAT IT CALLS A PUBLIC NUISANCE, THE OPERATION OF THE
24 562 COLLECTIVE, WHICH IT ALLEGES SHOULD NOT BE PERMITTED TO
25 OPERATE IN THE CITY.
26 ON THE OTHER END OF THE TABLE, THE DEFENDANT
27 CONTENDS THAT -- I BELIEVE IT WAS ON MAY THE 9TH OF THIS YEAR
28 AGENTS OF THE PLAINTIFF, SPECIFICALLY POLICE OFFICERS FROM