10 Marijuana Myths and Facts:

1. **Marijuana is Not Medicine.**

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

2. **Marijuana is Addictive.**

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

3. **Marijuana is a "Gateway Drug".**

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

4. **Medical Marijuana Collectives Cause Crime.**

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

5. **Medical Marijuana Causes an Increase in Teen use.**

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

6. **Marijuana Causes Traffic Collisions.**

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

7. **Marijuana is Dangerous for Young Minds.**

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

8. **Marijuana is More Potent Now Than Ever Before.**

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

9. **Marijuana Causes People to be Lazy and Unproductive.**

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

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

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

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After California decriminalized marijuana, teen arrest, overdose and dropout rates fell

WASHINGTON POST **Oct 2014**

By Christopher Ingraham

A new report from the Center on Juvenile and Criminal Justice adds to the growing body of evidence that legalizing or decriminalizing marijuana does not lead to any number of doomsday scenarios envisioned by legalization opponents. Looking specifically at California, where full marijuana decriminalization went into effect on Jan. 1, 2011, the report finds that "marijuana decriminalization in California has not resulted in harmful consequences for teenagers, such as increased crime, drug overdose, driving under the influence, or school dropout. In fact, California teenagers showed improvements in all risk areas after reform."

Table 1. California's marijuana reform was followed by improvements in 15-19 year-olds' risk indexes, both absolutely and compared to teenagers elsewhere in the country

Index		Year before (2010)	Year after (2011)	2 years after (2012)	Change
Violent Deaths	California	28.5	27.4	24.7	**-4%**
	Rest of US	38.3	37.9	N/A	**-1%**
Drug Overdose Deaths	California	3.0	2.4	2.3	**-20%**
	Rest of US	3.9	4.0	N/A	**4%**
Suicide	California	5.3	5.8	4.6	**9%**
	Rest of US	7.8	8.7	N/A	**11%**
Criminal Arrest	California	9,505.3	7,712.0	6,612.2	**-30%**
	Rest of US	14,711.1	13,572.8	11,908.0	**-19%**
Drug arrests*	California	718.4	593.8	551.6	**-23%**
	Rest of US	2,013.7	1,794.0	1,734.4	**-14%**
Property crime arrests	California	2,272.1	1,996.1	1,708.0	**-25%**
	Rest of US	3,229.1	3,045.4	2,784.4	**-14%**
DWI, marijuana**	California	0.289	0.240	0.282	**-3%**
	Rest of US	0.119	0.131	0.129	**+9%**
School dropout rate	California	14.7%	13.1%	11.4%	**-22%**
	Rest of US	N/A	N/A	N/A	

Notes: Death and crime rates are per 100,000 population age 15-19. Change is 2011 versus 2010 for mortality measures, and 2012 versus 2010 for arrest and DWI measures. School dropout is those failing to graduate on time as a percent of all eligible students. DWI marijuana is the proportion of fatal accidents involving a driver under age 20 in which marijuana is found by test. Vital statistics are not available nationally for 2012, nor are comparable school dropout rates. Different measures may account for differences in California and national numbers. Sources: Centers for Disease Control (2014); California Department of Public Health (2014); Criminal Justice Statistics Center (2013); Federal Bureau of Investigation (2013); National Highway Traffic Safety Administration (2014); California Department of Education (2014). *Excluding marijuana possession arrests in California. **California drug-tests a substantially greater proportion of drivers than other states and therefore finds more drug involvement. The measure used here maximizes marijuana presence by treating multiple drug tests a separate when in fact they probably include testing the same drivers more than once.

Center on Juvenile and Criminal Justice

Most notable in the above table is the drop in school dropout rates. Recent studies have suggested links between heavy marijuana use and low school completion rates. But many experts question the direction of causality in this relationship, suggesting that there could be any number of confounding factors that account for this relationship. While it's still early

in California's decriminalization experiment, the numbers above should suggest we cast a skeptical eye on claims of plummeting academic achievement in a post-legalization world.

In fact, as the report authors write: "By a variety of measures, California's teenage behaviors actually improved dramatically after marijuana was effectively legalized — improvements that occurred more weakly or not at all among older Californians and among teenagers nationwide."

Now of course this doesn't address causality, and these numbers shouldn't be taken to imply that decriminalization *caused* these declines. But they do show, pretty clearly, that in the two years since full-scale decriminalization went into effect, California's kids are still all right. The sky hasn't fallen. And they add to a mounting body of research that shows, for instance:

- that teen drug and alcohol use continues to fall, even as more states decriminalize marijuana and make it available for medical purposes;
- that states with medical marijuana laws haven't seen any uptick in teen marijuana use;
- that states with medical marijuana have actually seen decreases in prescription drug overdoses;
- that Alaska, where personal marijuana use has been *de facto* legalized for nearly 40 years, is completely average on a variety of economic and demographic indicators;
- and that traffic fatalities have fallen in Colorado since legalization there.

By contrast, there is little evidence of increased social harms in states where marijuana has been decriminalized. The one credible study I'm aware of is a DEA report finding that more Colorado drivers involved in car crashes are testing positive for marijuana use. But a bucket of salt is needed here: unlike alcohol, inactive marijuana metabolites remain in the body long after consumption - days or weeks, depending on frequency of use. But the presence of metabolites doesn't necessarily indicate you were high at the time of the test - only that you got high some time in the days or weeks prior.

Even if we accept that more Coloradans are using marijuana, and that some of them are getting behind the wheel while stoned, we still have to note that traffic fatalities are down overall - this is likely because it's far less dangerous to drive stoned than it is to drive drunk. This would suggest that some Coloradans are using marijuana in place of alcohol, rather than in addition to it.

In short, the barrier of proof facing legalization opponents is incredibly high. In order to present a compelling case against marijuana liberalization, they have to demonstrate A) that liberalization is associated with a negative outcome; B) that that association is indeed causal, not just coincidental; and C) that the harms from that negative outcome are greater than the myriad harms caused by blanket prohibition of marijuana. But so far, state experiments with liberalization have not produced any consequences that pass even that first test. Considering that we're now close to 20 years out from when California voters first legalized medical marijuana, this should be reassuring news for everyone.

LONG BEACH MEDICAL MARIJUANA TASK FORCE

POB 15027
Long Beach, CA 90815

Dear City of LB Medical Cannabis Task Force March 2015

RE: **ANALYSIS OF LB MEDICAL MARIJUANA (MMj) ORDINANCE DRAFT** - **Patient Perspective**

What has been proven in numerous scientific studies and a mountain of anecdotal evidence is that cannabis/marijuana does have medicinal value and has helped many citizens across the world with various maladies, disabilities and pain. The main concern before us is how to reasonably and compassionately distribute this medicine to those who need it.

As presented in the recent People v **Baniani** California Court of Appeals case (G04835), **"It would be cruel for those whose need for medical marijuana is the most dire to require that they devote their limited strength and efforts to the actual cultivation of the marijuana, and then wait months for it to grow so they can use it....."** In People v Urziceanu (CA App.4th), the court noted the Medical Marijuana Program Act (MMPA) was the Legislature's initial response to the CUA's (Compassionate Use Act – Prop 215) call to provide a plan "for the *safe and affordable distribution* of marijuana to all patients in medical need of marijuana....."

I personally experienced the painful, **prolonged deaths** of both my mother and other family members from cancer. It's not a pretty picture. At that time, cannabis was sadly not allowed as medicine. It is now, and we should do everything we can to alleviate the needless suffering in this world. We must never forget that a patient could be your mother, your sister, your friend or your child. While "abuse" does happen, we don't deprive cancer patients of pain meds because others might abuse it. (Prescription drugs are the most abused drug group in the nation.)

The **people of Long Beach** voted for the 1996 Prop 215 Compassionate Use Act, Proposition 19 (full legalization) and LB Prop A MMj tax measure (2/3 win). The citizens of this fair City have spoken. Mirroring this sentiment, 60% of the entire nation wants full legalization; 70% favor it medically. And, as people become more informed and enlightened, that number continues to increase. 24 states and numerous cities, including Philadelphia and Washington D.C. allow for some form of cannabis.

The **LB City Attorney (CA) proposed Ordinance** for Medical Marijuana collectives was written with little concern/compassion for sick patients and people with disabilities who rely on cannabis for their maladies and pain. It blatantly throws "due process" out the window, repeatedly insults the United States Constitution, and shamelessly disregards the rights of patients.

The following is an **in-depth analysis** of the 9-11-14 version of the proposed City MMj ordinance (**A copy is attached herein.**) Page and line #s correlate accordingly. This was presented to the Planning Commission at the 9-18-14 meeting. Changes made on subsequent versions are minimal and not as consequential. While this is not a complete list, it highlights some of the numerous stand-out problems with this draft.

Severely **limiting amounts that individuals can produce** contradicts the state MMPA provisions. Additionally, this ordinance would force individuals growing/possessing more than six mature plants, 12 immature plants and/or 8 oz of a useable form of marijuana to be governed by this ordinance—again contradicting the state MMPA law.

While the MMPA uses these numerical guidelines as a general rule, in recognition of the fact that the regulations are inadequate for many very ill patients, SB 420 allows patients to be exempted from them if they obtain a physician's statement that they need more. In deference to local autonomy, SB 420 also allows counties and cities to establish **higher but not lower guidelines** if they so choose. Strictly speaking, the guidelines do not constitute hard and fast limits on how much patients may legally have. This is because Prop 215 specifically allows patients whatever amount of marijuana they need for their own medical use..... (MMj Business definition p 6-14) (Individual production of MMJ p 6-26, p 7-3)

> Qualified patients claiming protection under Proposition 215 may possess an amount of marijuana that is "reasonably related to [their] current medical needs." (*People v. Trippet* (1997) Cal.App.4th)

According to California **Attorney General Kamala Harris** in a Dec 2011 letter to the California Legislature, "In simple terms, this means that the core right of qualified patients to cultivate and possess marijuana cannot be abridged." and "……the Pack decision suggests that if the State goes too far in regulating medical marijuana enterprises....the law might be preempted by the Controlled Substances Act." She ends her letter, "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."

In a second letter RE: Medical Marijuana Guidelines, Harris writes, "One point is certain—California law places a premium on **patients' rights to access marijuana** for medical use."

Allowing for non-regulated collectives of up to **ten people** would lessen any impact of storefronts, allow for patient groups to associate for mutual benefit, and keep costs down for many who cannot afford dispensary "prices." Otherwise, a family of four or five growing medicine for their cancer-ridden mother or child could be arrested and penalized. What about a group of disabled Veterans or AIDS patients who want to have a coop? (MMj Business means p 6-14) (Individual production of MMJ p 6-26, p 7-3)

Please note that the first two and last three **U.S. Presidents** used marijuana and would be considered criminals under current laws. Essentially, they could run the entire country but not one of the dispensaries. Even recently resigned Attorney General Eric Holder used it too. Just saying.....

A few more affirmative ideas on the proposed **point system**—positive points could be given for hiring a veteran or **someone with a disability**. Community service should be defined with more points given for additional altruistic activity. A plan for giving free or low-cost medicine to those who cannot afford it could be given extra points. (Community service p 23-20)

The definition of "**narcotics**" usually includes marijuana. So, in this draft, mere possession could be grounds to disqualify an applicant—no matter when it happened. (p 23-5)

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

Equal Access/Buffer zones: Another issue is that other concerned entities have also been ignored. One of the concerns shared by the three main groups—patients, collectives and neighborhoods—is the restriction of locations that will generally force facilities into the westside of Long Beach. Lifting the park and commercial corridor bans will greatly facilitate a more equitable distribution, reduce impact and create a safer access for patients and disabled persons. At the very least, only the larger **named** parks should have a buffer. Buffering all "**parkland**" is regulatory overkill. Parkland is abundant in this City and includes medians, beaches, mini-park areas, etc. As a prime example, one business was closed because it was too close to a water pump station deemed parkland. Areas adjacent beaches should be excluded from this restriction. (Buffer zones p 24-10)

The California state requirement is that dispensaries be located no less than 600 feet from **schools**—this is adequate and will free up other potential locations. 1000 feet is more than adequate; and 1500 feet is excessive and severely impairs equal access across the city. May I remind you that liquor/convenience stores (that sell far

more harmful substances like tobacco and alcohol) only need a 500 foot buffer. Interestingly, numerous studies have shown that **adolescent use goes down** when marijuana is decriminalized/legalized. (Buffer zones p 24-10)

Equal access is denied to those with disabilities under the current restrictions. It also impacts some districts far more and makes access much more difficult in other districts**. Limiting to industrial areas and certain CHW Districts could hamper transportation and endanger those with limited mobility.** Additionally, there is no logical reason to **restrict growing to the City of Long Beach**. There are many reasons to allow growers outside of the City to furnish MMj—diversity of strains targeting various ailments that would best suit patient needs, reduction in vital electricity, water and other utility usage, healthier plants outdoors, reduced probability of criminal activity that put growers at greater risk, decrease crop failure, availability of facilities--larger warehouses and land are not abundant in LB, etc. Other cities with successful programs do not have this requirement. (Location p 20-16 thru 21-1) (Cultivation in City p 28-4)

The Ordinance is so restrictive that it will not allow for **equal access** to patients in ALL districts—this flies in the face of the ADA and the CA State disability laws. And, although MMj is not currently considered in those laws, the spirit of those laws clearly champions persons with disabilities to have the right to full and equal access to public facilities. To meet this challenge, the Long Beach MMj accessible areas should include commercial, mixed and industrial zoning.

In having **excessive restrictions, the City is defeating its own purpose in considering people with disabilities**. If cooperatives are not allowed where citizens have reasonable access through public transportation, many (especially those in wheel chairs) will not be able to access the medicine they need. Additionally, **patient safety** may be at issue in limiting collectives mainly to industrial areas. Industrial zones are typically dark, devoid of pedestrian traffic and have limited access to public transportation. This could easily put patients with mobility issues at great risk.

Allowing **three to four dispensaries** per district would facilitate accessibility and lessen the impact on any given district or neighborhood. When the City is limited to only a few collectives, it actually creates a nuisance situation—too many people who need the medicine are forced onto fewer locations. This fosters traffic and parking problems and concerns about any heavily-impacted entity. In turn, the police will say that the collective is a "nuisance." It becomes a self-fulfilling prophecy. (Location per council district p 20-25, p 21-1)

Patients who work in these dispensaries may need to consume medicine. They may suffer from seizures or other maladies that necessitate regular doses of medication—just like pharmaceuticals. They should be able to medicate in a designated area away from the public. Note that they are allowed legal prescriptions or other medications. (Onsite prohibition p 25-11) (Prohibited acts p 43-1 thru 43-3)

Prohibited Acts: Cultivate, distribute, **possess**, or produce marijuana in plain view of, or in a place open to the public. This rule is overly broad, and would forbid a patient from carrying their medicine across a street, on a bus, or anywhere there is public access—even on their own property if they were in "plain view." With this provision, the patient would be violating the law the minute they walked out of the dispensary. (Prohibited Acts p 42-27)

Stipulation not allowing operation of a MMj business **"under the influence of MMJ"**. How is that defined? Traces of cannabis can be found in the body for up to 30 days after consumption. What about prescription drugs? Should all people not be allowed to work if they consume drugs of any kind—including coffee, over-the-counter cold meds, Vicodin, etc etc.? Most workers or volunteers are MMj patients who may be medicating with this herb. And, "under the influence" has not been readily defined as studies in the U.S. have been severely curtailed by the Federal government. (Prohibited Acts p 43-8)

Possession of MMj not in a sealed package—many situations could come up whereby a person is carrying a package that is not sealed. Again, over-reaching, over-regulation. There is no stipulation in the MMPA that MMj must be consumed at the person's residence or that a patient cannot transport medicine that is not sealed. (Prohibited acts p 43-12)

According to the California Attorney General Guidelines in 2008, "Courts have found an implied defense to the

transportation of medical marijuana when the "quantity transported and the method, timing and distance of the transportation are reasonably related to the patient's current medical needs." (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1551.)

Obtain MMj other than MMj business—what if a person belongs to a small co-op? What if they get it from their caregiver? Our prisons do not need to be filled with sick/disabled patients while violent criminals are set free because of overcrowding. (Prohibited acts p 43-23)

Prohibition of delivery or transport to a patient—what about a caregiver? **What if the patient is severely disabled and is not mobile?** What happened to equal access as prescribed by the ADA and State laws? Even pharmacies can deliver prescriptions and over-the-counter meds. Transportation of Medical Cannabis is legal under state law (per People v. Urziceanu (2005) 132 Cal.App.4th 747,785). (Prohibited acts p 44-2)

Hours of operation should be between 9 am and 9 pm to facilitate people who have jobs. (p 26-11)

Not all patients can "smoke" the medicine and must rely on **edibles, oils or other forms of medicine**. Edibles are created with concentrates which are allowable within the Attorney General Guidelines. This is denied per policy created by the CA's office. There are safe methods of extracting the medicine from the plant and/or it can be brought in from other sources. (Edibles and extractions p 31-23, 31-27)

Does any other business require **City residency**? Liquor stores? Pharmacies? What about people who work here? This is a ridiculously unnecessary and cumbersome requirement. (City residency p 27-10)

What is the need and the purpose for a collective to be required to violate the **HIPPA and 4th Amendment Rights** of it's members? The draft **repeatedly** states that **all** records must be available for City inspection, "including information about patients and caregivers." In only one section of these demands does it say that confidential info may be submitted in a manner that maintains confidentiality. (Records p 36-9 thru 36-15) (Disclosure of records p 36-22) (Audits p 37-11) (Consent p 37-18 thru 37-22) (Without search warrant p 38-2 thru 38-6) (Reporting sales—without limitation p 38-9 thru 38-15) (Surveillance cameras p 39-10 thru 39-18)

Possible solution: Each patient and/or caregiver could be assigned a number by the collective, put on the back of their recommendation letter, and used for purposes of inspection. The name, personal data and other identifying info MUST remain confidential.

Additionally, **warrantless searches** are 4th Amendment violations for all concerned and totally disregards **HIPPA protections** and privacy laws for patients. Suppose you or your child needed this medicine; do you want the entire City of LB to know about your personal business? Warrantless searches aka "**raids**" foster bribery and graft, confiscation of property without record, lack of due process, intimidation of patients, and open the door to serious corruption. This also includes 24-hour video access by law enforcement. Even state IDs are voluntary. (Records p 36-9 thru 36-15) (Disclosure of records p 36-22) (Audits p 37-11) (Consent p 37-18 thru 37-22) (Without search warrant p 38-2 thru 38-6) (Reporting sales—without limitation p 38-9 thru 38-15) (Surveillance cameras p 39-10 thru 39-18)

And, have we forgotten that the U.S. Constitution **4th Amendment** still exists:

> The **4th Amendment** originally enforced the notion that "each man's home is his castle", secure from unreasonable searches and seizures of property by the government. It protects against arbitrary arrests, and is the basis of the law regarding search warrants, stop-and-frisk, safety inspections, wiretaps, and other forms of surveillance, as well as being central to many other criminal law topics and to privacy law.

Reporting sales—requires name, address of grower, seller and purchaser. Again over-regulation which violates **HIPPA laws and 4th Amendment protections**. It puts all involved at risk as a target for crime, corruption, asset forfeiture, policing for profit, DEA raids and possible self-incrimination. Unfortunately, it is still considered a

Schedule 1 drug regardless of a mountain of evidence that proves otherwise. Would you want the whole City to know that you were seeing a Psychiatrist? Or needing medicine from one of these clinics? It also speaks to "**wholesale" transactions**—but other sections require cultivation by the entity that distributes it. (Reporting sales p 38-9 thru 38-15, 38-18) (Transportation 29-9) (Cultivation p 5-18)

The 4th District CA Court of Appeals (People v Baniani, Aug 2014) The court opined: "….. First, the purpose of the MMPA is to ensure the promise of the CUA is fulfilled and qualified patients have safe access to affordable medical marijuana. **We do not think the Legislature intended a seriously ill individual whose physician has recommended use of medical marijuana, and who is physically or otherwise unable to participate in the acts involved in cultivating medical marijuana, cannot simply pay money to his or her collective in exchange for the recommended medicine…….** Moreover, for some the cultivation and processing would not be completed until it was too late to provide any relief. The MMPA does not anticipate a patient who has received a physician's recommendation must thereafter wait months to lawfully acquire medical marijuana."

Former Chief McDonnell contends that patients they have observed at the dispensaries were not seriously ill and were not entitled to be patients. Firstly, we don't believe that the requirements for the Police Deparment included a medical certification. It is **illegal to practice medicine without a license**. Seondly, can you please tell me what a cancer patient looks like? What about AIDS, migraines, chronic pain?? These decisions are best left to a patient and their doctor—wouldn't you want the same? Just because one does not see a wheelchair, chemotherapy symptoms such as baldness, and/or seizures/tremors, doesn't mean they are not suffering.

The **LAPD 's Chief of Police** conducted studies and made the results public. He concluded that despite neighborhoood complaints, most medical marijuana clinics are not typically the magnets for crime that critics often portray. He said, "**Banks are more likely to get robbed** than medical marijuana dispensaries." These findings are consistent with those of the Rand Corporation whose study found that crime rates rose in surrounding neighborhoods when dispensaries were shut down. Additionally, a recent research report from UCLA found no relationship between the density of dispensaries and violent or property crime.

In some scientific studies, it has been shown that with decriminalization/legalization there has been dramatic reduction in violent crimes, overall law-breaking, suicides, drug addiction, alcoholism, traffic deaths, etc. In fact, legitimate studies have shown that when marijuana is legalized/decriminalized, adolescent use, school drop out, crime, arrests, death from opioid and alcohol overdose **goes down**.

According to the **CUA and MMPA, the medical conditions** that are included are, "Serious medical conditions means all of the following medical conditions: AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms (including but not limited to spasms associated with multiple sclerosis), seizures (including butnot limited to seizures associated with epilepsy), severe nausea, any other chronic or persistent medical symptom that either: (a) substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990. (b) if not alleviated may cause serious harm to the patient's safety or physical or mental health."

14th Amendment: .....nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

It is the overall sense of our LB Medical Marijuana Task Force that **this MMj Ordinance is destined to fail** on many counts. It presents as a **litigation landmine** which will cost taxpayers large sums of money. The document is full of policies and reflects opinions that are personal to the makers. An unreasonable ordinance will only serve to increase the likelihood of "street dealing", thus lining the pockets of the gangs and cartels. Violence, territorial disputes and other gang activity are just another by-product.

It is our sincere desire to have an ordinance that is reasonable and workable for all concerned. **We recognize the City Council as the policy-making body of this City** and truly appreciate your compassion and wisdom in this issue.

Our Long Beach Medical Marijuana Task Force has spent a great deal of time and effort creating a MMJ

Ordinance that not only has addressed federal preemption concerns (Pack decision), but many other litigious issues as well. It is attached here as well. We would sincerely appreciate your consideration of our reasonable and workable LB Medical Marijuana Ordinance.

And, considering the sentiments of Long Beach residents, at least 24 states, numerous cities including Philadelphia and Washington DC, this City Council could progressively look at the possibility of **full legalization or decriminalization.**

Acting head of the **U.S. Justice Department's Civil Rights Division** Vanita Gupta wrote, "The solution is clear: Instead of taxpayers spending millions of dollars on this unnecessary enforcement and keeping folks.....in prison for the rest of their lives, states could follow Colorado and Washington by taxing and regulating marijuana and investing saved enforcement dollars in education, substance abuse treatment, and prevention and other health care." (Oct 2014)

At present, the CA draft MMj Ordinance has been considered at the Planning Commission and is being sent back to Council for further direction and deliberation. Numerous documents regarding this issue were sent to the Planning Commission (posted with their agendas) to educate and inform them of current developments. Please feel free to review any and all of these as they will be pertinent to your decision making. You will also find additional information attached. **We would be happy to offer assistance to you or provide information prior to this being heard at a Council.** Please feel free to call me at (562) 421-8012 should you have any questions or have a request for information.

Peace be with you,

Diana Lejins
Advocates for Disability Rights
Chair, Long Beach Medical Marijuana Task Force

* *A genuine leader is not a searcher for consensus but a molder of consensus.* Martin Luther King

* ***Better the occasional faults of a Government that lives in a spirit of charity than the constant omission of a Government frozen in the ice of its own indifference.*** President Franklin Delano Roosevelt

Abbreviations:

CA	City Attorney
CUA	Proposition 215 – Compassionate Use Activities 1996
CUP	Conditional Use Permit
LB	Long Beach
MMj	Medical Marijuana
MMPA	SB 420 - Medical Marijuana Program Act 2004

CBS NEWS June 25, 2014

Can marijuana heal a wounded warrior?

Matt Kahl made it home after two tours in Afghanistan, but was wracked with pain from physical injuries, and on a host of anti-anxiety medication to try and treat his mental anguish.

"About ten months after I got back, I attempted suicide," Kahl told CBS News' Barry Petersen.

"I was completely hopeless," recalled the veteran, who said he was on about 15 different medications.

Until the day he tried marijuana.

"Suddenly, my extremely overactive, hyper-vigilant mind started to calm down," he told Petersen, "and my pain gradually started to go away, too. I needed less of these other medications, and shortly afterwards, I determined that I absolutely have to move to a state that allows this so that I can get my life back."

He moved his family to Colorado and now works with a group called Grow4Vets. He and other volunteers recently spent a day putting together bags of marijuana products that are given away on holidays, like Memorial Day.

P**TSD treatment inadequate, study shows**
Two recent studies confirm widespread veteran concern with VA mental health care.

The marijuana is meant to treat war wounds -- both the mental and the physical kind that doctors often treat with drugs like oxycontin. According to the VA, 20 percent of veterans returning from Afghanistan and Iraq suffer from post-traumatic stress. Current treatments range from therapy to prescription drugs, but the group wants to replace pills with pot, according to veteran and Grow4Vets founder Roger Martin.

"Anybody that's been on narcotic medication especially wants to get off of it," he said. "I really have not met anybody who just enjoys being in a drug stupor."

But because marijuana is still considered a Schedule 1 drug at the federal level, there has been very little research into the effects of pot and post-traumatic stress disorder. The House recently voted down a bill that would allow VA doctors to speak with patients about medicinal marijuana, even in states like Colorado where it's legal.

Soldiers and pot have been together since the Vietnam War, as pot shop owner Toni Fox knows well. Her father came home from Vietnam suffering from post-traumatic stress disorder. Marijuana helped but it was illegal, so not always available.

"He struggled his whole life," she said. "When I was 14 he ended up committing suicide, and it was directly related to the post-traumatic stress disorder from Vietnam."

Which is why she gives Grow4Vets marijuana from her crop area, and money from the shop's tip jar.

"I believe in my heart of hearts that, if he would have had access to cannabis, he would be alive today," said Fox.

Critics are still dubious, given the fact there is little to no scientific proof that pot actually helps with post-traumatic stress disorder.

"Why the hell not? Why don't we study it? Why don't we run these clinical trials?" said Kahl. "I'm absolutely convinced that it works."

For Matt and wife Aimeé, the relief he gets from marijuana means a second chance at healing from Afghanistan, and that's nothing less than a second chance at life.

Colorado Legalization Report Card

Posted on June 26, 2014 by David Downs

Colorado tourism has likely surged since legalization.

Plenty of police leaders promised the apocalypse if Colorado taxed and regulated pot for adults over 21. After six months of retail sales in the state, those law enforcement figures have lost some credibility.

Drug law reform group Drug Policy Alliance released a six month report card on Colorado noting that: “It is far too early to make any definitive declarations about social trends. There are, however, some encouraging signs that have been documented in Colorado since the first retail stores officially opened on Jan. 1, 2014.”

Some talking points:

– crime is down 10.1 percent in Denver from the same period one year ago. Violent crimes have dropped 5.2 percent, according to Uniform Crime Reports. Burglary and robbery rates at medical pot shops have also declined since sales began January 1.

– marijuana sales have generated $10.8 million in taxes in the first four months of 2014, including $1.9 million collected specifically to improve Colorado schools.

– $9 million is flowing to research into the medical efficacy of cannabis.

– an estimated 1,000-2,000 jobs cannabis industry jobs have been created.

– 54 percent of Colorado voters remain in support of pot legalization and regulation.

– Colorado home prices are up 8.7 percent in 2014 and Colorado’s governor said legal weed has not tarnished the state’s brand.

For a more broad report card, we can turn to the latest numbers on teen drug use. In 2011, national surveys show 23.1 percent of high school students had used marijuana within the past month. In 2013, it was 23.4 percent, a statistically insignificant difference. Pot use went down nationally among high school seniors, and that was after two states legalized it in 2012.

The *New York Times* reports that: “Because of the lag in reporting many health statistics, it may take years to know legal marijuana’s effect — if any — on teenage drug use, school expulsions or the number of fatal car crashes.

It was only in January, for example, that the Colorado State Patrol began tracking the number of people pulled over for driving while stoned. Since then, marijuana-impaired drivers have made up about 12.5 percent of all citations for driving under the influence of drugs or alcohol.”

Criminal pot cases in Colorado also fell 65 percent in 2013 under the first full year of legalization for personal recreational use, NYT reports. The state could save up to $12-40 million per year not pursuing cases, DPA states.

*Smell the Truth – Powered by Trumedia

Medical marijuana laws linked to lower prescription painkiller

States that have legalized the use of medical marijuana to manage chronic pain and other conditions have a 25 percent lower rate of deaths from opioid drug overdose than states where medical marijuana is illegal, according to a new study.

These findings suggest laws that make cannabis available to manage chronic pain and other illnesses may be useful in the U.S. health care system's uphill battle to reduce prescription painkiller abuse.

The researchers at Johns Hopkins Bloomberg School of Public Health and the Philadelphia Veterans Affairs Medical Center found rates of death from prescription painkiller overdoses climbed steadily from 1999 to 2010. But in states where medical marijuana use is legal, the rates of overdose were, on average, 25 percent lower. The study looked at data on death certificates from the Centers for Disease Control and Prevention.

"In absolute terms, states with a medical marijuana law had about 1,700 fewer opioid painkiller overdose deaths in 2010 than would be expected based on trends before the laws were passed," said the study's lead author, Dr. Marcus Bachhuber of the Philadelphia Veterans Affairs Medical Center and the University of Pennsylvania, in a news release.

The study, which was published Monday in the journal JAMA Internal Medicine, does not indicate that patients with access to medical marijuana aren't using prescription painkillers, but rather that they may be using them less frequently, which could lower risk for overdose.

Prior to 1999, medical marijuana became legal in California, Oregon and Washington states, with another 10 states legalizing use in the decade that followed. There are currently 23 states in the U.S. where medical marijuana is legal.

But while some lawmakers remain wary of passing laws that ease restrictions on marijuana, the rates of overdose from prescription painkillers continue to skyrocket. Earlier this month, an investigation conducted by Consumer Reports found prescriptions written by doctors for addictive opioid painkillers like OxyContin, Percocet and Vicodin have increased by 300 percent in the last decade. In addition, deaths from overdose are up 400 percent since 1999.

Doctors who prescribe marijuana do so in order to help patients manage pain and discomfort from conditions such as cancer and multiple sclerosis because they say the drug is less addictive than prescription painkillers. But opponents argue that regular marijuana use can be equally dangerous to narcotics. Currently, cannabis is classified under the federal Controlled Substances Act as a Schedule I drug, the strictest classification, along with heroin and LSD.

ACLU OF WASHINGTON APPLAUDS SUPREME COURT DECISION UPHOLDING RIGHTS OF MEDICAL MARIJUANA PATIENTS

Sep 19, 2013

Olympia, WA

The ACLU of Washington hailed a decision by the Washington Supreme Court today recognizing the right of medical marijuana patients to raise a medical necessity defense in court. The ACLU-WA filed a friend-of-the-court brief in the case (*State v. Kurtz*) saying that the state's Medical Use of Marijuana Act did not supersede the common law medical necessity defense, and that medical marijuana patients should be able to cite both medical necessity and state law in defending themselves. A medical necessity defense is available to someone who has violated a law, but was justified in doing so because the harm being avoided is greater than the harm of violating the law.

"This ruling is an important victory for the rights of medical marijuana patients in Washington. It recognizes that the voters, lawmakers, and the courts have determined that there are legitimate medical uses for marijuana and that patients should be able to exercise their rights as needed," said Mark Cooke, ACLU of Washington Policy Counsel.

In 2010, William Kurtz was charged with manufacturing and possession of marijuana. At the trial court, Mr. Kurtz attempted to raise both a statutory defense via the state's Medical Use of Marijuana Act, as well as the longstanding common law medical necessity defense. The trial court did not allow either of these defenses to be presented, and Mr. Kurtz was found guilty.

In ruling in Mr. Kurtz's favor today, the court found that he should have been able to present evidence to support a medical necessity defense. Further, that although the Medical Use of Marijuana Act and the common law medical necessity defense at times overlap, there was never intent by the legislature to invalidate the common law and to find otherwise would "undermine the legislature's humanitarian goals."

The ACLU-WA's friend-of-the-court brief was written by cooperating attorney Shawn J. Larsen-Bright of Dorsey Whitney LLP and ACLU-WA Legal Director Sarah Dunne and Policy Counsel Mark Cooke.

After California decriminalized marijuana, teen arrest, overdose and dropout rates fell

WASHINGTON POST **Oct 2014**

By Christopher Ingraham

A new report from the Center on Juvenile and Criminal Justice adds to the growing body of evidence that legalizing or decriminalizing marijuana does not lead to any number of doomsday scenarios envisioned by legalization opponents. Looking specifically at California, where full marijuana decriminalization went into effect on Jan. 1, 2011, the report finds that "marijuana decriminalization in California has not resulted in harmful consequences for teenagers, such as increased crime, drug overdose, driving under the influence, or school dropout. In fact, California teenagers showed improvements in all risk areas after reform."

Table 1. California's marijuana reform was followed by improvements in 15-19 year-olds' risk indexes, both absolutely and compared to teenagers elsewhere in the country

Index		Year before (2010)	Year after (2011)	2 years after (2012)	Change
Violent Deaths	California	28.5	27.4	24.7	**-4%**
	Rest of US	38.3	37.9	N/A	**-1%**
Drug Overdose Deaths	California	3.0	2.4	2.3	**-20%**
	Rest of US	3.9	4.0	N/A	**4%**
Suicide	California	5.3	5.8	4.6	**9%**
	Rest of US	7.8	8.7	N/A	**11%**
Criminal Arrest	California	9,505.3	7,712.0	6,612.2	**-30%**
	Rest of US	14,711.1	13,572.8	11,908.0	**-19%**
Drug arrests*	California	718.4	593.8	551.6	**-23%**
	Rest of US	2,013.7	1,794.0	1,734.4	**-14%**
Property crime arrests	California	2,272.1	1,996.1	1,708.0	**-25%**
	Rest of US	3,229.1	3,045.4	2,784.4	**-14%**
DWI, marijuana**	California	0.289	0.240	0.282	**-3%**
	Rest of US	0.119	0.131	0.129	**+9%**
School dropout rate	California	14.7%	13.1%	11.4%	**-22%**
	Rest of US	N/A	N/A	N/A	

Notes: Death and crime rates are per 100,000 population age 15-19. Change is 2011 versus 2010 for mortality measures, and 2012 versus 2010 for arrest and DWI measures. School dropout is those failing to graduate on time as a percent of all eligible students. DWI marijuana is the proportion of fatal accidents involving a driver under age 20 in which marijuana is found by test. Vital statistics are not available nationally for 2012, nor are comparable school dropout rates. Different measures may account for differences in California and national numbers. Sources: Centers for Disease Control (2014); California Department of Public Health (2014); Criminal Justice Statistics Center (2013); Federal Bureau of Investigation (2013); National Highway Traffic Safety Administration (2014); California Department of Education (2014). *Excluding marijuana possession arrests in California. **California drug-tests a substantially greater proportion of drivers than other states and therefore finds more drug involvement. The measure used here maximizes marijuana presence by treating multiple drug tests a separate when in fact they probably include testing the same drivers more than once.

Center on Juvenile and Criminal Justice

Most notable in the above table is the drop in school dropout rates. Recent studies have suggested links between heavy marijuana use and low school completion rates. But many experts question the direction of causality in this relationship, suggesting that there could be any number of confounding factors that account for this relationship. While it's still early

in California's decriminalization experiment, the numbers above should suggest we cast a skeptical eye on claims of plummeting academic achievement in a post-legalization world.

In fact, as the report authors write: "By a variety of measures, California's teenage behaviors actually improved dramatically after marijuana was effectively legalized — improvements that occurred more weakly or not at all among older Californians and among teenagers nationwide."

Now of course this doesn't address causality, and these numbers shouldn't be taken to imply that decriminalization *caused* these declines. But they do show, pretty clearly, that in the two years since full-scale decriminalization went into effect, California's kids are still all right. The sky hasn't fallen. And they add to a mounting body of research that shows, for instance:

- that teen drug and alcohol use continues to fall, even as more states decriminalize marijuana and make it available for medical purposes;
- that states with medical marijuana laws haven't seen any uptick in teen marijuana use;
- that states with medical marijuana have actually seen decreases in prescription drug overdoses;
- that Alaska, where personal marijuana use has been *de facto* legalized for nearly 40 years, is completely average on a variety of economic and demographic indicators;
- and that traffic fatalities have fallen in Colorado since legalization there.

By contrast, there is little evidence of increased social harms in states where marijuana has been decriminalized. The one credible study I'm aware of is a DEA report finding that more Colorado drivers involved in car crashes are testing positive for marijuana use. But a bucket of salt is needed here: unlike alcohol, inactive marijuana metabolites remain in the body long after consumption - days or weeks, depending on frequency of use. But the presence of metabolites doesn't necessarily indicate you were high at the time of the test - only that you got high some time in the days or weeks prior.

Even if we accept that more Coloradans are using marijuana, and that some of them are getting behind the wheel while stoned, we still have to note that traffic fatalities are down overall - this is likely because it's far less dangerous to drive stoned than it is to drive drunk. This would suggest that some Coloradans are using marijuana in place of alcohol, rather than in addition to it.

In short, the barrier of proof facing legalization opponents is incredibly high. In order to present a compelling case against marijuana liberalization, they have to demonstrate A) that liberalization is associated with a negative outcome; B) that that association is indeed causal, not just coincidental; and C) that the harms from that negative outcome are greater than the myriad harms caused by blanket prohibition of marijuana. But so far, state experiments with liberalization have not produced any consequences that pass even that first test. Considering that we're now close to 20 years out from when California voters first legalized medical marijuana, this should be reassuring news for everyone.

LONG BEACH MEDICAL MARIJUANA TASK FORCE

POB 15027
Long Beach, CA 90815

Dear Mayor Robert Garcia and Honorable City Councilmembers October 2014

RE: **LB MEDICAL MARIJUANA (MMj) ORDINANCE DRAFT**

What has been proven in numerous studies and anecdotal evidence is that cannabis/marijuana does have medicinal value and has helped many citizens across the world with various maladies, disabilities and pain. The biggest concern before us is how to reasonably and compassionately distribute this medicine to those who need it. As presented in the recent People v **Baniani** California Court of Appeals case (G04835), **"It would be cruel for those whose need for medical marijuana is the most dire to require that they devote their limited strength and efforts to the actual cultivation of the marijuana, and then wait months for it to grow so they can use it....."** In People v Urziceanu (CA App.4th), the court noted the Medical Marijuana Program Act (MMPA) was the Legislature's initial response to the CUA's (Compassionate Use Act – Prop 215) call to provide a plan "for the *safe and affordable distribution* of marijuana to all patients in medical need of marijuana....."

I personally experienced the painful, **prolonged deaths** of both my mother and other family members from cancer. It's not a pretty picture. At that time, cannabis was sadly not allowed as medicine. It is now, and we should do everything we can to alleviate the needless suffering in this world. We must never forget that a patient could be your mother, your sister, your friend or your child. While "abuse" does happen, we don't deprive cancer patients of pain meds because others abuse it. (Prescription drugs are the most abused drug group in the nation.)

The **people of Long Beach** voted for the 1996 Prop 215 Compassionate Use Act, Proposition 19 (full legalization) and LB Prop A MMj tax measure. The citizens of this fair City have spoken. Mirroring this sentiment, 60% of the entire nation wants legalization. And, as people become more informed and enlightened, that number continues to increase.

The **City Attorney (CA) proposed Ordinance** for Medical Marijuana collectives was written with little concern/compassion for sick patients and people with disabilities who rely on cannabis for their maladies and pain. This CA draft is little more than a punitive, miserably failed 5.87 ordinance (2010) on steroids. It blatantly throws "due process" out the window, repeatedly insults the United States Constitution, and shamelessly disregards the rights of patients. Fraught with litigation landmines (5.87 earned over 30 lawsuits), it promotes a biased agenda and deprives equal access those who do need it. By creating a non-workable ordinance, it only serves as a quasi-ban without actually calling it so.

The following is an **in-depth analysis** of the 9-11-14 version of the proposed City MMj ordinance (**A copy is attached herein.**) Page and line #s correlate accordingly. This was presented to the Planning Commission at the 9-18-14 meeting. Changes made on subsequent versions are minimal and not as consequential. While this is not a complete list, it highlights some of the numerous stand-out problems with this draft.

By requiring that every dispensary obtain a **conditional use permit (CUP)**, the new ordinance appears to have the same flaw that the Appellate court disapproved of in the Pack Case (Pack v Superior Court - City of Long Beach 2011). The City determines which collectives are permissible and those that are not. It then collects fees as a

condition of continued operation by the permitted collectives. A CUP would be construed to be tantamount to approval and is preempted by federal law. A business-license model that is revenue neutral would satisfy the Pack decision. (Nothing intended to condone p 2-11, p 9-16 & throughout)

A CUP becomes void if the business is closed more than five days—totally unreasonable. What if they close during the holidays or for renovation or for a myriad of other reasons? Collectives should be given ample time to "cure" any problems that might exist. (**Closure after five days** p 10-4)

For a CUP, it is required that the owner obtain **insurance** before being approved—putting the cart before the horse. (Insurance required p 14-7, 14-13)

Severely **limiting amounts that individuals can produce** contradicts the state MMPA provisions. Additionally, this ordinance would force individuals growing/possessing more than six mature plants, 12 immature plants and/or 8 oz of a useable form of marijuana to be governed by this ordinance—again contradicting the state MMPA law. While the MMPA uses these numerical guidelines as a general rule, in recognition of the fact that the regulations are inadequate for many very ill patients, SB 420 allows patients to be exempted from them if they obtain a physician's statement that they need more. In deference to local autonomy, SB 420 also allows counties and cities to establish **higher but not lower guidelines** if they so choose. Strictly speaking, the guidelines do not constitute hard and fast limits on how much patients may legally have. This is because Prop 215 specifically allows patients whatever amount of marijuana they need for their own medical use..... (MMj Business definition p 6-14) (Individual production of MMJ p 6-26, p 7-3)

> Qualified patients claiming protection under Proposition 215 may possess an amount of marijuana that is "reasonably related to [their] current medical needs." (*People v. Trippet* (1997) Cal.App.4th)

According to California **Attorney General Kamala Harris** in a Dec 2011 letter to the California Legislature, "In simple terms, this means that the core right of qualified patients to cultivate and possess marijuana cannot be abridged." and "……the Pack decision suggests that if the State goes too far in regulating medical marijuana enterprises....the law might be preempted by the Controlled Substances Act." She ends her letter, "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."

In a second letter RE: Medical Marijuana Guidelines, Harris writes, "One point is certain—California law places a premium on **patients' rights to access marijuana** for medical use."

Allowing for non-regulated collectives of up to **ten people** would lessen any impact of storefronts, allow for patient groups to associate for mutual benefit, and keep costs down for many who cannot afford dispensary "prices." Otherwise, a family of four or five growing medicine for their cancer-ridden mother or child could be arrested and penalized. What about a group of Veterans or AIDS patients who want to have a coop? (MMj Business means p 6-14) (Individual production of MMJ p 6-26, p 7-3)

The "**point system"** is extremely problematic. It is clearly is over-reaching, over regulating and indeterminate. Points could be levied against the dispensaries for potential workers with even the most inconsequential misdemeanors without regard to gravity of the "crime." Additionally, the most severe felony (murder/rape) is given the same weight as a simple misdemeanor (stealing a loaf of bread). Since approximately 25% of our population has been in jail at some time, this could eliminate one quarter of citizens able to work at a dispensary. Suppose an 18-year-old garners a misdemeanor for drinking in public or mere possession of a small amount of marijuana—is he/she supposed to wear a scarlet letter for the remainder of their life? (Business managers/owners p 13-23, 13-26) (Criminal history p 22-19 thru 23-19)

The collective operators and employees/volunteers are held to **higher standards than the police**, police explorers and other people who carry guns and enforce the law. (For marijuana use, LBPD has a two-year look-back period. On employment advertisements, only felonies are mentioned to disqualify an applicant.) Additionally, convictions can be appealed and overturned. Even the U.S. President (who has used marijuana) is recognizing that people

need to be pardoned for lower-level crimes so that they can be allowed to work. Is this City now taking on the job of omnipotent judge and jury? While a point system might work, this one desperately needs to be reviewed and re-vamped. (Business managers/owners p 13-23, 13-26) (Criminal history p 22-19 thru 23-19)

And, speaking of presidents—at the very least, the first two and last three **U.S. Presidents** used marijuana and would be considered criminals under current laws. Essentially, they could run the entire country but not one of the dispensaries. Even recently resigned Attorney General Eric Holder used it too. Just saying.....

In essence, this City ordinance asks dispensary operators to break **fair employment laws**. California employers cannot ask applicants about a prior arrest that did not lead to conviction, nor may they ask about an applicant's referral to or participation in a pretrial or post-trial diversion program. Employers also may not seek or use records relating to these arrests. California also prohibits employers from asking about convictions that have been sealed, expunged, or statutorily eradicated. **Employers also may not ask about certain older marijuana offenses.**

Federal protections for employment applicants: Title VII of the Civil Rights Act of 1964 protects applicants and employees from discrimination in every aspect of employment, including screening practices and hiring. Because arrest and incarceration rates are so much higher for African Americans and Latinos, an employer that adopts a blanket policy of excluding all applicants with a criminal record might be guilty of race discrimination.

The Equal Employment Opportunity Commission (EEOC) has issued guidance explaining how employers can screen out applicants whose **criminal records** pose an unreasonable risk without engaging in discrimination. In deciding whether a particular offense should be disqualifying, employers must consider: (a) the nature and gravity of the criminal offense or conduct (b) how much time has passed since the offense or sentence, and (c) the nature of the job (including where it is performed, how much supervision and interaction with others the employee will have, and so on).

A few more affirmative ideas on the **point system**—positive points could be given for hiring a veteran or someone with a disability. Community service should be defined with more points given for additional altruistic activity. A plan for giving free or low-cost medicine to those who cannot afford it could be given extra points. (Community service p 23-20)

p.s. The mention of **"moral turpitude"** is so vague that even the courts have not found an exacting definition. As "possession for sale of controlled substances" has been listed under this premise, everyone who has or will be involved with a dispensary could be considered censurable. (p 19-8)

The definition of "**narcotics**" usually includes marijuana. So, in this draft, mere possession could be grounds to disqualify an applicant—no matter when it happened. (p 23-5)

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

Regulatory compliance history gives little consideration for previous applicants who had spent large sums of money adhering to regulations and were compliant before the City dramatically changed the 5.87 Ordinance. (p 23-7 thru 23-19)

There should be some sort of **"grandfather" clause** that allows established collectives to continue operating if the Council changes zoning or other location issues in the future. When people put their life savings into a collective, they shouldn't lose everything because of political whims. Also, if a collective is established and a prohibited entity (schools, etc) opens near it, the collective should be allowed to operate in the same location without penalty.

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

Equal Access/Buffer zones: Another issue is that other concerned entities have also been ignored. One of the concerns shared by the three main groups—patients, collectives and neighborhoods—is the restriction of locations that will generally force facilities into the westside of Long Beach. Lifting the park and commercial corridor bans will greatly facilitate a more equitable distribution, reduce impact and create a safer access for patients and disabled persons. At the very least, only the larger **named** parks should have a buffer. Buffering all "**parkland**" is regulatory overkill. Parkland is abundant in this City and includes medians, beaches, mini-park areas, etc. As a prime example, one business was closed because it was too close to a water pump station deemed parkland. Areas adjacent beaches should be excluded from this restriction. (Buffer zones p 24-10)

The California state requirement is that dispensaries be located no less than 600 feet from **schools**—this is adequate and will free up other potential locations. 1000 feet is more than adequate; and 1500 feet is excessive and severely impairs equal access across the city. May I remind you that liquor stores (that sell far more harmful substances like tobacco and alcohol) only need a 500 foot buffer. Interestingly, numerous studies have shown that **adolescent use goes down** when marijuana is decriminalized/legalized. (Buffer zones p 24-10)

The Council also directed CA Parkin to (address) [7] development of a mechanism accommodation of **previously vetted marijuana dispensaries**. Not only has this been undermined, but rather they have penalized former collectives that have already lost so much. Additionally, the City changed course midstream several times on this issue and many dispensaries were caught in the crossfire. They would have been considered in violation of laws and ineligible at this time. Also, this draft discounts people who might have ANY criminal complaints—whatever happened to the premise that one is innocent until proven guilty? (Unlawful ownership p 19-13) (Point system, p 22-20 thru 23-19)

Equal access is denied to those with disabilities under the current restrictions. It also impacts some districts far more and makes access much more difficult in other districts. Limiting to industrial areas and certain CHW Districts could hamper transportation and endanger those with limited mobility. Additionally, there is no logical reason to **restrict growing to the City of Long Beach**. There are many reasons to allow growers outside of the City to furnish MMj—diversity of strains targeting various ailments that would best suit patient needs, reduction in vital electricity, water and other utility usage, healthier plants outdoors, reduced probability of criminal activity that put growers at greater risk, decrease crop failure, availability of facilities--larger warehouses and land are not abundant in LB, etc. (Location p 20-16 thru 21-1) (Cultivation in City p 28-4)

The Ordinance is so restrictive that it will not allow for **equal access** to patients in all districts—this flies in the face of the ADA and the CA State disability laws. And, although MMj is not currently considered in those laws, the spirit of those laws clearly champions persons with disabilities to have the right to full and equal access to public facilities. To meet this challenge, the Long Beach MMj accessible areas should include commercial, mixed and industrial zoning.

In having **excessive restrictions**, the City is defeating its own purpose in considering people with disabilities. If cooperatives are not allowed where citizens have reasonable access through public transportation, many (especially those in wheel chairs) will not be able to access the medicine they need. Additionally, **patient safety** may be at issue in limiting collectives mainly to industrial areas. Industrial zones are typically dark, devoid of pedestrian traffic and have limited access to public transportation. This could easily put patients with mobility issues at great risk.

Allowing **three to four dispensaries** per district would facilitate accessibility and lessen the impact on any given district or neighborhood. When the City is limited to only a few collectives, it actually creates a nuisance situation—too many people who need the medicine are forced onto fewer locations. This fosters traffic and parking problems and concerns about any heavily-impacted entity. In turn, the police will say that the collective is a "nuisance." It becomes a self-fulfilling prophecy. (Location per council district p 20-25, p 21-1)

Patients who work in these dispensaries may need to consume medicine. They may suffer from seizures or other maladies that necessitate regular doses of medication—just like pharmaceuticals. They should be able to medicate in a designated area away from the public. Note that they are allowed legal prescriptions or other medications. (Onsite prohibition p 25-11) (Prohibited acts p 43-1 thru 43-3)

Security guard: Requirement of an armed guard—not necessary. Conveys the wrong message. All storefronts must have adequate **parking**. Their security guard should regularly check surrounding areas—within a block radius of the collective. (Security guard p 40-6)

Prohibited Acts: Cultivate, distribute, **possess**, or produce marijuana in plain view of, or in a place open to the public. This rule is overly broad, and would forbid a patient from carrying their medicine across a street, on a bus, or anywhere there is public access—even on their own property if they were in "plain view." With this provision, the patient would be violating the law the minute they walked out of the dispensary. (Prohibited Acts p 42-27)

Stipulation not allowing operation of a MMj business **"under the influence of MMJ"**. How is that defined? Traces of cannabis can be found for up to 30 days after consumption. What about prescription drugs? Should all people not be allowed to work if they consume drugs of any kind—including coffee, over-the-counter cold meds, Vicodin, etc etc.? Most workers or volunteers are MMj patients who may be medicating with this herb. And, "under the influence" has not been readily defined as studies in the U.S. have been severely curtailed by the Federal government. (Prohibited Acts p 43-8)

Possession of MMj not in a sealed package—many situations could come up whereby a person is carrying a package that is not sealed. Again, over-reaching, over-regulation. There is no stipulation in the MMPA that MMj must be consumed at the person's residence or that a patient cannot transport medicine that is not sealed. (Prohibited acts p 43-12)

According to the California Attorney General Guidelines in 2008, "Courts have found an implied defense to the **transportation** of medical marijuana when the "quantity transported and the method, timing and distance ofthe transportation are reasonably related to the patient's current medical needs." (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1551.)

Obtain MMj other than MMj business—what if a person belongs to a co-op/collective? What if they get it from their caregiver? (Prohibited acts p 43-23)

Prohibition of delivery or transport to a patient—what about a caregiver? What if the patient is severely disabled and is not mobile? What happened to equal access as prescribed by the ADA and State laws? Even pharmacies can deliver prescriptions and over-the-counter meds. Transportation of Medical Cannabis is legal under state law (per People v. Urziceanu (2005) 132 Cal.App.4th 747,785). (Prohibited acts p 44-2)

Police calls—report numbers of ALL calls to the business. Not all calls may be revealed to the business. (p 46-4)

Hours of operation should be between 9 am and 9 pm to facilitate people who have jobs. (p 26-11)

Limitations on inventory: The MMj business shall not maintain any more mj than the amount stated on the business' permit application to the City. How would you know how many sick patients you will be helping ahead of time? How much MMj a collective maintains should correlate with the needs of the patient, not some arbitrary amount decided before they even have patients. And, as with any business, that amount will fluctuate accordingly. (Limitations on inventory p 27-1)

Not all patients can "smoke" the medicine and must rely on **edibles, oils or other forms of medicine**. Edibles are created with concentrates which are allowable within the Attorney General Guidelines. This is denied per policy created by the CA's office. There are safe methods of extracting the medicine from the plant and/or it can be brought in from other sources. (Edibles and extractions p 31-23, 31-27)

In a later section, it describes testing for **edibles**, storage and labeling—is it OK or not???? (Testing p 33-27) (Storage p 39-23) (MMj infused products p 40-13 thru 41-12)

Does any other business require **City residency**? Liquor stores? Pharmacies? This is a ridiculously unnecessary and cumbersome requirement. (City residency p 27-10)

According to the draft, "No MMj business shall operate for **profit**." This needs to be explicitly defined. (p32-7)

Screening immature plants is not rocket science and does not require a degree. This is another prime example of over-reaching, over-restricting and over-regulating. It only serves to drive up costs and make it difficult for patients to afford. The Health Department could be tasked with doing periodic inspections as they do for restaurants. (p34-16)

Reporting requirements are regulatory overkill and could well be considered self-incriminating, thus violating the 5th Amendment. The government cannot force someone to incriminate themselves. The City may be considered co-conspirators. (p27-26, 27-28)

What is the need and the purpose for a collective to be required to violate the **HIPPA and 4th Amendment Rights** of it's members? The draft **repeatedly** states that **all** records must be available for City inspection, "including information about patients and caregivers." In only one section of these demands does it say that confidential info may be submitted in a manner that maintains confidentiality. (Records p 36-9 thru 36-15) (Disclosure of records p 36-22) (Audits p 37-11) (Consent p 37-18 thru 37-22) (Without search warrant p 38-2 thru 38-6) (Reporting sales—without limitation p 38-9 thru 38-15) (Surveillance cameras p 39-10 thru 39-18)

Possible solution: Each patient and/or caregiver could be assigned a number by the collective, put on the back of their recommendation letter, and used for purposes of inspection. The name, personal data and other identifying info MUST remain confidential.

Additionally, **warrantless searches** are 4th Amendment violations for all concerned and totally disregards **HIPPA protections** and privacy laws for patients. Suppose you or your child needed this medicine; do you want the entire City of LB to know about your personal business? Warrantless searches aka "**raids**" foster bribery and graft, confiscation of property without record, lack of due process, intimidation of patients, and open the door to serious corruption. This also includes 24-hour video access by law enforcement. Even state IDs are voluntary. (Records p 36-9 thru 36-15) (Disclosure of records p 36-22) (Audits p 37-11) (Consent p 37-18 thru 37-22) (Without search warrant p 38-2 thru 38-6) (Reporting sales—without limitation p 38-9 thru 38-15) (Surveillance cameras p 39-10 thru 39-18)

And, have we forgotten that the U.S. Constitution **4th Amendment** still exists:

The **4th Amendment** originally enforced the notion that “each man’s home is his castle”, secure from unreasonable searches and seizures of property by the government. It protects against arbitrary arrests, and is the basis of the law regarding search warrants, stop-and-frisk, safety inspections, wiretaps, and other forms of surveillance, as well as being central to many other criminal law topics and to privacy law.

Reporting sales—requires name, address of grower, seller and purchaser. Again over-regulation which violates **HIPPA laws and 4th Amendment protections**. It puts all involved at risk as a target for crime, corruption, asset forfeiture, policing for profit, DEA raids and possible self-incrimination. Unfortunately, it is still considered a Schedule 1 drug regardless of a mountain of evidence that proves otherwise. Would you want the whole City to know that you were seeing a Psychiatrist? Or needing medicine from one of these clinics? It also speaks to "**wholesale" transactions**—but other sections require cultivation by the entity that distributes it. (Reporting sales p 38-9 thru 38-15, 38-18) (Transportation 29-9) (Cultivation p 5-18)

There is still a conflict between state medical marijuana law and federal law. Under the **5th Amendment** to the Constitution, people cannot be compelled to incriminate themselves.

As an afterthought, the Council directive re a **task force** was added. Rather than help formulate the ordinance as was originally intended, this group has been tasked to a few token directives. It speaks to a mediation process which contrasts an earlier dictate of a "zero tolerance policy." Membership is limited to three from the collectives, three from the neighborhoods, and only ONE patient advocate. What if that one person were sick or absent for any reason? Isn't the reason we are here is for the patients? (MMj Task force p 47-25 thru 48-1) (Zero tolerance p

2-19)

By stating that the ordinance dictates a "**zero tolerance**" policy, does that mean that there is no way for any dispensary can cure even an inadvertent violation of the ordinance. And wouldn't that amount to a "taking" by Long Beach? Whatever happened to "due process?" (Zero tolerance p 2-19)

According to Wikipedia: A **zero**-**tolerance** is a policy of punishing any infraction of a rule, regardless of accidental mistakes, ignorance, or extenuating circumstances.

Vera Institute of Justice says: "Certain facts are clear: zero tolerance does not make schools more orderly or safe—in fact the opposite may be true." Z**ero tolerance** policies helped to create a school-to-prison pipeline.

"A red flag should go up anytime a person in a position of responsibility utters the words 'zero tolerance,' because that means they do not have the confidence to make a decision in their discipline, they do not have the compassion to see differences between situations, and they do not have the administrative or managerial skills to make the kind of decisions that create a thriving institution." Ret Deputy Chief LAPD Stephen Downing

The 4th District CA Court of Appeals (People v Baniani, Aug 2014) The court opined: "….. First, the purpose of the MMPA is to ensure the promise of the CUA is fulfilled and qualified patients have safe access to affordable medical marijuana. **We do not think the Legislature intended a seriously ill individual whose physician has recommended use of medical marijuana, and who is physically or otherwise unable to participate in the acts involved in cultivating medical marijuana, cannot simply pay money to his or her collective in exchange for the recommended medicine…….** Moreover, for some the cultivation and processing would not be completed until it was too late to provide any relief. The MMPA does not anticipate a patient who has received a physician's recommendation must thereafter wait months to lawfully acquire medical marijuana."

Our committee, the **Long Beach Medical Marijuana Task Force**, has been allowed only a few brief token meetings with the City Attorney's office AFTER the draft had been written. Per Council directive on Dec 17, 2013, a task force was supposed to be created to help frame a workable ordinance. The group the CA proposes is too little, too late, and they have "taken" our established task force name without our permission. The menial and meaningless chores this group has been assigned are amusing at best.

In a Signal Hill Tribune article Mar 21, 2014 Parkin believes in drawing a hard line that the role of the City Attorney is **not** to shape policies and agendas, but to act as a nonpartisan advisor. Parkin said, "I am responsible to the mayor and City Council to provide them with neutral legal advice not subject to my legislative priorities or opinions." He continued, "(one of) The three most pressing challenges of the City relating to the Long Beach City Attorney's Office are: • reduce City liability through aggressive risk management"

Despite saying this during his campaign, Parkin is proposing a medical marijuana ordinance that is rife with policies and agendas that were not directed by the City Council. When the last MMj ordinance was in effect, people invested hundreds of thousands of dollars based on their belief the CA had provided an effective law. They spent millions on improvements and permits – all to comply with a law that was not properly drafted. Now, the newest ordinance ordinance is replete with the **same problems** that plagued the original 5.87 law plus many additional concerns.

The City Attorney's office will proclaim that they met with stakeholders throughout the process. Truth be told, our patient group was allowed only two meetings (one hour and 50 minutes total for a 52-page extraordinarily complex document) During the first meeting we were told that **they didn't care** if the City was sued and in the second meeting we were told that nothing would change. Not only were our concerns ignored; but even more egregious and unreasonable restrictions were piled on.....so much for value of community input and consensus.

You will most likely hear from **LBPD Chief McDonnell** who has said numerous things in the past that were **myth based**, not scientifically grounded. His statements mirror **misinformation** published by the California Narcotic Officer's Association, an organization whose life blood depends upon maintaining the drug war status quo. He has cited "problems " with the dispensaries, yet public records requests have shown that there are no records on

calls for service to these entities. Neither are there records regarding calls to banks and liquor/convenience stores which in other studies show a much higher crime rate than dispensaries in other cities. In other scientific studies, it has been shown that with decriminalization/legalization there has been dramatic reduction in violent crimes, overall law-breaking, suicides, drug addiction, alcoholism, traffic deaths, etc. In fact, legitimate studies have shown that when marijuana is legalized/decriminalized, adolescent use, school drop out, crime, arrests, death from opioid and alcohol overdose goes down.

The **LAPD 's Chief of Police** conducted studies and made the results public. He concluded that despite neighborhoood complaints, most medical marijuana clinics are not typically the magnets for crime that critics often portray. He said, "**Banks are more likely to get robbed** than medical marijuana dispensaries." These findings are consistent with those of the Rand Corporation whose study found that crime rates rose in surrounding neighborhoods when dispensaries were shut down. Additionally, a recent research report from UCLA found no relationship between the density of dispensaries and violent or property crime.

In 2009, the LAPD received reports of 71 robberies at more than 350 banks in the city, compared to 47 robberies at more than 800 MMj dispensaries. (Perhaps we should ban the banks instead.)

Chief McDonnell also contends that patients they have observed at the dispensaries were not seriously ill and were not entitled to be patients. Firstly, we don't believe that the requirements for the Police Deparment included a medical certification. It is **illegal to practice medicine without a license**. Seondly, can you please tell me what a cancer patient looks like? What about AIDS, migraines, chronic pain?? These decisions are best left to a patient and their doctor—wouldn't you want the same? Just because one does not see a wheelchair, chemotherapy symptoms such as baldness, and/or seizures/tremors, doesn't mean they are not suffering.

According to the **CUA and MMPA, the medical conditions** that are included are, "Serious medical conditions means all of the following medical conditions: AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms (including but not limited to spasms associated with multiple sclerosis), seizures (including butnot limited to seizures associated with epilepsy), severe nausea, any other chronic or persistent medical symptom that either: (a) substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990. (b) if not alleviated may cause serious harm to the patient's safety or physical or mental health."

Ret Superior Court Judge James Gray said it best when he finished reading the Chief's testimony, "The only real question we should ask ourselves is: do we want the marijuana to be sold by regulated and licensed business people whose product is tested and the sales taxed, or by unlicensed criminals?"

On the subject of the LB Police Department, their "**standard" procedure** of vandalizing, smashing required surveillance cameras to hide their misdeeds, destroying property, confiscating medicine and other property without proper documentation, brutalizing and arresting employees and patients, and other dubious actions need to be curtailed and investigated. Respect for law enforcement is at an all-time low; and this type of activity does nothing positive to help that image.

> 14th Amendment: .....nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

It is the overall sense of our LB Medical Marijuana Task Force that **this MMj Ordinance is destined to fail** on many counts. It presents as a **litigation landmine** which will cost taxpayers large sums of money. The document is full of policies and reflects opinions that are personal to the makers. An unreasonable ordinance will only serve to increase the likelihood of "street dealing", thus lining the pockets of the gangs and cartels. Violence, territorial disputes and other gang activity are just another by-product.

An even larger question that comes to mind is, "who and how" would this be administered? **At what cost** to the taxpayers? Will it be a hotbed of corruption, graft, bribery? Will we need a larger City Attorney Department to handle the lawsuits? How will it impact an already overburdened justice system? One astute Planning Commissioner pointed out that the City would have to designate a whole floor of City Hall for this endeavor.

It is our sincere desire to have an ordinance that is reasonable and workable for all concerned. **We recognize the City Council as the policy-making body of this City** and truly appreciate your compassion and wisdom in this issue.

Our Long Beach Medical Marijuana Task Force has spent a great deal of time and effort creating a MMJ Ordinance that not only has addressed federal preemption concerns (Pack decision), but many other litigious issues as well. You were furnished this draft several months ago and it is attached here as well. We would sincerely appreciate your consideration of our reasonable and workable LB Medical Marijuana Ordinance.

And, considering the sentiments of Long Beach residents, at least 23 states, numerous cities including Philadelphia and Washington DC, this City Council could progressively look at the possibility of **full legalization or decriminalization.**

Acting head of the U.S. Justice Department's **Civil Rights Division** Vanita Gupta wrote, "The solution is clear: Instead of taxpayers spending millions of dollars on this unnecessary enforcement and keeping folks.....in prison for the rest of their lives, states could follow Colorado and Washington by taxing and regulating marijuana and investing saved enforcement dollars in education, substance abuse treatment, and prevention and other health care." (Oct 2014)

At present, the CA draft MMj Ordinance has been considered at the Planning Commission and is being sent back to Council for further direction and deliberation. Numerous documents regarding this issue were sent to the Planning Commission (posted with their agendas) to educate and inform them of current developments. Please feel free to review any and all of these as they will be pertinent to your decision making. You will also find additional information attached. **We would appreciate meeting with you at your convenience prior to this being heard at a Council.** Please feel free to call me at (562) 421-8012 should you have any questions and/or to set up a meeting.

Peace be with you,

Diana Lejins
Advocates for Disability Rights
Chair, Long Beach Medical Marijuana Task Force

* *A genuine leader is not a searcher for consensus but a molder of consensus.* Martin Luther King

* *Better the occasional faults of a Government that lives in a spirit of charity than the constant omission of a Government frozen in the ice of its own indifference.* President Franklin Delano Roosevelt

Abbreviations:

CA	City Attorney
CUA	Proposition 215 – Compassionate Use Activities 1996
CUP	Conditional Use Permit
LB	Long Beach
MMPA	SB 420 - Medical Marijuana Program Act 2004

CERTIFIED FOR PUBLICATION Filed 8/22/14

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT -

Plaintiff and Respondent, v. **BORZOU BANIANI**, G048535 (Super. Ct. No. 10HF1852)

Defendant and Appellant. O P I N I O N

Appeal from a judgment of the Superior Court of Orange County, David A. Hoffer, Judge. Reversed and remanded.

Law Office of Scott C. Thomas and Scott C. Thomas; Law Offices of Glew & Kim, Christopher Glew; for Defendant and Appellant.

Kamala D. Harris, Attorney General, Dane R. Gillette, Chief Assistant Attorney General, Julie L. Garland, Assistant Attorney General, Charles C. Ragland and Kimberley A. Donohue, Deputy Attorneys General, for Plaintiff and Respondent.

Defendant, a founding member of a medical marijuana cooperative, was charged with a sale of marijuana (Health & Saf. Code, §§ 11360, subd. (a); all further undesignated statutory references are to this code) and possession of marijuana for sale (§ 11359). Because we find he was entitled to a defense under the MMPA and the error in precluding the defense was prejudicial, we reverse.

FACTS AND PROCEDURE

A. *Procedural Background*

Defendant was charged in an information with a sale of marijuana on March 23, 2010 (§ 11360, subd. (a); count one) and possession of marijuana for sale on April 7, 2010 (§ 11359; count two). His defense was that he had a physician's recommendation to use medical marijuana, he ran a medical marijuana cooperative in compliance with the MMPA, he was not present on the date of the sale, and the sale was made by a person who did not comply with the protocol of the cooperative. As noted above, the first jury hung six to six on the sales count and nine to three for not guilty on the possession for sale count.

In the second trial, the court held defendant was not entitled to a defense under the MMPA. The second jury was unable to reach a verdict on count one and found defendant guilty on count two, possession of marijuana for sale. The court placed defendant on three years of formal probation and imposed various fines, fees, and conditions. The court expressly authorized defendant's continued use of medical marijuana due to his medical condition. Count one was then dismissed on the People's motion.

B. *Facts*

1. *Prosecution Evidence*

In March 2010, Elijah Hayward worked as an undercover narcotics detective with the Newport Beach Police Department. Using a fake name and driver's license, he visited a physician and obtained a recommendation to use medical marijuana. On March 23, 2010, Hayward went to a two-story business building located on Campus Drive, based on information a marijuana dispensary was located there. He went to an office on the second floor. On the door was a sign that stated, "by appointment only." Hayward knocked and saw someone peek through the blinds. A male in his 20's, with dark hair and an olive complexion answered the door. The male said his name was Sean, and invited Hayward in.1 Sean directed Hayward to a small waiting room and asked for his identification and physician's recommendation, which Hayward then gave him. Sean left and entered another room. After Hayward heard what sounded like a copying machine, Sean reappeared in the waiting room, returned the identification and recommendation to Hayward, and gave him a two-page

membership application for Herbal Run Marijuana Collective (Herbal Run). Hayward signed the application and gave it back to Sean. Sean took the signed membership application back into the same room he had taken Hayward's identification and recommendation.

Defendant identified Sean as Shajad Khalaj, the treasurer of Herbal Run Marijuana Collective.
When Sean returned, he showed Hayward into another room. This one contained a countertop and two refrigerators with clear, glass doors. There were a number of jars of marijuana on display and a dry erase board on the wall. Hayward said the board contained the names of different strains of marijuana and their prices. Hayward told Sean he wanted an eighth of an ounce of one of the strains. Sean weighed it out and Hayward paid him $60. Sean placed the container of marijuana in a bag and gave Hayward a marijuana cigarette and a small brownie, neither of which had Hayward requested.

On April 7, 2010, Officer Brian Mack of the Newport Beach Police Department was dispatched to the same location on Campus Drive based on reports of the smell of burnt marijuana at the location. Mack too smelled burnt marijuana. Mack knocked on the door and the smell of burnt marijuana got stronger when defendant answered the door. Mack explained why he was there and defendant said he had a marijuana recommendation permitting him to smoke marijuana.
Mack entered the office and asked defendant what business was run at the location. Defendant said he operates a property management and real estate investment company, Advantage. He added he also runs a marijuana dispensary in Costa Mesa and he uses the Advantage office as a storage facility.

Defendant unlocked doors to separate rooms, enabling the officers to search those rooms. During the search, officers found, inter alia, 78 pre-rolled marijuana cigarettes, seven lollipops labeled "candy containing marijuana," 24 chocolate bars containing marijuana, 12 plastic packets of salad dressing containing marijuana, a glass jar containing a pound of marijuana, a silver canister containing 16 grams of marijuana, and a plastic bag containing marijuana "shake." The officers also found a white dry erase board listing strains of marijuana and prices for the different strains. Additionally, the police found a three-ring binder containing a ledger of business transactions, and $310.

2. *Defense Evidence*
After the court held the defendant was not entitled to a defense under the MMPA, the defense introduced the following evidence. Defendant had a valid physician's recommendation to use medical marijuana, and a valid state medical marijuana identification card and caregiver license, meaning he could be a caregiver to a patient with a recommendation for marijuana use.

Defendant started a medical marijuana collective, Herbal Run, because he had an uncle who passed away from pancreatic cancer. It was not defendant's intent to sell marijuana, as the collective is a nonprofit entity. Prior to creating the collective, defendant consulted with Attorney Stewart Richlin. Richlin, who also testified, drafted the collective's bylaws, reviewed state laws and the Attorney General's Guidelines with defendant, and filed the nonprofit articles of incorporation for Herbal Run. Additionally, defendant acquired a State of California Board of Equalization seller's permit. His first indoor marijuana "grow" was with three other members of the collective in August 2009. Shortly afterward there were 10 members in the collective. Prior to becoming members the individuals were required to sign membership contracts drafted by Richlin.

Defendant invested money into the various "grows." He was not attempting to and did not make any profit off the "grows." The "grow" that resulted in the marijuana seized in April 2010, was the result of indoor and outdoor "grows." Those "grows" belonged to everyone in the collective, but Steven Sonders and an individual named John were the actual growers.

Defendant described the intake procedure whereby an individual may join the collective. Herbal Run's Web page did not have a street address on it. Neither did its business cards. To join the collective, individuals would call the telephone number on the Web site or business card. A member of Herbal Run would then take down the individual's information, including name, address, identification number, and the recommending physician's name and telephone number. The recommendation would then be confirmed with the recommending physician before an appointment was made for the individual to come into the office. At the appointment, an Herbal Run member would review the bylaws with the individual and find out what the person could contribute to the process. Individuals who refused to contribute were not permitted to join.

In April 2010, Herbal Run had 70 to 75 patients. Defendant asked members to donate either time or money toward the "grow." When asked what activities the members contributed, defendant stated: "Everybody would put together, if they can help with the grow, if they had any experience with the grow, if they can just water the plants or trim or make butter or cook cookies." All the applicants were required to give time to the collective, but those who could not physically contribute to the cultivation of the plants donated money.

Defendant said the three-ring binder seized by the police is a log of the money donations made to Herbal Run. The log notes show whether the person making the donation was from a delivery or from "a walk-in," someone who called first and then made an appointment. The reason prospective members had to make an appointment was because a member needed to be present to process the application and members were not always there. Individuals were not permitted entry without having first made an appointment.

Defendant trained members who handled new patients. He specifically trained them to explain to an applicant the requirement of contributing time and effort. Defendant said he was not present on March 23, 2010, when Sean and Hayward engaged in a transaction. Defendant was visiting his grandmother in Iran. He added the two-page document Hayward said he signed was "not [a] complete document." Defendant said he did not find the two-page document Hayward said he signed. Defendant retained all his "patient" records. There was no record from March 23, 2010, and Sean never told defendant about the transaction. Sean should not have permitted an individual who had not gone through prescreening to enter.

Defendant explained the prices on the dry erase board were for patients who could not contribute their time because they were too sick and who would prefer to pay. The amount was based on the expenses claimed by the growers. Defendant does not keep any money from monetary donations; that goes to the collective's growers to reimburse them for their costs. Defendant said he did not believe the growers were making a profit and he never attempted to make a profit.

Other members of Herbal Run testified about the requirements for obtaining medical marijuana from Herbal Run. Each testified to donating time or experience in exchange for medical marijuana.

DISCUSSION

Prior to the second trial, the prosecutor brought an Evidence Code section 402 motion to preclude defendant from asserting a defense under the MMPA. The defendant argued he did nothing illegal because he was a qualified patient whose physician recommended his use of medical marijuana, he formed a medical marijuana collective, Herbal Run, and operated the collective in compliance with the MMPA and the Attorney General's Guidelines. Specifically, he claimed his actions were protected under section 11362.775 of the MMPA and that section 11362.775 does not preclude the exchange of money for medical marijuana when the money is used to cover the costs of cultivation. The district attorney

argued sales are not protected by the MMPA. He also asserted the MMPA did not apply because Herbal Run was a for profit organization. The court held defendant was not entitled to the benefit of the defense because there was evidence he charged for the marijuana. Consequently, defendant was precluded from presenting evidence on the defense and the jury was not instructed on it. Defendant claims the court prejudicially erred. We agree.

A. *Standard of Review*

"'It is well settled that a defendant has a right to have the trial court . . . give a jury instruction on any affirmative defense for which the record contains substantial evidence [citation]—evidence sufficient for a reasonable jury to find in favor of the defendant [citation]—unless the defense is inconsistent with the defendant's theory of the case [citation]. In determining whether the evidence is sufficient to warrant a jury instruction, the trial court does not determine the credibility of the defense evidence, but only whether "there was evidence which, if believed by the jury, was sufficient to raise a reasonable doubt . . . ." [Citations.]' [Citations.]" (*People v. Mentch* (2008) 45 Cal.4th 274, 288.) Specifically in cases raising the issue of whether a defendant is entitled to a defense under the Compassionate Use Act (CUA) or MMPA, the defenses "relate directly to the nature of the defendant's conduct as opposed to a collateral matters." (*People v. Jackson* (2012) 210 Cal.App.4th 525, 533.) Consequently, "those defenses only require that a defendant raise a reasonable doubt as to whether the elements of the defenses have been proven." (*Ibid*.) When the trial court addresses this issue, it does not consider the credibility of the witnesses. That issue is left to the jury to decide. (*Ibid*.; *People v. Villanueva* (2008) 169 Cal.App.4th 41, 49.)

B. *Background: The CUA, MMPA, and the Attorney General's Guidelines*

In November 1996, the electorate enacted section 11362.5 as part of Proposition 215. The CUA was enacted "[t]o ensure seriously ill Californians have the right to obtain and use medical marijuana for medical purposes," when their use of medical marijuana has been recommended by a physician in the treatment for illness. (§ 11362.5, subd. (b)(1)(A).) The electorate enacted the CUA to ensure such patients and their primary caregivers2 are not subject to criminal prosecution for obtaining and using marijuana for medical purposes. (§ 11362.5, subd. (b)(1)(B).) To that end, subdivision (d) of section 11362.5, provides that section 11357 [prohibiting possession of marijuana]

The CUA defines a primary caregiver as "the individual designated by the person exempted under this section who has consistently assumed responsibility for the housing, health, and safety of that person." (§ 11362.5, subd. (e).) and section 11358 [prohibiting cultivation of marijuana] do not apply to a primary caregiver or a qualified patient. "Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician." (§ 11362.5, subd. (d).)

In addition to assuring qualified patients have access to medical marijuana, the CUA was intended "[t]o 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." (§ 11362.5, subd. (b)(1)(C).) On the whole, "the [CUA] is a narrowly drafted statute designed to allow a qualified patient and his or her primary caregiver to possess and cultivate marijuana for the patient's personal use despite the penal laws that outlaw these two acts for all others." (*People v. Urziceanu* (2005) 132 Cal.App.4th 747, 772-773.)

While the CUA expressly refers to sections 11357 and 11358 (§ 11362.5, subd. (d)), at least one court has found the CUA also provides, in appropriate cases, an implied defense to a charge of transporting marijuana (§ 11360, subd. (a)). *People v. Trippet* (1997) 56 Cal.App.4th 1532, involved an appeal from convictions for possession of more than 28.5 grams of marijuana (§ 11357, subd. (c)) and transportation of marijuana (§ 11360, subd. (a)) prior to Proposition 215's passage and enactment of the CUA (§ 11362.5). The defendant had attempted to use a medical necessity defense and presented

the testimony of her physician. With the Attorney General's agreement, the appellate court found the CUA could be applied retroactively. (*People v. Trippet*, *supra*, 56 Cal.App.4th at pp. 1544-1545.) More pertinent to the issue presented in the present case, the court had to determine whether the CUA provided a possible defense to the charge of transporting marijuana.

The appellate court noted the CUA provided a defense to two specific sections pertaining to marijuana—section 11357 [possession of marijuana] and 11358 [cultivation of marijuana] (*People v. Trippet*, *supra*, 56 Cal.App.4th at pp. 1543-1544)—and the CUA was not intended to make wholesale changes to the criminal law relating to existing marijuana prohibitions (*id*. at p. 1546). That being said, the court noted a limited defense to a charge of transporting marijuana necessarily exists under the CUA, notwithstanding the fact that section 11362.5 does not list section 11360 as a statute that does not apply to qualified patients and caregivers. The Attorney General conceded as much. (*People v. Trippet*, *supra*, 56 Cal.App.4th at p. 1550.) **"[T]he voters could not have intended that a dying cancer patient's 'primary caregiver' could be subject to criminal sanctions for carrying otherwise legally cultivated and possessed marijuana down a hallway to the patient's room."** (*Ibid*.; see *People v. Emmal* (1998) 68 Cal.App.4th 1313, 1315 [transporation conviction upheld where drug was moved 20 feet]; see also *People v. Ormiston* (2003) 105 Cal.App.4th 676, 683 [transportation conviction upheld where defendant walked while in possession of drug].)

In 2003, the Legislature found qualified patients and their caregivers had been prevented from obtaining the protections intended by the CUA (Stats. 2003, ch. 875, § 1, subd. (a)(2)), and responded by enacting the MMPA (§ 11362.7 et. seq.) which became effective on January 1, 2004. The MMPA added "18 new code sections that address the general subject matter covered by the CUA." (*People v. Kelly* (2010) 47 Cal.4th 1008, 1014.) Included therein were sections providing for the issuance of identification cards for qualified patients (§ 11362.71 — 11362.755), a section setting forth the amount a marijuana that may be possessed by qualified patients (§ 11362.77), a section listing places where the use of medical marijuana is prohibited (§ 11362.79), and a section urging Regents of the University of California to create the California Medical Marijuana Research Program (§ 11362.9). **Relevant to the issue at hand, the MMPA also permits qualified patients and their designated primary caregivers to join together "in order collectively or cooperatively to cultivate marijuana for medical purposes" without being subject to "state criminal sanctions** under Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570." (§ 11362.775.) The MMPA has expanded the scope of protection beyond that initially provided by the CUA, which was limited to cultivation of and possession of medical marijuana. (*People v. Urziceanu*, *supra*, 132 Cal.App.4th at p. 784.)

In 2010, the Legislature added section 11362.768 to the MMPA. (Stats. 2010, ch. 603, § 1.) **This section implicitly recognizes the lawfulness of a "marijuana cooperative, collective, dispensary, operator, establishment or provider who possesses, cultivates, or distributes medical marijuana pursuant to" the MMPA, but prohibits such entities from operating "within a 600-foot radius of a school."** (§ 11362.768, subd. (b).) **"This section shall apply only to a medical marijuana cooperative, collective, dispensary, operator, establishment, or provider that is authorized by law to possess, cultivate, or distribute medical marijuana and that has a storefront or mobile retail outlet which ordinarily requires a local business license."** (§ 11362.768, subd. (e).)

In 2008, before the enactment of section 11362.768 and pursuant to the requirement set forth in section 11362.81,3 the Attorney General issued Guidelines concerning marijuana grown of medical use. (Cal. Atty. Gen., Guidelines for the Security and Non-diversion of Marijuana Grown for Medical Use (Aug. 2008) <http://ag.ca.gov/cms_attachments/press/pdfs/n1601_medicalmarijuanaguidelines.pdf> [as of Aug. 15, 2014] (Guidelines).) The Guidelines noted the California State Board of Equalization (BOE) filed a notice that it would issue seller's permit to tax medical marijuana transactions. Possession of a seller's permit would not, however, permit *unlawful* sales of marijuana. (Guidelines, § I.D., pp. 2-3) The BOE Special Notice

"[T]he Attorney General shall develop and adopt appropriate guidelines to ensure the security and nondiversion of marijuana grown for medical use by patients qualified under the Compassionate Use Act of 1996." (§ 11362.81, subd. (d).) Information on Sales Tax and Registration for Medical Marijuana Sellers stated even those who do not make a profit from selling medical marijuana, must pay taxes on the sales. (BOE, Special Notice (June 2007), p. 2 <http://www.boe.ca.gov/news/pdf/173.
pdf> [as of Aug. 15, 2014].) The guidelines note medical marijuana cooperatives and collectives are not authorized to make a profit from the sale or distribution of medical marijuana. (Guidelines, § IV.B.1, p. 9.)

The Guidelines also provide guidance to groups acting collectively or cooperatively in "cultivating and distributing marijuana for medical purposes." (Guidelines, § IV.A., p. 8.) Cooperatives must file articles of incorporation and cannot be organized to make a profit for themselves. (Guidelines, § IV.A.1, p. 8, citing Corp. Code, §§ 12201, 12300, 12311, subd. (b).) The guidelines further state cooperatives should not "sell" medical marijuana to "non-members." (Guidelines, § IV.A.2, p. 8.) However, **the guidelines provide medical marijuana may be provided for free to qualified patients and caregivers; and may be provided in exchange for services rendered**, "[a]llocated based on *fees that are reasonably calculated to cover overhead costs and operating expenses*," or a combination of services and fees. (Guidelines, § IV.B.6, p. 10, italics added.)

C. *Defendant was Entitled to a Defense Under the MMPA.*
The prosecution relied primarily on *People v. Mentch*, *supra*, 45 Cal.4th 274, and *People ex rel. Trutanich v. Joseph* (2012) 204 Cal.App.4th 1512 for the proposition that defendant was not entitled to a defense under the MMPA. In *People v. Mentch*, the defendant was charged with cultivating marijuana (§ 11358) and possessing marijuana for sale (§ 11359) among other charges not relevant here. He came to the attention of law enforcement as the result of large deposits of over $2,000 in small bills that reeked of marijuana. He deposited $10,750 in a two-month period. (*People v. Mentch*, *supra*, 45 Cal.4th at p. 278.) When his residence was searched, police found 187 marijuana plants in different stages of growth. Mentch admitted he sold marijuana, but claimed to have only sold to five medical marijuana users. (*Id*. at pp. 278-279.)

One medical marijuana user testified he gave Mentch $150 to $200 a month for medical marijuana. Another testified she had a physician's recommendation, she obtained marijuana from Mentch every month, and paid $200 to $250 cash for an ounce of marijuana. Mentch testified he opened Hemporium, a caregiving and consulting business to give people safe access to medical marijuana. (*People v. Mentch*, *supra*, 45 Cal.4th at pp. 279-280.) He said he provided medical marijuana to five qualified patients and he did not always charge them. He said the money he received was used to pay for the cost of cultivating and distributing the medical marijuana. (*Id*. at p. 280.) A narcotics investigator testified Mentch may have personally used some of the marijuana he grew, but opined defendant's operation was primarily run for profit. (*Id*. at p. 279.)

The issue in *People v. Mentch* was whether defendant was entitled to an instruction on the primary caregiver defense under the CUA. (*People v. Mentch*, *supra*, 45 Cal.4th at p. 288.) The charged offenses purportedly occurred prior to the effective date of the MMPA. (*Id*. at p. 278.) After finding Mentch did not qualify for the primary caregiver defense provided by the CUA in section 11362.5 because there was no evidence he had "'"*consistently* assumed responsibility for the housing, health, or safety of [the patient]"'" as required by section 11362.5 (*People v. Mentch*, *supra*, 45 Cal.4th at pp. 284-285)—an issue not presented here—the court concluded the defendant would not have been entitled to a defense under section 11362.765 of the MMPA either. (*People v. Mentch*, *supra*, 45 Cal.4th at pp. 291-292.)
People v. Mentch is of limited value to our analysis. First, it involved the application of section 11362.765, and whether Mentch qualified as a primary caregiver, issues not present here. The applicable statute in the present matter is section

11362.775. The conduct protected by section 11362.775 extends in appropriate cases to violations of section 11360. Subdivision (a) of that section not only refers to transportation, but also the sale of marijuana. (§ 11360, subd. (a).) Second, *Mentch* was decided prior to the Legislature's enactment of section 11362.768 in 2010. That section prohibits medical marijuana cooperatives, collectives, dispensaries, or establishments from operating within 600 feet of a school (§ 11362.768, subd. (b)) and applies to organizations or individuals "authorized by law to . . . distribute medical marijuana and that [have] a storefront or mobile *retail* outlet which ordinarily requires a business license" (§ 11362.768, subd. (e), italics added). **The Legislature therefore assumed a qualified patient or organization could, in certain circumstances, charge for medical marijuana. Thus, the existence of "retail" storefronts or outlets.** Of course, the existence of such means of distributing medical marijuana to qualified patients or primary caregivers does not mean a dispensary, storefront, or mobile outlet may be run for profit or sell medical marijuana to those who have not received a physician's recommendation for use of medical marijuana. (See § 11362.765, subd. (a) [nothing in section authorizes the distribution of marijuana for profit].)

People ex rel. Trutanich v. Joseph, *supra*, 204 Cal.4th 1512, involved the application of a city attorney for an injunction. Joseph operated a storefront business known as Organica. A "confidential source" of the United States Drug Enforcment Agency (DEA) entered Orangica and purchased marijuana for $100. Over a week later, a DEA agent went into Orangica and paid $100 for marijuana. That same day, a search of the business turned up over 100 pounds of marijuana, over 260 pounds of edible products and beverages containing hashish oil, large amounts of hashish and hash oil, more than three pounds of psilocybin, and over $16,000 in cash. The DEA also recovered records demonstrating Organica had approximately 1,772 "patients." (*Id*. at p. 1516.) Opposing the injunction, Joseph argued Organica did not constitute a nuisance because his action was authorized by the CUA and the MMPA. (*Id*. at p. 1521.)

Like the decision in *People v. Mentch*, *supra*, 45 Cal.4th 274, the decision in *People ex rel. Trutanich v. Joseph*, *supra*, 204 Cal.App.4th 1512, has limited application here. Without analysis, the court concluded "[n]either section 11362.775 nor section 11362.765 immunizes the marijuana sales activity conducted at Orangica. Section 11362.775 protects group activity 'to cultivate marijuana for medical purposes.' It does not cover dispensing or selling marijuana." (*People ex rel. Trutanich v. Joseph*, *supra*, 204 Cal.App.4th at p. 1523.) This statement does not appear to take into consideration two facts. First, section 11362.775 specifically applies to alleged violations of section 11360, the penal statute prohibiting the sale of marijuana. Second, as in *People v. Mentch*, *supra*, 45 Cal.4th 274, the appellate court in *People ex rel. Trutanich v. Joseph* did not consider the effect of section 11362.768, a Legislative enactment that inherently recognizes the lawfulness of the disbursement of medical marijuana from storefront or mobile retail outlets. (§ 11362.768, subd. (e).)

More pertinent to the present case are the decisions in *People v. Urziceanu*, *supra*, 132 Cal.App.4th 747, and *People v. Jackson*, *supra*, 210 Cal.App.4th 525. In *People v. Urziceanu*, the defendant was convicted of conspiring to sell marijuana prior to the enactment of the MMPA. The appellate court concluded the CUA did not provide a defense to the conspiracy charge, but found (1) **the MMPA could be applied retroactively to the defendant's matter** and (2) the MMPA provided a potential defense to the charge. (*People v. Urziceanu*, *supra*, 132 Cal.App.4th at pp. 758-759.)

The *Urziceanu* court noted the MMPA was the Legislature's initial response to the CUA's call to provide a plan "'for the safe *and affordable distribution* of marijuana to all patients in medical need of marijuana'" as set forth in section 11362.5, subdivision (b)(1)(C). (*People v. Urziceanu*, *supra*, 132 Cal.App.4th at p. 769, italics added.) Unlike the CUA, which limited its application to charges of possession of marijuana (§ 11357) and cultivation of marijuana (§ 11358), section 11362.775, enacted as part of the MMPA, specifically provided a defense to additional charges, including possession of marijuana *for purpose of sales* (§ 11359), among other charges. One of the other statutes specifically listed in section 11362.775 is section 11360. That section generally prohibits the transportation *and sale* of marijuana. (§ 11360, subd. (a).) Notably, the effect of the MMPA generally, and section 11362.775 specifically, "represents a dramatic

change in the prohibitions on the use, distribution, and cultivation of marijuana for" qualified patients and primary caregivers. (*People v. Urziceanu*, *supra*, 132 Cal.App.4th at p. 785.)

The court further found section 11362.775's "specific itemization of the marijuana sales law indicates it contemplates the formation and operation of medicinal marijuana cooperatives that would receive reimbursement for marijuana and the services provided in conjunction with the provision of that marijuana." (*People v. Urziceanu*, *supra*, 132 Cal.App.4th at p. 785.) **The court concluded the Legislature thereby "exempted those qualifying patients and primary caregivers who collectively or cooperatively cultivate marijuana for medical purposes from criminal sanctions for possession for sale, transportation or furnishing marijuana, maintaining a location for unlawfully selling, giving away, or using controlled substances, managing a location for the storage, distribution of any controlled substance for sale, and the laws declaring the use of property for these purposes a nuisance." (*Ibid*.)**

That the Legislature intended such a result is further evidenced by its subsequent enactment of section 11362.768. As noted above, this section implicitly recognizes the lawfulness of a "marijuana cooperative, collective, dispensary, operator, establishment or provider who possesses, cultivates, or distributes medical marijuana pursuant to" the MMPA, and only prohibits such entities from operating "within a 600-foot radius of a school." (§ 11362.768, subd. (b).) If such activities by patients and primary caregivers were unlawful altogether, there would be no need to enact a statute prohibiting such entities only within 600 feet of a school.

Like defendant, the defendant in *People v. Jackson*, *supra*, 210 Cal.App.4th 525, was charged with sale of marijuana, possession of marijuana for sale, and the prosecutor sought to foreclose the defendant from asserting a defense under the MMPA. Jackson testified at the hearing on the prosecutor's motion. He testified he and five other individuals cultivated medical marijuana for the 1,600 other members of the cooperative, and the cooperative did not generate profits for himself or the other growers. (*Id*. at p. 529.) Although the court found the collective was not operated for profit, it concluded that based on the large size of the organization, Jackson could not establish the organization was collectively cultivating medical marijuana within the meaning of the MMPA, and denied him a MMPA defense. (*Ibid*.)

The court found a defendant is entitled to a defense under the MMPA if he or she raises but a reasonable doubt as to whether the defense applies. The MMPA provides a defense when a defendant shows that members of the collective or cooperative: "(1) are qualified patients who have been prescribed marijuana for medicinal purposes, (2) collectively associate to cultivate marijuana, and (3) are not engaged in a profit-making enterprise." (*People v. Jackson*, *supra*, 210 Cal.App.4th at p. 529.)

Important to the facts presented in the present case, the court stated **the MMPA does not require all the members of the collective or cooperative to actively participate in the cultivation process and their contribution to the organization "may be limited to financial support by way of marijuana purchases from the organization."** (*People v. Jackson*, *supra*, 210 Cal.App.4th at pp. 529-530.) In the present case, there was evidence defendant had a physician's recommendation to use medical marijuana, he started Herbal Run and set it up as a not for profit corporation, he acquired a sellers license from the BOE, he did not make a profit on marijuana sold to qualified Herbal Run patients, and the money provided in exchange for marijuana was given to the growers to reimburse them for their costs. This evidence raised a reasonable doubt as to the application of the defense. Defendant was therefore entitled to a defense under the MMPA. Whether Herbal Run was operated for profit or not, would then be determined by the jury. (*People v. Jackson*, *supra*, 210 Cal.App.4th at p. 533; *People v. Villanueva*, *supra*, 169 Ca.App.4th at p. 49.)

The prosecutor argued defendant was not entitled to the defense because the MMPA did not legalize the sale of medical marijuana. He asserted that while it may be lawful for a qualified patient unable to take part in the actual

tending to the plants, or to devote time and effort on behalf of Herbal Run, to support the organization strictly through monetary contributions, the prosecutor argued any monetary contribution could not be contemporaneous with an exchange of marijuana. According to the prosecutor, such an individual would have to make his or her monetary contribution *prior* to the planting of the marijuana the patient would eventually be given.

The MMPA does not impose this limitation on qualified patients. First, **the purpose of the MMPA is to ensure the promise of the CUA is fulfilled and qualified patients have safe access to affordable medical marijuana. We do not think the Legislature intended a seriously ill individual whose physician has recommended use of medical marijuana, and who is physically or otherwise unable to participate in the acts involved in cultivating medical marijuana, cannot simply pay money to his or her collective in exchange for the recommended medicine. It would be cruel for those whose need for medical marijuana is the most dire to require that they devote their limited strength and efforts to the actual cultivation of the marijuana, and then wait months for it to grow so they can use it, or to require that they make their monetary contribution and then wait months for the marijuana to be planted, grown, and harvested before they may lawfully be provided medical marijuana.** Moreover, for some the cultivation and processing would not be completed until it was too late to provide any relief. **The MMPA does not anticipate a patient who has received a physician's recommendation must thereafter wait months to lawfully acquire medical marijuana.**

Of course, the MMPA did not make lawful all sales of marijuana. The defense it provides is limited to those qualified patients and primary caregivers who associate together in a collective or cooperative. (§ 11362.775.) Additionally, sales for profit remain illegal. However, **given the MMPA's purpose, one provision in the MMPA implicitly recognizes the legality of store front dispensaries, collectives or cooperatives (§ 11362.768), and another provision specifically provides a defense to violation of sections 11360 (sale or transportation of marijuana) and 11359 (possession of marijuana for sale), we conclude a member of a collective or cooperative may purchase medical marijuana from the collective or cooperative so long as the sale is not for profit. The district attorney's limited interpretation of section 11362.775 defeats the stated purpose of the MMPA to make access to medical marijuana easier for patients, and is contrary to a fair reading of the section.** Section 11362.775 was written to provide a defense to a charge of selling marijuana in appropriate circumstances. Were this not the Legislature's intent, there would have been no need to list section 11360 or section 11366 [opening or maintaining a place for the purpose of selling or giving away marijuana] as statutes to which the defense applies.

The court's failure to permit the defense was prejudicial. (*People v. Watson* (1956) 46 Cal.2d 818, 836.) When defendant was provided the defense in the first trial, the jury was unable to reach a verdict on the possession of marijuana for sale charge. When he was denied the defense in the second trial, the jury convicted him of possessing marijuana for sale. The Attorney General relies on *People v. Saddler* (1979) 24 Cal.3d 671, 684, for the proposition that if the court erred in failing to instruct the jury on the MMPA defense, the fact that the MMPA defense instruction was given in the first case and that jury was unable to reach a verdict does not establish prejudice. That reliance is misplaced.

Saddler involved an instruction to the effect that when a defendant testifies, the jury may draw adverse inferences from the defendant's failure to explain or deny evidence against him. (*People v. Saddler*, *supra*, 24 Cal.3d at p. 677.) While the instruction was not constitutionally improper, our Supreme Court found the evidence did not support giving the instruction in that case. (*Id*. at p. 675.) Here, on the other hand, the error consisted of completely denying defendant not only a defense, but the defense he was relying upon. If the jury accepted the defendant's version of the facts and it had been instructed regarding the MMPA defense, "it is reasonably probable that a result more favorable to" defendant would have occurred. (*People v. Watson, supra*, 46 Cal.2d at p. 836.)

DISPOSITION: **The judgment is reversed and the matter is remanded.** MOORE, ACTING P. J.

CBS NEWS June 25, 2014

Can marijuana heal a wounded warrior?

Matt Kahl made it home after two tours in Afghanistan, but was wracked with pain from physical injuries, and on a host of anti-anxiety medication to try and treat his mental anguish.

"About ten months after I got back, I attempted suicide," Kahl told CBS News' Barry Petersen.

"I was completely hopeless," recalled the veteran, who said he was on about 15 different medications.

Until the day he tried marijuana.

"Suddenly, my extremely overactive, hyper-vigilant mind started to calm down," he told Petersen, "and my pain gradually started to go away, too. I needed less of these other medications, and shortly afterwards, I determined that I absolutely have to move to a state that allows this so that I can get my life back."

He moved his family to Colorado and now works with a group called Grow4Vets. He and other volunteers recently spent a day putting together bags of marijuana products that are given away on holidays, like Memorial Day.

PTSD treatment inadequate, study shows
Two recent studies confirm widespread veteran concern with VA mental health care.

The marijuana is meant to treat war wounds -- both the mental and the physical kind that doctors often treat with drugs like oxycontin. According to the VA, 20 percent of veterans returning from Afghanistan and Iraq suffer from post-traumatic stress. Current treatments range from therapy to prescription drugs, but the group wants to replace pills with pot, according to veteran and Grow4Vets founder Roger Martin.

"Anybody that's been on narcotic medication especially wants to get off of it," he said. "I really have not met anybody who just enjoys being in a drug stupor."

But because marijuana is still considered a Schedule 1 drug at the federal level, there has been very little research into the effects of pot and post-traumatic stress disorder. The House recently voted down a bill that would allow VA doctors to speak with patients about medicinal marijuana, even in states like Colorado where it's legal.

Soldiers and pot have been together since the Vietnam War, as pot shop owner Toni Fox knows well. Her father came home from Vietnam suffering from post-traumatic stress disorder. Marijuana helped but it was illegal, so not always available.

"He struggled his whole life," she said. "When I was 14 he ended up committing suicide, and it was directly related to the post-traumatic stress disorder from Vietnam."

Which is why she gives Grow4Vets marijuana from her crop area, and money from the shop's tip jar.

"I believe in my heart of hearts that, if he would have had access to cannabis, he would be alive today," said Fox.

Critics are still dubious, given the fact there is little to no scientific proof that pot actually helps with post-traumatic stress disorder.

"Why the hell not? Why don't we study it? Why don't we run these clinical trials?" said Kahl. "I'm absolutely convinced that it works."

For Matt and wife Aimeé, the relief he gets from marijuana means a second chance at healing from Afghanistan, and that's nothing less than a second chance at life.

Originally published September 24 2014

Cannabis dissolves cancerous tumor in young infant, deemed a 'miracle baby' by physician

by Carolanne Wright

(NaturalNews) Instead of opting for chemotherapy and radiation in an attempt to shrink an inoperable brain tumor, the father of an eight-month-old baby pushed for alternative treatment with cannabis oil. The baby's physician, Dr. William Courtney, was initially skeptical early in his career about cannabis as medicine but has since seen such impressive results that he's now a staunch advocate for its use.

"They were putting cannabinoid oil on the baby's pacifier twice a day, increasing the dose... And within two months there was a dramatic reduction, enough that the pediatric oncologist allowed them to go ahead with not pursuing traditional therapy," said Dr. Courtney in an interview with *The Huffington Post*.

At four months, the tumor was completely gone. And after eight months of treatment, the brain tissue was considered completely normal.

Dr. Courtney notes that the successful application of cannabis to heal means that "this child, because of that, is not going to have the long-term side effects that would come from a very high dose of chemotherapy or radiation... currently the child's being called a miracle baby, and I would have to agree that this is the perfect response that we should be insisting is frontline therapy for all children before they launch off on all medications that have horrific long term side effects."

A healing phenomenon

Cannabis has a wide range of reported therapeutic uses -- from cancer to asthma, as well as from neurodegenerative diseases to autoimmune disorders. Several U.S. states have recognized the beneficial healing aspects of cannabis and have therefore made it available for medicinal purposes. On the other hand, two states, Washington and Colorado, have taken this a step further and legalized cannabis for recreational use.

Numerous studies support the incredible healing capacity of cannabis, especially regarding cancer. The National Cancer Institute alone has documented 25 studies on the exceptional power that cannabis possesses to halt the progression of cancer. In animal tests, two forms of liver cancer -- hepatic adenoma tumors and hepatocellular carcinoma -- decreased when cannabis was given. Benign tumors in other organs, such as the pancreas, testes, uterus and mammary and pituitary glands, were diminished as well. Several reviews also found that cannabinoids appear to encourage cancer cell death (apoptosis), while preserving normal cells. Moreover, cannabis induces programmed cell death in breast cancer cell lines and offers protection against both colorectal and lung cancer.

The list of benefits could seemingly go on forever. To learn more about the wonder of cannabis, have a look at this comprehensive documentary by leading researchers and physicians in the field.

If we want to see change in the world, we need to be the change.

ORDINANCE NO.

AN ORDINANCE OF THE CITY COUNCIL OF THE CITY OF LONG BEACH AMENDING THE LONG BEACH MUNICIPAL CODE BY ADDING CHAPTER 21.XX; AND BY REPEALING CHAPTER 5.89, ALL RELATING TO MEDICAL MARIJUANA

WHEREAS, the people of the State of California have enacted Proposition 215, the Compassionate Use Act of 1996 ("CUA") (codified in Health and Safety Code Section 11362.5, *et seq.*), which allows for the possession and cultivation of marijuana for medical use by certain qualified persons; and

WHEREAS, the CUA creates a limited exception from criminal liability for seriously ill persons who are in need of medical marijuana for specified medical purposes and who obtain and use medical marijuana under limited circumstances; and

WHEREAS, in 2004, the State of California enacted Senate Bill 420, the Medical Marijuana Program Act ("MMPA") (codified in California Health and Safety Code Section 11362.7 *et seq*.), which purports to clarify the scope of the CUA, and also which recognizes the right of cities and other governing bodies to adopt and enforce rules and regulations consistent with the MMPA; and

WHEREAS, notwithstanding the passage of the CUA and MMPA, the cultivation, possession, and distribution of marijuana is strictly prohibited by federal law and specifically by the Controlled Substances Act ("CSA") (codified in 21 U.S.C. Section 841); and Section 841 of the CSA makes it unlawful for a person to manufacture, distribute, dispense, or

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possess with intent to manufacture, distribute, or dispense marijuana; and

WHEREAS, the regulations for medical marijuana uses are not adequate at the state level to address the impacts on the City of medical marijuana, making it appropriate for local regulation of the impacts of medical marijuana uses; and

WHEREAS, pursuant to the City's police powers authorized in Article XI, Section 7, of the California Constitution, the Long Beach Municipal Code, and other provisions of California law including, but not limited to California Government Code Section 38771, the City has the power through its City Council to determine, for purposes of the public health, safety, and welfare, the appropriate uses of land within a local jurisdiction's borders; and

WHEREAS, nothing in this Chapter is intended to promote or condone the production, distribution, or possession of marijuana in violation of any applicable law; and

WHEREAS, this Chapter is to be construed to protect the public over medical marijuana related interests; and

WHEREAS, operation of a medical marijuana dispensary is a revocable privilege and not a right in the City. There is no property right for an individual or entity to have a medical marijuana business in the City; and

WHEREAS, the City has a zero tolerance policy for violations of this Chapter; and

WHEREAS, the City Council wishes to repeal Chapter 5.89 of the Municipal Code ("Medical Marijuana Dispensary Ban") in its entirety and at the same time adopt regulations allowing for the limited existence of medical marijuana dispensaries in the City of Long Beach;

NOW, THEREFORE, the City Council of the City of Long Beach ordains as follows:

Section 1. Chapter 21.XX of the Long Beach Municipal Code is added to read as follows:

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Chapter 21.XX

MEDICAL MARIJUANA

21.XX. 010 Purpose.

The primary purpose of this Chapter is to protect the public health, safety, and welfare of the residents and patients of the City by prescribing the manner in which medical marijuana dispensaries can operate in the City.

This Chapter regulates the use, acquisition, cultivation, production, and distribution of medical marijuana in a manner that is consistent with California Health and Safety Code sections 11357 through 11362.9, also referred to as the Compassionate Use Act ("CUA") and the Medical Marijuana Program Act ("MMPA"). The CUA and MMPA do not provide a legal manner for patients to obtain medical marijuana unless the patient grows the marijuana or the marijuana is grown by the patient's primary caregiver, or the marijuana is grown collectively by patients. The following regulations are intended to apply to all medical marijuana business operations in the City whether by a patient or primary caregiver, or a collective of patients, or any medical marijuana related entity allowed under the state law. Medical marijuana cultivation and production can have an impact on health, safety and community resources, and this Chapter is intended to allow medical marijuana distribution and cultivation only where it will have a minimal impact. To do so, the following regulations:

Provide for a means for cultivation, production, and distribution

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of marijuana to patients who qualify to obtain, possess, and use marijuana for medical purposes under the CUA and MMPA;

Protect public health and safety through reasonable limitations on medical marijuana business operations as they relate to noise, air, and water quality, food safety, neighborhood and patient safety, security for the dispensary location and its personnel, and other health and safety concerns;

Promote lively street life and high quality neighborhoods by limiting the concentration of any medical marijuana businesses in the City;

Impose fees to cover the cost to the City of regulating medical marijuana related operations in an amount sufficient for the City to recover its related costs;

Adopt a mechanism for monitoring compliance with the provisions of this Chapter;

Create regulations that address the particular needs of the residents and patients of the City and coordinate with laws that may be enacted by the State regarding the same;

Facilitate the implementation of the CUA and MMPA without going beyond the authority granted by it;

Allow medical marijuana related operations only by individuals and entities that have demonstrated an intent and ability to comply with this Chapter;

Protect public safety and residential areas by limiting the areas of the City where medical marijuana businesses may operate;

The provisions in this Chapter that are different from State law are consistent with the City's responsibility to protect the public health, safety, and welfare as authorized by the inherent local police power authority granted to the City by Article XI, § 7 of the California Constitution. The City intends that both State law and this Chapter apply within the City.

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21.XX.020 Definitions.

A. “Advertise” means the act of drawing the public's attention, whether in print or on the television, internet, cellular network, or radio, to a medical marijuana business in order to promote the sale of medical marijuana by the business.

B. “Business Manager” means the individual designated by the owner of the medical marijuana business as the person responsible for all operations of the business in the absence of the owner from the business property. Business manager shall include any person with managerial authority in the business, and any person that has access to lock or unlock the safe, to unlock or lock the business, or set or disarm the alarm.

C. “Cultivation” or “Cultivate” means:

i. All phases of growth of marijuana from seed to harvest; or

ii. Preparing, packaging or repackaging, labeling or relabeling of a usable form of marijuana.

D. “Cultivation Facility” means a permitted medical marijuana business that is authorized to cultivate, produce, and harvest marijuana plants for a medical use for distribution by such medical marijuana business.

E. “Distribute” or “Distribution” means the actual, constructive or attempted transfer, delivery, sale, or dispensing to another, with or without remuneration.

F. “Financier” means any person or entity who lends money, grants, donates, or otherwise provides assets to any person applying for a permit or who has been issued a permit under this Chapter. Financier shall not include a bank, savings and loan association, credit union, or industrial bank supervised and regulated by an agency of the State or federal government.

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G. “Marijuana” means the same as the term "marijuana" as set forth in California Health and Safety Code section 11018 which defines “marijuana” as all parts of the plant Cannabis sativa L., whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or resin. It does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination.

H. “Medical Marijuana” means marijuana used for medical purposes in accordance with California Health and Safety Code Sections 11362.5, *et seq.*

I. “Medical Marijuana Business” means:

i. Any association of four (4) or more individuals that cultivates, produces, sells, distributes, possesses, transports or makes available medical marijuana to qualified patients and their designated primary caregivers who associate at a particular location or Property within the boundaries of the City of Long Beach to collectively cultivate or distribute medical marijuana in accordance with California Health and Safety Code Sections 11362.5, *et seq*. For purposes of this Chapter, the term medical marijuana cooperative, collective, or dispensary shall have the same meaning as medical marijuana business. Medical marijuana business includes, but is not limited to, dispensary storefront locations, cultivation facilities, and medical marijuana-infused product manufacturers.

ii. Any person that cultivates, produces, sells, distributes, possesses, transports more than six mature marijuana plants or twelve (12) immature marijuana plants, or eight (8) ounces of a useable form of

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marijuana for medical use, pursuant to California Health and Safety Code section 11362.5, *et seq*.

iii. The term medical marijuana business shall not include the private possession, production, or medical use of no more than six (6) mature marijuana plants or twelve (12) immature marijuana plants, or eight (8) ounces of a useable form of marijuana by a patient or caregiver in the residence of the patient.

J. "Medical Marijuana-Infused Product" means a marijuana-infused, edible, ingestible, or inhalable product, including but not limited to topical solutions and vaporizers.

K. "Medical Marijuana-Infused Product Manufacturer" means a licensed and permitted marijuana-infused product manufacturer.

L. "Medical Marijuana Plant" means a marijuana seed that is germinated and all parts of the growth therefrom including, without limitation, roots, stalks and leaves. For purposes of this Chapter, the portion of a medical marijuana plant harvested from the plant or converted to a usable form of medical marijuana for medical use is not considered part of the plant upon harvesting.

M. "Permittee" means the medical marijuana business named on the conditional use permit and business license, and all individuals named in the conditional use permit application or later reported to the City, including without limitation, owners, business managers, financiers, and individuals owning any part of an entity that holds a financial or ownership interest in a medical marijuana business.

N. "Place Open To The General Public" means any property owned, leased, or used by a public entity, and any place on private property open to the public, common areas of buildings, private clubs, vehicles, those portions of any private property upon which the public has an express or implied license to enter or remain, and any place visible from such places. "Place open to the

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general public" shall not include any fenced area of a private residence regardless of whether it can be seen from a place open to the public.

O. "Possess" or "Possession" means having physical control of an object, or control of the property in which an object is located, or having the power and intent to control an object, without regard to whether the one in possession has ownership of the object. Possession may be held by more than one (1) person at a time. Use of the object is not required for possession. The owner of a medical marijuana business shall be considered in possession of the medical marijuana business at all times. The business manager of a medical marijuana business shall be considered in possession of the medical marijuana business at all times that the business manager is on the property of the business or has been designated by the owner as the business manager in the absence of the owner in accordance with this Chapter.

P. "Property" means a distinct and definite location, which may include a building, a part of a building, a room or any other defined contiguous area.

Q. "Primary Caregiver" means the same as that term in California Health and Safety Code Sections 11362.5 and 11362.7 which define "primary caregiver" as an individual, designated by a qualified patient, who has consistently assumed responsibility for the housing, health, or safety of that qualified patient.

R. "Produce" or "Production" means:

i. Preparing, compounding, processing, encapsulating, packaging or repackaging, labeling or relabeling of marijuana or its derivatives, whether alone or mixed with any amount of any other substance; or

ii. Combining marijuana with any other substance for distribution, including storage and packaging for resale.

S. "Responsible person" means any individual who is the owner,

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partial owner, or occupant of real property, last registered owner and/or legal owner of a vehicle, the holder, business manager, or the agent of the holder of any permit, or the party or agent of a party to any agreement covered by this Chapter; or the owner or authorized agent of any business, company or entity subject to this Chapter.

T. "Restricted Area" means the portion of a medical marijuana business location within which the licensee defines on its application it intends to cultivate, distribute, possess or produce medical marijuana and which area is clearly identified as the restricted area on the floor plan submitted with the medical marijuana business CUP application for the business.

U. "Violation of Any Law" means a plea or finding of a violation of any law in a criminal, civil, or administrative proceeding, whether part of a plea agreement, settlement agreement, or determination by an arbitrator, hearing officer, court, or jury.

21.XX.030 Permit required.

A. It shall be unlawful for any person or entity to operate, in or upon any property, a medical marijuana business without obtaining a conditional use permit pursuant to the requirements of this Chapter and Chapter 21.25.

The permit requirement set forth in this Chapter shall be in addition to, and not in lieu of, a Long Beach business license and any other licensing and permitting requirements imposed by any other federal, state or local law, including, but not limited to, a California seller's permit and building and occupancy permits.

B. The issuance of any permit pursuant to this Chapter does not create an exception, defense, or immunity to any person or entity from criminal liability for the cultivation, production, distribution, transportation, or possession of marijuana.

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A single conditional use permit shall be required for each property or combination of properties from which a medical marijuana business operates.

C. A conditional use permit issued pursuant to this Chapter shall become null and void upon the closure of the business for more than five (5) days, and/or the relocation of the business to a different location, and/or a change in ownership of the business

i. The following shall be deemed a change in location:

(a) Any relocation or expansion that includes a separate piece of property, building suite, or parcel of land from the initially permitted Property;

(b) Any expansion of the initially permitted Property which represents a greater than fifty percent (50%) increase in the square footage of space devoted to the medical marijuana business operations, including the restricted areas;

(c) The lawful conduct of activity regulated by this Chapter by a Permittee shall be limited to those activities expressly indicated on the Medical Marijuana Collective Permit application.

The Permittees of a medical marijuana business are only those persons disclosed in the application or subsequently disclosed to the City in accordance with this Chapter. A transfer of a conditional use permit is prohibited unless the incoming medical marijuana business and its owners, business managers, financiers, and any individuals owning any part of an entity that holds a financial or ownership interest in the medical marijuana business submit the application information required by section 21.XX.050 of this Chapter.

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21.XX.040 General permit provisions.

A. The general procedures and requirements of conditional use permits, as more fully set forth in Chapter 21.25, "Conditional Use Permits," shall apply to conditional use permits. To the extent there is any conflict between the provisions of this Chapter and Chapter 21.25, the provisions of this Chapter shall control for conditional use permits related to medical marijuana businesses.

i. Insurance required. A medical marijuana business must at all times maintain workers' compensation insurance, public liability insurance with minimum limits of One Hundred Fifty Thousand Dollars ($150,000) for any one person and Six Hundred Thousand Dollars ($600,000) for any one accident, and public property damage insurance with a minimum limit of One Hundred Thousand Dollars ($100,000) for any one accident.

ii. Costs of inspection, enforcement, and abatement.

B. In the event the City incurs costs in the inspection, enforcement, abatement, surrender, or any other requirements to remove medical marijuana or related equipment or property from any medical marijuana business, or any person cultivating, producing, distributing or possessing marijuana, the business and responsible persons shall reimburse the City all actual costs incurred by the City for such inspection, enforcement, or abatement.

All actual costs required by this section shall constitute a lien upon the property upon which the medical marijuana business is situated. The lien for any inspection, enforcement, or abatement costs shall attach thirty (30) days after the responsible parties are notified of the costs, and shall remain until the fee is paid or the property sold in payment thereof.

C. Landlord duty.

D. It shall be unlawful for the owner of a building to lease space or allow the use of any portion of the building by a medical marijuana business

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unless the tenant has a valid conditional use permit and a valid business license or has applied for and not been denied a conditional use permit and/or business license and no marijuana is located on the property until a permit has been issued by the City.

21.XX.050 Conditional use permit application.

A. Application requirements.

i. In addition to the general conditional use permit application requirements of Chapter 21.25, an application for a conditional use permit shall include completed forms provided by the City for that purpose. The applicant shall use the application to demonstrate its compliance with this Chapter and any other applicable law, rule, or regulation. The application shall include the following information:

ii. Name and address of the owner or owners of the medical marijuana business in whose name the permit is proposed to be issued.

iii. If an owner is a corporation, the name and address of all officers or directors of the corporation and of any person holding issued and outstanding capital stock of the corporation.

iv. If an owner is a partnership, association, or company, the name and address of any person holding an interest therein and the managing members. If a managing member is an entity rather than an individual, the same disclosure shall be required for each entity with an ownership interest until a managing member that is a natural person is identified.

v. If an owner is not a natural person, the organizational documents for all entities identified in the application, identification of the natural person that is authorized to speak for the

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entity and contact information for that person.

vi. Name and address of:

(a) Any business managers of the medical marijuana business, if the business manager is proposed to be someone other than the owner;

(b) All financiers of the medical marijuana business; and

(c) All agents of the medical marijuana business who either:

(1) act with managerial authority,

(2) provide advice to the medical marijuana business for compensation, or

(3) receive periodic compensation totaling $1,000.00 or more in a single year for services related to the medical marijuana business.

vii. A statement indicating whether any of the named owners, members, business managers, financiers, primary caregivers, or persons named on the application have been:

(a) Denied an application for a conditional use permit pursuant to this Chapter, or any similar state or local licensing or permitting law, rule, or regulation, or had such a license or permit suspended or revoked.

(b) Convicted of violating any law, other than a traffic violation infraction, or completed any portion of a sentence due to a violation of any law.

(c) Convicted of driving or operating other machinery under the influence of alcohol, drugs, or medication, driving while impaired, or any comparable law, or a

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misdemeanor related to abuse of alcohol or a controlled substance.

(d) Owners, members, business managers, or financiers of any other medical marijuana business in any location, Long Beach or otherwise, at any time, and the status of the other business(es) as of the date the application is submitted.

viii. Proof of ownership or legal possession of the Property at which the medical marijuana business will be located. If the medical marijuana business is not the owner of the property of the business, the applicant shall provide written authorization to the City from the property owner to enter the property for inspection of the property on a form approved by the City.

ix. A certificate for proof of insurance signed by a qualified agent of an insurance company evidencing the existence of valid and effective policies of workers' compensation and public liability and property damage insurance naming the City and its officers and employees as an additional named insured on the liability policy at least to the limits required by section 21.XX.040(A) of this Chapter, the limits of each policy, the policy number(s), the name of the insurer, the effective date, and expiration date of each policy, and a copy of an endorsement placed on each policy requiring ten days' notice by mail owner or business manager before the insurer may cancel the policy for any reason.

x. An operating plan for the proposed medical marijuana business, including the following information:

(a) A description of all the products and services to be provided by the medical marijuana business.

(b) A schedule depicting the hours of operation.

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(c) A description of the procedures for cash handling and audits.

(d) A dimensioned floor plan, clearly labeled, showing:

(1) The layout of the facility and the floor plan in which the medical marijuana business is to be located;

(2) The principal uses of the floor area depicted on the floor plan, including but not limited to the areas where non-patients will be permitted, private consulting areas, storage areas, retail areas, areas for cash handling and storage, and restricted areas where medical marijuana will be located; and

(3) Electrical, mechanical, plumbing, disabled access compliance pursuant to Title 24 of the State of California Code of Regulations and the federally mandated Americans with Disabilities Act;

(4) The separation of the areas that are open to persons who are not patients from those areas open to patients; and

(5) Any other information required by the City in its review of the application.

(6) d. A neighborhood safety and responsibility plan that demonstrates how the applicant will comply with the requirements of this Chapter and abate associated crime and nuisance conditions in the immediate vicinity of the marijuana business, and how the business will fulfill its responsibilities to the neighborhood including outreach and dispute resolution.

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(e) For cultivation facilities, and medical marijuana businesses that produce medical marijuana-infused products, a plan that specifies:

(1) The methods to be used to prevent the growth of harmful mold and compliance with limitations on discharge into the wastewater system of the city as set forth in Long Beach Municipal Code Chapter 15.16, "Industrial Waste and Wastewater."

(2) A minimum of a one-hour fire separation wall between the cultivation facility and any adjacent business.

(3) All ventilation systems used to control the environment for the plants that describes how such systems operate with the systems preventing any odor leaving the property. Such plan shall also include all ventilation systems used to mitigate noxious gases or other fumes used or created as part of the production process.

B. Additional requirements.

i. A lighting plan showing the lighting outside of the marijuana business and compliance with applicable City requirements.

ii. Color images and a site plan indicating locations of proposed signage.

iii. A fully legible copy of one valid government issued form of photo identification, such as a State Driver's License or Identification Card and Livescan fingerprinting completed at the Long Beach Police Department. This requirement shall apply to all owners, business managers, financiers, and caregivers employed by or under contract to provide services to the medical marijuana business,

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including all individuals who have an interest as described herein of any portion of the medical marijuana business, directly or as an agent, or a member, partner or officer of a corporation, partnership, association or company.

iv. A plan for disposal of any medical marijuana or medical marijuana-infused product that is not sold to a patient or primary caregiver in a manner that protects any portion thereof from being possessed or ingested by any person or animal.

v. A plan for ventilation of the medical marijuana business that describes the ventilation systems that will be used to prevent any odor of medical marijuana off the property of the business.

vi. A description of all toxic, flammable, or other materials regulated by a federal, state, or local government that would have authority over the business if it was not a marijuana business, that will be used or kept at the medical marijuana business, the location of such materials, and how such materials will be stored, subject to review and approval by the Fire Marshall.

vii. A statement of the amount of the projected daily average and peak electric load anticipated to be used by the business and certification from the landlord and utility provider that the property is equipped to provide the required electric load, or necessary upgrades that will be performed prior to final inspection of the property.

viii. A statement signed under penalty of perjury by each owner or business manager that they have read, understand, and shall ensure compliance with the terms of this Chapter.

ix. Fee required.

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Any application for a conditional use permit shall be accompanied by the conditional use permit application fee, criminal background check fee, and any other applicable fees.

x. Investigation.

For purposes of this Chapter, the investigation of the application by the City is not complete until the Department of Development Services has:

(a) Determined the application is complete,

(b) Determined the medical marijuana business is prepared and able to operate in compliance with all applicable laws,

(c) Obtained all other information the City Manager determines necessary to make a recommendation whether to approve the permit application with conditions or deny the permit application, and

(d) Prepared the documentation necessary to support the recommended action to the City's Planning Commission.

xi. Approval requirements.

Once the Department of Development Services deems an application complete, the matter will be set for hearing in accordance with Chapter 21.21 of the Long Beach Municipal Code.

The City Manager or his designee will deny any application that does not meet the requirements of this Chapter or any other applicable law, rule, or regulation or that contains any false or incomplete information.

The conditions of an approval of a conditional use permit shall include, at a minimum, operation of the business in compliance with all of the plans and information made part of the application.

21.XX.060 Persons prohibited as permittees and business managers.

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A. It shall be unlawful for any of the following persons to have an ownership or a financial interest in a medical marijuana business, and no permit provided by this Chapter shall be issued to or held by, and no medical marijuana business shall be managed by:

i. Any person until the annual inspection fee has been paid;

ii. Any person who has been convicted within the previous ten (10) years of a felony or a crime of moral turpitude, or who is currently on parole or probation for the sale or distribution of a controlled substance;

iii. Any natural person who is under twenty-one (21) years of age; or

iv. Any person who operates or manages or has operated or managed a medical marijuana business contrary to the provisions of this Chapter, any other applicable law, rule or regulation or conditions imposed on land use or license approvals, or contrary to the terms of the plans submitted with the permit application, or amended as permitted by this Chapter, or has operated a business in violation of any law.

v. A licensed physician making patient recommendations;

vi. A person permitted to operate pursuant to this Chapter who, while lawfully operating, or who, at the time of application, has failed to remedy an outstanding delinquency for taxes owed, or an outstanding delinquency for judgments owed to a government;

vii. A sheriff, deputy, police officer, or prosecuting officer, or an officer or employee of the state or local governing

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authority;

viii. Any person applying for a conditional use permit to operate a medical marijuana business who has been permitted to operate another medical marijuana business in the City pursuant to this Chapter.

21.XX.070 Location of medical marijuana businesses.

A. Fixed location required.

i. It shall be unlawful to operate a medical marijuana business or to grow medical marijuana outside of an enclosed building. All conditional use permits shall be issued for a specific fixed location within an enclosed building.

B. Location – permitted use in zoning district.

C. A conditional use permit may be issued only if the medical marijuana business is located in an area zoned for the following:

i. As "Community Automobile-Oriented District (“CCA”), Regional Highway District (“CHW”), or “Industrial" for a medical marijuana business dispensary only;

ii. As "industrial" for a medical marijuana business cultivation site only;

(a) As "industrial" for a medical marijuana business dispensary and cultivation site; or

(b) As “industrial” for a medical marijuana-infused product manufacturer.

D. Location – total per council district.

No more than one (1) medical marijuana business dispensary and four (4) medical marijuana business shared dispensary and cultivation sites or stand-alone medical marijuana business cultivation sites may operate

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in any council district. No more than eighteen (18) medical marijuana business conditional use permits may operate within the City.

E. Priority of medical marijuana business location.

i. Based on the zoning restrictions and limitations on concentration of medical marijuana businesses in the City, to determine the priority of a medical marijuana business application and the proximity of applicants' properties, applicants meeting all application requirements shall have priority based on the accumulation of points based on the following criteria:

(a) Suitability of the proposed property:

(1) Applicant demonstrates proposed location exceeds all buffer zones established in subsection (F) by at least five hundred (500) feet (1 point);

(2) Proposed property possesses air scrubbers or a filtration system capable of eliminating odors from escaping the building or commitment to do so before operating (1 point);

(3) Proposed property is located within 1000 feet of a public transportation hub, stop, or station;

(b) Suitability of security plan:

(1) The applicant's security plan includes the presence of security personnel on premises twenty-four (24) hours per day (1 point);

(2) The applicant's security plan demonstrates a method to track and monitor inventory so as to prevent theft and diversion of marijuana (1 point);

(3) The applicant's security plan describes the enclosed, locked facility that will be used to

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secure or store marijuana when the location is both open and closed for business, and the steps taken to ensure marijuana is not visible to the public (1 point);

(4) The applicant's security plan includes measures to prevent the diversion of marijuana to persons under the age of twenty-one (21) (1 point);

(5) Applicant demonstrates security measures exceeding the requirements of this Chapter, including but not limited to brick or concrete construction or additional fire and/or security alarms (1 point);

(c) Suitability of business plan and financial record keeping:

(1) The applicant describes a staffing plan that will provide and ensure safe dispensing, adequate security, theft prevention, and the maintenance of confidential information (1 point);

(2) Applicant provides an operations manual that demonstrates compliance with this Chapter (1 point);

(d) Criminal history:

(1) Applicants without any felony conviction(s) (1 point);

(2) Applicants without any misdemeanor conviction(s) (1 point);

(3) Applicants without any pending criminal complaint(s) (1 point);

(4) Applicants certify as a condition of maintaining the revocable conditional use permit that they will not employ any person with any type of felony

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conviction (1 point);

(5) Applicants certify as a condition of maintaining the revocable conditional use permit that they will not employ as managers or employees any person with any narcotics related misdemeanor conviction (1 point).

(e) Regulatory compliance history:

(f) Applicants and financiers have not had a permit or license revoked by the City of Long Beach (1 point);

(1) Applicants have not had administrative penalties assessed against their business or the location of their business (1 point);

(2) Applicants have not operated a medical marijuana business in violation of any provision of the Long Beach Municipal Code within five (5) years (1 point);

(3) Applicants operated a medical marijuana business in violation of any provision of the Long Beach Municipal Code within five (5) years (-5 points).

(g) Community service:

(1) Applicants demonstrate involvement in the community, other non-profit association, or neighborhood association (1 point).

ii. In the event review of the applications of two (2) or more eligible medical marijuana business applicants within the same district results in the same total number of points assigned, the City will utilize a lottery to determine which applicant receives priority.

F. No medical marijuana business may be located in residential

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zoning districts.

G. It shall be unlawful to operate a medical marijuana business in a building which contains a residence, within a dwelling unit within any zoning district, or within a residential zoning district or within a mixed-use development that includes a residence.

H. Separation from schools, parks, and other medical marijuana uses.

The property identified in the conditional use permit application must be located in accordance with the following:

i. The medical marijuana business is not located within one thousand five hundred (1,500) feet of a public or private high school or Educational Partnership High School ("EPHS") or within one thousand (1,000) feet of a public park or a public or private kindergarten, elementary, middle, or junior high school.

ii. The medical marijuana business is not located within one thousand (1,000) feet of any other medical marijuana business.

iii. The distances specified in this subsection shall be determined by the horizontal distance measured in a straight line from the property line of the school, park, or other medical marijuana business to the closest property line of the lot on which the medical marijuana business is located, without regard to intervening structures.

I. Limitations on medical marijuana businesses.

J. The following shall be the minimum requirements for a medical marijuana business:

i. The area of a medical marijuana business dispensary is two thousand (2,000) square feet or less and at least five hundred (500) square feet are dedicated to a lobby and/or waiting area;

ii. The area of a medical marijuana business

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cultivation site is five thousand (5,000) square feet or less;

iii. The business distributes medical marijuana only in accordance with this Chapter and California law; and

iv. The business includes a secured and locked medical marijuana dispensary room, one or more private rooms for consultation on the medical use of marijuana, and a separate reception area for screening of patients and waiting for non-patients.

21.XX.080 Requirements related to operation of medical marijuana businesses.

K. Onsite use prohibited.

i. No marijuana shall be smoked, eaten, or otherwise consumed or ingested within the medical marijuana business.

L. Restriction on access to restricted area.

i. No person, other than a patient, licensee, employee, or a contractor shall be in the medical marijuana dispensary room. No patient shall be allowed entry into the medical marijuana dispensary room without showing their valid picture ID.

M. Display of permits required.

i. The name and contact information for the owner or owners and any business manager of the medical marijuana business, the conditional use permit, the business license, and the sales tax seller's permit shall be conspicuously posted in the business.

N. Business conducted within building.

i. Any and all cultivation, production, distribution, possession, storage, display, sales or other distribution of marijuana shall occur only within an enclosed area of a medical marijuana business and shall not be visible from the exterior of the business.

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ii. Consultations by medical professionals shall not be permitted at a medical marijuana business nor as a permitted accessory use at a medical marijuana business.

iii. Owner or business manager required on property.

O. No medical marijuana business shall be managed by any person other than the Permittee or the business manager listed on the application for the permit or a renewal thereof. Such Permittee or business manager shall be on the property and responsible for all activities within the licensed business during all times when the business is open.

P. Hours of operation.

i. A medical marijuana business shall be closed to the public, and no sale or other distribution of marijuana shall occur upon the property between the hours of seven o'clock (7:00) p.m. and eight o'clock (8:00) a.m.

Q. Use of pesticides.

R. No pesticides or insecticides which are prohibited by federal, state, or local law for fertilization or production of edible produce shall be used on any marijuana cultivated, produced or distributed by a medical marijuana business. A medical marijuana business shall comply with all applicable federal, state, and local law regarding use and disposal of pesticides.

i. Ventilation required.

S. A medical marijuana business shall be ventilated so that the odor of marijuana cannot be detected at the exterior of the medical marijuana business or at any adjoining use or property.

i. Use of carbon dioxide generators prohibited.

The medical marijuana business shall not use carbon dioxide generators, burners, or converters of any kind. Medical marijuana businesses are prohibited from altering normal air composition in any manner.

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ii. Limitations on inventory.

T. The medical marijuana business shall not maintain any more marijuana within the property than is permitted under applicable state law. The medical marijuana business shall not maintain any more marijuana than the amount stated on the business' permit application to the City. The medical marijuana business shall maintain current records evidencing the status and number of patients for whom they cultivate or dispense medical marijuana. The medical marijuana business shall maintain current records evidencing the strains of marijuana cultivated and sold.

i. City residency requirement.

Patients obtaining medical marijuana from medical marijuana businesses must bona fide residents of the City of Long Beach. Patients must provide proof of City residency upon joining the membership of a medical marijuana business. Medical marijuana businesses must verify and maintain patient proof of residency.

ii. Reporting requirements.

(a) A medical marijuana business shall report to the City Manager or his designee each of the following within the time specified. If no time is specified, the report shall be provided within seventy-two hours of the event.

(b) Transfer or change of financial interest, business manager, financier, or primary caregiver in the permit application at least thirty days before the transfer or change.

(c) Sales and taxable transactions and file sales and use tax reports to the City monthly.

(d) A violation of any law by any Permittee or applicant of a medical marijuana business.

(e) Reports of all criminal activity or attempts of

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violation of any law at the medical marijuana business or related thereto shall be reported to the Long Beach Police Department within twelve hours of occurrence.

iii. Cultivation within the City required.

(a) All medical marijuana distributed from a medical marijuana business must be cultivated within the City of Long Beach.

(b) Medical marijuana cultivated within in the City boundaries may not be transported or disseminated out of the City of Long Beach.

(c) Medical marijuana cultivation shall be limited to single level growing areas, all stacks or multi-story growing methods are prohibited.

iv. Delivery between medical marijuana businesses.

U. It shall be unlawful for any person to transport medical marijuana, except as specifically allowed by applicable law, unless the medical marijuana being transported meets the following requirements:

i. All medical marijuana-infused products are hand-packaged, sealed and labeled as provided in this Chapter and the products stored in closed containers that are labeled as provided in this section.

ii. All medical marijuana in a usable form for medicinal use is packaged and stored in closed containers that are labeled as provided in this section.

iii. Each container used to transport medical marijuana is labeled with the amount of medical marijuana or medical marijuana-infused products, or the number and size of the plants, in the container. The label shall include the name and address of the medical marijuana business that the medical marijuana is being

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transported from and the name and address of the medical marijuana business that the medical marijuana is being transported to. The label shall be shown to any law enforcement officer who requests to see the label.

iv. Unless otherwise specifically allowed by applicable law, medical marijuana may be transported only:

(a) From a medical marijuana cultivation facility to a medical marijuana business; and

(b) Which medical marijuana business is owned by the same person as owns the cultivation facility; and

(c) When determining and reporting the route to take, Permittees should select the most direct route that provides safety and efficiency.

v. Disposal of medical marijuana and marijuana byproducts.

V. All medical marijuana and any product containing a usable form of marijuana must be made unusable and unrecognizable prior to removal from the business in compliance with all applicable laws. This provision shall not apply to licensed law enforcement acting in the course of their duties.

W. Possession of mature flowering plants.

X. No more than one-half of the medical marijuana plants within a medical marijuana business may be mature, flowering plants producing a usable form of marijuana.

Y. Advertisement.

Z. A medical marijuana business may not advertise in a manner that is inconsistent with the medicinal use of medical marijuana. A medical marijuana business may not advertise in a manner that is misleading, deceptive, false, or is designed to appeal to minors. Advertisement that promotes medical

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marijuana for recreational or any use other than for medicinal purposes shall be a violation of this Chapter. The following conditions shall apply:

i. Except as otherwise provided in this paragraph, it shall be unlawful for any person permitted under this Chapter or any other person to advertise any medical marijuana or medical marijuana-infused product anywhere in the city where the advertisement is in plain view of or in a place open to the general public, including advertising utilizing any of the following media: illuminated signs, signs incorporating green crosses or other marijuana related symbol, any billboard or other outdoor general advertising device as defined by the zoning regulations of the City; any sign mounted on a vehicle; any hand-held or other portable sign; or any handbill, leaflet or flier directly handed to any person in a public place, left upon a motor vehicle, or posted upon any public or private property. The prohibition set forth in this paragraph shall not apply to:

(a) Any sign located on the same lot as a medical marijuana business which exists solely for the purpose of identifying the location of the medical marijuana business and which otherwise complies with this Chapter and any other applicable city laws and regulations;

(b) Any advertisement contained within a newspaper, magazine, or other periodical of general circulation within the City or on the Internet; or

(c) Advertising which is purely incidental to sponsorship of a charitable event by a medical marijuana business or a medical marijuana-infused products manufacturer.

(d) No medical marijuana business shall distribute or allow the distribution of any marijuana without

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charge within a marijuana business or any place open to the public for the purpose of promotion or advertising.

(e) No medical marijuana business shall distribute or allow the distribution of any coupon or similar writing, electronically or on paper, which purports to allow the bearer to exchange the same for any marijuana product, either free or at a discount.

(f) No medical marijuana business shall sell, distribute, or provide, or allow the sale, distribution, or provision of, products marked with its name or logo, other than packaging in which medical marijuana is sold or on medical marijuana products. This prohibition shall not prevent employees of the business from wearing uniforms with the name or logo of the medical marijuana business while working for the business on the business property.

The owner or manager is required to respond by phone or email within twenty-four hours of contact by a city official concerning their medical marijuana business at the phone number or email address provided to the City as the contact for the business. Each twenty-four (24) hour period during which an owner or manager does not respond to the city official shall be considered a separate violation.

AA. Additional requirements for production of medical marijuana.

i. No medical marijuana business may produce or distribute concentrated or any form of synthetic cannabis.

ii. No medical marijuana business may use metals, butane, propane or other flammable product, or produce flammable vapors to process marijuana. No medical marijuana business may utilize an extraction method of any kind.

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iii. Packaging at a medical marijuana business.

All dispensed medical marijuana must be packaged in a manner which clearly shows the name of the dispensary providing the medical marijuana, name of the patient receiving the medical marijuana, date the marijuana is dispensed, amount of marijuana dispensed, and amount paid by the patient to obtain the marijuana.

iv. No medical marijuana business shall operate for profit.

BB. Cash and in-kind contributions, reimbursements, and reasonable compensation provided by patients toward the medical marijuana business' actual expense to grow, cultivate, and provide medical marijuana shall be allowed provided that they are in strict compliance with State Law. All such cash and in-kind amounts and items shall be fully documented in accordance with Section _____ of this Chapter.

21.XX.090 Lab testing of medical marijuana required.

A. A medical marijuana business must ensure that usable marijuana and plants are tested for pesticides, mold and mildew, and THC percentages in accordance with this section prior to the transfer of marijuana to a consumer.

B. As part of the cultivation process, medical marijuana businesses must ensure marijuana is segregated into batches, that each batch is placed in an individual container or bag, and that a label is attached to the container or bag that includes at least the following information:

i. A unique identifier;

ii. The name of the person who transferred it; and

iii. The dates the marijuana batch was cultivated and made available for sale at the dispensary storefront.

iv. Sampling. The medical marijuana business must

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ensure that random samples from each batch are separated in an amount necessary to conduct the applicable test, that the samples are labeled with the batch's unique identifier, and are properly submitted for testing.

v. Testing. The medical marijuana business must ensure that each sample is tested for pesticides, mold, and mildew and for an analysis of the levels of tetrahydrocannabinol (THC) and Cannabidiol (CBD).

(a) Immature Plants. An immature plant may be tested for pesticides, mold, or mildew by conducting a macroscopic or microscopic screening to determine if the plant has visible pesticide residue, mold, or mildew.

(b) Flowers or other usable marijuana plant material. Medical marijuana in the form of flowers or other plant material must be:

(1) Tested for pesticides, mold, and mildew using valid testing methodologies and macroscopic or microscopic screening may not be used;

(2) Tested for pesticides by testing for the following analytes:

1) (i) Chlorinated Hydrocarbons;

2) (ii) Organophosphates;

3) (iii) Carbamates; and

4) (iv) Pyrethroids; and

(3) Analyzed, using valid testing methodologies, to determine the levels of THC and CBD.

C. Edibles and liquids. If medical marijuana used in the edible or liquid has been tested in accordance with this section and tested negative for

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pesticides, mold, or mildew, the edible or liquid does not need to be tested for pesticides, mold, and mildew but does need to be tested for an analysis of the levels of THC and CBD. If the medical marijuana used in the edible or liquid was not tested in accordance with this section, the edible or liquid must be tested for pesticides, mold or mildew in accordance with this section.

D. Laboratory Requirements. A medical marijuana business must ensure that all testing, except for testing of immature plants, is done by a third party or laboratory that:

i. Uses valid testing methodologies; and

ii. Has a Quality System for testing of pesticides, mold, and mildew that is compliant with the:

(a) 2005 International Organization for Standardization 17025 Standard; or

(b) 2009 National Environmental Laboratory Accreditation Conference Institute TNI Standards.

(c) Macroscopic or microscopic screening of immature plants must be conducted by a person who has a minimum of a bachelor's degree in horticulture, botany, plant pathology, microbiology, or an equivalent degree but is not required to be done by a laboratory.

E. Testing Results. A laboratory must provide testing results to the medical marijuana business signed by an official of the laboratory who can attest to the accuracy of the results, and that includes the levels of pesticides, mold, or mildew detected and the levels of THC and CBD.

i. if an immature plant has visible pesticide residue, mold, or mildew it must be deemed to test positive and must be destroyed.

ii. A sample of marijuana shall be deemed to test positive for mold and mildew if the sample has levels that exceed the

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maximum acceptable counts in the Pharmacopeia, Section 1111 (May 1, 2009), incorporated by reference Appendix A.

(a) A sample of usable marijuana shall be deemed to test positive for pesticides with a detection of more than 0.1 parts per million of any pesticide.

(b) If an immature plant or sample of marijuana tests positive for pesticides, mold, or mildew based on the standards in this section, the medical marijuana business must ensure the entire batch from which the sample was taken is destroyed and must document how many or how much was destroyed, and the date of destruction.

iii. In-house testing. A medical marijuana business may perform its own testing as long as the testing complies with this section.

F. he medical marijuana business may permit laboratory personnel or other persons authorized to test access to secure or restricted access areas of the facility where marijuana or immature plants are stored. The medical marijuana business must log the date and time in and out of all such persons.

21.XX.100 Right of entry – records to be maintained.

A. Records to be maintained.

Each Permittee shall keep a complete set of books of account, invoices, copies of orders and sales, shipping instructions, bills of lading, weigh bills, correspondence, bank statements including cancelled checks and deposit slips and all other records necessary to show fully the business transactions of such Permittee Receipts shall be maintained in a computer program or by pre-numbered receipts and used for each sale. The records of the business shall clearly track medical marijuana product inventory

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purchased and/or grown and sales and disposal thereof to clearly track revenue from sales of any medical marijuana from other paraphernalia or services offered by the medical marijuana business. The Permittee shall also keep and maintain records documenting proof of Long Beach residency for each patient procuring medical marijuana at a medical marijuana business. The Permittee shall also maintain inventory records evidencing that no more medical marijuana was within the medical marijuana business than allowed by applicable law for the number of patients who designated the medical marijuana business owners as their primary caregiver. All such records shall be open at all times during business hours for the inspection and examination of the City or its duly authorized representatives. The City may require any Permittee to furnish such information as it considers necessary for the proper administration of this Chapter. The records shall clearly show the source, amount, price and dates of all marijuana received or purchased, and the amount, price, dates and patient or caregiver for all medical marijuana sold.

B. Separate bank accounts.

i. The revenues and expenses of the medical marijuana business shall not be commingled in a checking account or any other bank account with any other business or individual person's deposits or disbursements.

ii. Disclosure of records.

C. By applying for a conditional use permit, the Permittee provides consent to disclose the information required by this Chapter, including information about patients and caregivers. Any records provided by the Permittee that include patient or caregiver confidential information may be submitted in a manner that maintains the confidentiality of the documents. Any document that the applicant considers eligible for protection shall be clearly marked as confidential, and the reasons for such confidentiality shall be stated on the

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document. In the event that the licensee does appropriately submit documents so as not to be disclosed, the City shall not disclose it to other parties who are not agents of the City, except law enforcement agencies. If the City finds that such documents are subject to inspection, it will provide at least twenty-four (24) hour notice to the applicant prior to such disclosure.

D. Audits.

i. The City may require an audit of the books of account and records of a medical marijuana business on such occasions as it may consider necessary, including but not limited to ensuring compliance with LBMC section 3.80.261(H). Such audit may be made by an auditor selected by the City Manager that shall likewise have access to all books and records of the medical marijuana business. The expense of any audit determined necessary by the City shall be paid by the medical marijuana business.

E. Consent to Inspection.

Application for a conditional use permit or operation of a medical marijuana business, or leasing property to a medical marijuana business, constitutes consent by the applicant, and all owners, managers and employees of the business and the owner of the property to permit the City Manager to conduct routine inspections of the medical marijuana business to ensure compliance with this Chapter or any other applicable law, rule or regulation.

F. The owner or business manager on duty shall retrieve and provide the records of the business pertaining to the inspection. For purposes of this Chapter, inspections of medical marijuana businesses and recordings from security cameras in such businesses are required to be produced as part of the routine policy of inspection and enforcement of this Chapter for the purpose of protecting the public safety, individuals operating and using the services of the

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medical marijuana business, and the adjoining properties and neighborhood.

G. Application for a conditional use permit constitutes consent to inspection of the business as a public property without a search warrant, and consent to seizure of any surveillance records, camera recordings, reports or other materials required as a condition of a medical marijuana permit without a search warrant. Should the owner or business manager refuse to comply with this section, the City will obtain an administrative search warrant.

i. Reporting of source, quantity and sales.

H. The records to be maintained by each medical marijuana business shall include the source and quantity of any marijuana distributed, produced or possessed within the property. Such reports shall include, without limitation, for both cultivation, acquisitions from wholesalers and transactions to patients or caregivers, the following:

i. Name and address of grower, seller and purchaser;

ii. Date, weight, type of marijuana and dollar amount or other consideration of transaction; and

iii. For wholesale transactions, the state and City, if any, sales and use tax license number of the seller.

21.XX.110 Requirements related to monitoring and security of medical marijuana businesses.

All components of the security plan submitted with the application, as it may be amended, shall be in good working order, monitored and secured twenty-four hours per day. A separate security system is required for each business. The security plan must include, at a minimum, the following security measures:

i. Video cameras.

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I. A medical marijuana business shall install and maintain a video surveillance system that monitors no less than the front and rear of the Property, and all points of ingress and egress at the business. The surveillance system shall:

i. Capture a full view of the public right-of-ways and any parking lot under the control of the medical marijuana business;

ii. Be of adequate quality, color rendition and resolution to allow the ready identification of any individual committing a crime anywhere on or adjacent to the exterior of the property;

iii. Record and maintain video for a minimum of thirty (30) days and be accessible via the Internet by the Long Beach Police Department. A Public Internet Protocol (IP) address and user name/password is also required to allow the Long Beach Police Department to view live and recorded video from these cameras over the Internet. Consent is given by the Medical Marijuana Collective under this subsection to the provision of said recordings or live video feed to the Police Department without requirement for a search warrant, subpoena or court order;

iv. Use of safe for storage.

J. The medical marijuana business shall install and use a safe for storage of any processed marijuana and cash on the property when the business is closed to the public. The safe shall be incorporated into the building structure or securely attached thereto. For medical marijuana-infused products that must be kept refrigerated or frozen, the business shall lock the refrigerated container or freezer in place of use of a safe so long as the container is affixed to the building structure.

i. Alarm system.

K. The medical marijuana business shall install and use a fire

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and burglar alarm system that is monitored by a company that is staffed twenty-four hours a day, seven days a week. The security plan submitted to the City shall identify the company monitoring the alarm, including contact information, and the City shall be updated within seventy-two (72) hours of any change of monitoring company.

i. Security guard.

The medical marijuana business shall hire and maintain an armed guard, licensed by the State of California, generally located at an indoor guard station, during all hours of operation. The security guard should only be engaged in activities related to providing security for the facility.

21.XX.120 Requirements for public health and labeling.

i. Medical marijuana-infused products.

L. The production of any medical marijuana-infused product shall be at a medical marijuana-infused product manufacturer that meets all requirements of a retail food establishment as set forth in Chapter 8.45 of this Code. The Permittee shall comply with all applicable state and local health regulations related to the production, preparation, labeling, and sale of prepared food items.

i. Labeling and packaging requirements.

M. All medical marijuana sold or otherwise distributed by the Permittee shall be packaged and labeled in a manner that advises the purchaser that it contains marijuana and specifies the amount of marijuana in the product, that the marijuana is intended for medical use solely by the patient to whom it is sold, and that any resale or redistribution of the medical marijuana to a third person is prohibited. In addition, the label shall be in print large enough to be readable and shall include:

i. Potential food allergy ingredients, including but

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not limited to milk, eggs, fish, shellfish, tree nuts, peanuts, wheat, and soybeans.

ii. All additives used to extract THC, including, without limitation, pesticides, herbicides and fertilizers that were used in the cultivation of the medical marijuana used in the product.

(a) The following warning:

THIS PRODUCT CONTAINS MARIJUANA. THIS PRODUCT IS MANUFACTURED WITHOUT ANY REGULATORY OVERSIGHT FOR HEALTH, SAFETY OR EFFICACY. THERE MAY BE HEALTH RISKS ASSOCIATED WITH THE INGESTION OR USE OF THIS PRODUCT.

N. The product shall be packaged in a sealed container that cannot be opened without obvious damage to the packaging.

21.XX.130 Medical marijuana business permit application process.

i. Any medical marijuana business desiring a conditional use permit required by this Chapter shall, prior to initiating operations, complete and file an application on a form supplied by the City, and shall submit the completed application to the Department of Development Services with payment of a nonrefundable processing and notification fee, as established by the City Council by resolution.

(B)

21.XX.140 Compliance with other applicable law.

i. Application of state and federal law.

O. Except as may be provided otherwise in this Chapter, or rules adopted pursuant to this Chapter or interpretations by the City, any law or regulation adopted by the state governing the cultivation, production, possession or distribution of marijuana for medical use shall also apply to medical marijuana

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businesses in the City. Provided however, if a state law or regulation permits what this Chapter prohibits, this Chapter shall prevail. Compliance with any applicable state law or regulation that does not permit what this Chapter prohibits shall be deemed an additional requirement for issuance or denial of any license under this Chapter, and noncompliance with any applicable state law or regulation is unlawful and shall be grounds for revocation or suspension of any license issued under this Chapter. No medical marijuana business shall continue operations in violation of an additional state law or regulation, which does not permit what this Chapter prohibits, applicable within the City after the effective date of the state law or regulation.

i. Revocation of permit upon applicable state or federal prohibition.

P. If the state prohibits the cultivation, production, possession or other distribution of marijuana through a medical marijuana businesses, or if a court of competent jurisdiction determines that the federal government's prohibition of the cultivation, production, possession or other distribution of marijuana through medical marijuana businesses supersedes state law, any permit issued pursuant to this Chapter shall be deemed to be immediately revoked by operation of law, with no ground for appeal or other redress on behalf of the Permittee.

i. Revocable privilege.

Q. A conditional use permit is a revocable privilege, and no applicant therefor or holder thereof shall be deemed to have acquired any property interest therein.

21.XX.140 Prohibited acts.

It shall be unlawful for any person to:

i. Cultivate, distribute, possess, or produce marijuana in plain view of, or in a place open to the general public.

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ii. Smoke, use or ingest on the property of the medical marijuana business:

(a) Marijuana,

(b) Alcoholic beverage, or

(c) A controlled substance, except in compliance with the directions of a legal prescription for the person from a doctor with prescription writing privileges.

(d) Operate or be in physical control of any medical marijuana business, liquor establishment, vehicle, aircraft, or motorboat while under the influence of alcohol, medical marijuana, or other intoxicant.

(e) Possess medical marijuana that is not in a sealed package in a location where the possessor is not authorized to possess or consume medical marijuana.

(f) Possess more than six (6) mature marijuana plants or twelve (12) immature marijuana plants, or two (2) ounces of marijuana without a conditional use permit. It shall be an affirmative defense to this charge if a legitimate recommendation from a qualified physician of the patient for whom the marijuana is being grown includes a recommendation for an increased amount of marijuana as medically necessary to address the patient's debilitating medical condition.

(g) Obtain marijuana from a person who is not permitted as a medical marijuana business.

(h) Possess or operate a medical marijuana business in violation of this Chapter.

(i) Distribute medical marijuana without a conditional use permit or outside of the restricted area of the

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medical marijuana business.

(j) Deliver or transport medical marijuana to a patient.

(k) Permit any other person to violate any provision of this Chapter or any condition of an approval granted pursuant to this Chapter, or any law, rule or regulation applicable to the use of medical marijuana or the operation of a medical marijuana business.

(l) Lease any property to a medical marijuana business that has marijuana on the property without a conditional use permit from the City.

21.XX.150 Suspension or revocation of permit.

i. A conditional use permit may be suspended or revoked for any violation of this Chapter in accordance with the procedures provided in Long Beach Municipal Code Chapter 21.21.

R. If the City revokes or suspends a permit, the business may not move any marijuana from the property except under the supervision of the Long Beach Police Department.

21.XX.160 Term of permit – renewals – expiration of permit.

i. Term of permit.

S. A conditional use permit shall be valid for five (5) years. The permit shall expire on the last day of the month in which the permit is issued of the year following issuance or renewal of the permit.

T. Renewal of permit.

U. The Permittee shall apply for renewal of the conditional use permit at least forty-five days before the expiration of the permit. The Permittee

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shall apply for renewal using forms provided by the City. If the applicant fails to apply for renewal at least forty-five days before the expiration of the permit but does apply for renewal prior to expiration of the permit, the City may process the renewal application if the applicant submits a late filing fee of Five Thousand Dollars ($5,000) at the time of submittal of the renewal application.

i. The renewal permit fee, and late fee if applicable, shall accompany the renewal application. Such fee is nonrefundable.

ii. In the event there has been a change to any of the plans identified in the permit application which were submitted to and approved by the City with the application or an earlier renewal, the renewal application shall include specifics of the changes or proposed changes in any of such plans.

iii. In the event any person who has an interest as described in the disclosures made to the City pursuant to this Chapter, or any business manager, financier, agent as defined herein or employee has been charged with or accused of violations of any law since such disclosure, the renewal application shall include the name of the violator, the date of the violation, the court and case number where the violation was filed and the disposition of the violation with the renewal application.

iv. In the event the business permit has been suspended or revoked or a Permittee has received any notice of violation of any law, the renewal application shall include a copy of the notice, suspension or revocation.

v. The renewal application shall include proof of payment of all applicable taxes required by the LBMC and verification that the business has a valid state seller's permit in good standing.

vi. The renewal application shall include a summary

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report for the previous twelve (12) months showing the amount of marijuana purchased, the amount of marijuana sold, the forms in which marijuana was sold, the number of patients and the number of primary caregivers who received marijuana, the police report numbers or case numbers of all police calls to the medical marijuana business and for calls resulting in a charge of a violation of any law, the charge, case number and disposition of any of the charges.

vii. The City shall not accept renewal applications after the expiration of the permit, but instead shall require the applicant to file a new permit application.

viii. In the event there have been allegations of violations of this Chapter by any of the Permittees or the business submitting a renewal application, the City may hold a hearing prior to approving the renewal application. The hearing shall be to determine whether the application and proposed Permittees comply with this Chapter and whether the operation of the business has been in compliance with this Code.

V. Nonpayment of tax.

W. In the event a medical marijuana business that has been open and operating and submitting monthly sales and use tax returns to the City ceases providing sales and use tax returns to the City for a period of three (3) months or longer, the conditional use permit shall be deemed to have expired and a new permit shall be required prior to reopening at the property.

21.XX.170 City manager authorized to issue rules.

The City Manager or his designee may adopt rules and regulations that the City Manager determines are reasonably necessary to implement the requirements of this Chapter.

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21.XX.180 Violation and enforcement.

i. Any person violating any provision of this Chapter or knowingly or intentionally misrepresenting any material fact in procuring a conditional use permit, shall be deemed guilty of a misdemeanor punishable by a fine of not more than one thousand dollars ($1,000) or by imprisonment for not more than twelve (12) months, or by both such fine and imprisonment.

Any person who engages in any medical marijuana business operations without a conditional use permit, or after a conditional use permit application has been denied, or a medical marijuana permit has been suspended or revoked, shall be guilty of a misdemeanor.

As a nuisance per se, any violation of this Chapter shall be subject to injunctive relief, revocation of the certificate of occupancy for the property, disgorgement and payment to the City of any and all monies unlawfully obtained, costs of abatement, costs of investigation, attorney fees, and any other relief or remedy available at law or equity. The City may also pursue any and all remedies and actions available and applicable under local and state law for any violations related to the operation of a medical marijuana business.

Any violation of the terms and conditions of the conditional use permit, of this Chapter, or of applicable local or state regulations and laws shall be grounds for permit suspension or revocation.

21.XX.190 Establishment of a Medical Marijuana Task Force.

i. A Long Beach Medical Marijuana Task Force is established. The Task Force shall consist of seven (7) members. Appointments to the Task Force shall be made and vacancies on the Task

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Force shall be filled by the Mayor and City Council in accordance with the provisions in Chapter 2.18 of this Code. Services of the members of the Task Force shall be voluntary and members will serve without compensation.

ii. All members of the Task Force shall be residents of the City. The Task Force shall be comprised of the following members:

iii. Three Task Force members shall be representatives from three separate medical marijuana businesses operating in the City;

iv. Three Task Force members shall be representatives of recognized neighborhood organizations which have at least one medical marijuana business operating within its boundaries; and

v. One Task Force member shall be a representative of a local patient advocacy organization with a background in working to protect the interests of medical marijuana patients.

vi. The Medical Marijuana Task Force shall have the power and duty to:

(a) Recommend to the City operational and safety standards for medical marijuana businesses operating in the City;

(b) Develop and make recommendations for a mediation process to be used by operators of medical dispensaries, patients, and neighbors of dispensaries to address community concerns and nuisance issues and resolve conflicts and disputes.

vii. Sunset provision.

The Medical Marijuana Task Force shall terminate by operation of law on December 31, 2017, and after that date, the City Attorney shall

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cause this section to be removed from the Code.

21.XX.200 SEverability.

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.

21.XX.210 Review of regulations.

On or before the first anniversary of the effective date of this Chapter, the City Council shall review the effectiveness of these regulations, and shall enact modifications, if necessary.

Section 2. Chapter 5.89 of the Long Beach Municipal Code is hereby repealed.

Section 3. The City Clerk shall certify to the passage of this ordinance by the City Council and cause it to be posted in three (3) conspicuous places in the City of Long Beach, and it shall take effect on the thirty-first (31st) day after it is approved by the Mayor.

I hereby certify that the foregoing ordinance was adopted by the City Council of the City of Long Beach at its meeting of _____, 20__, by the following vote:

Ayes: Councilmembers: _____

_____

_____

_____

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Noes: Councilmembers: _____

_____

Absent: Councilmembers: _____

_____

_____
City Clerk

Approved: _____ _____
(Date) Mayor

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California Democrats write marijuana legalization into party platform

Published: March 10, 2014

California Democrats voted overwhelmingly to add marijuana legalization to the state party's official platform on Sunday, marking a shift from current Gov. Jerry Brown's own position on the drug.

According to the Sacramento Bee, the issue was approved by a near-unanimous voice vote at the party's annual convention in California. As a result, the party platform for state Democrats will officially support *"the legalization, regulation and taxation of pot in a manner similar to that of tobacco or alcohol."*

Despite the move, however, the issue is not expected to be put up for a vote during the 2014 midterms. Instead, advocates have decided to wait until 2016, when a larger percentage of the population is engaged with the national election and when more money could be spent to push messages.

Speaking out in support of legalization, California's Lt. Gov. Gavin Newsom said the state has fallen behind public opinion since it first voted to approve medical marijuana, and the time has come to take the next step forward.

"It's time for all of us to step up and step in and lead once again in California, just as we did in 1996. We did just that with medical marijuana," he told convention attendees on Saturday, according to the Huffington Post. *"But for almost 20 years now, we've sat back admiring our accomplishment while the world, the nation, and states like Colorado and Washington have passed us by. ... It's time to legalize, it's time to tax, it's time to regulate marijuana for adults in California."*

Colorado and Washington both voted to legalize recreational marijuana use in 2012, becoming the first two states in the US to do so.

Newsom's comments, meanwhile, certainly fall in line with shifts in public opinion. According to a Public Polling Institute of California survey released in late 2013, 55 percent of residents support legalizing marijuana. Of that number, 47 percent support legalization with restrictions similar to those levied on alcohol, while 8 percent favor allowing anyone to purchase the drug.

Widespread support aside, Gov. Jerry Brown does not seem to agree with the state Democratic party at large. Speaking on NBC's "Meet the Press" in early March, Brown said he was concerned with the consequences of allowing anyone to purchase and smoke pot.

"The problem with anything, a certain amount is okay," he said, according to the Huffington Post. *"But there is a tendency to go to extremes. And all of a sudden, if there's advertising and legitimacy, how many people can get stoned and still have a great state or a great nation? The world's pretty dangerous, very competitive. I think we need to stay alert, if not 24 hours a day, more than some of the potheads might be able to put together."*

Outside of California, other states are also considering legalizing recreational pot use. As RT reported previously, Alaska is set to vote on the issue this August, while Oregon and Washington, DC, are also considering similar measures.

Last April, a nationwide Pew poll found marijuana supporters gaining steam, with a majority of Americans supporting legalization for the first time in the survey's history.

Denver Murder Rate Cut in Half After Marijuana Legalization. Coincidence?

The Free Thought Project
John Vibes
May 20, 2014

According to statistics recently released by the government in Denver, the amount of robberies and violent crimes significantly decreased since marijuana legalization went into effect. It is important to mention that this strong correlation is not definitive proof that legalization is the cause of this drop in crime, but it does strongly suggest that this is the case.

These statistics are especially convincing considering the short amount of time that this drastic reduction in crime has taken place. In just one short year the number of homicides dropped by 52.9%. Sexual assaults were reduced by 13.6%. Robberies were down by 4.8% and assaults were down by 3.7%.

The statistics measured the first few months of the year for both 2013 and 2014, and then compared those numbers with one another to determine whether they were higher or lower after legalization went into effect.

There are many different factors contributing to this drop in crime, and it is likely that marijuana legalization is a very big piece of the puzzle. Legalization has had a profound impact on local economies, and has created a large boom in new residents who have moved to the area to flee persecution. This increase in prosperity surely has some effect on the amount of robberies and burglaries that have taken place.

Additionally, marijuana is traditionally known to mellow people out and calm them down, making them far less likely to act out in anger or plan a murder.

One final possibility that comes to mind is the fact that possibly, police resources are being diverted towards serious crimes instead of nonviolent offenses. Unfortunately, they are still writing plenty of fines and locking up plenty of people for nonviolent offenses, but marijuana smokers and traders have been one of the largest group of persecuted nonviolent offenders for a very long time.

See the UCR Citywide Report

John Vibes is an author, researcher and investigative journalist who takes a special interest in the counter culture and the drug war. In addition to his writing and activist work he is also the owner of a successful music promotion company. In 2013, he became one of the organizers of the Free Your Mind Conference, which features top caliber speakers and whistle-blowers from all over the world. You can contact him and stay connected to his work at his Facebook page. You can find his 65 chapter Book entitled "Alchemy of the Timeless Renaissance" at bookpatch.com.

OPED: PSST... GOVERNMENT-SUPPLIED MARIJUANA PROGRAM TURNS 30

Each month Irvin Rosenfeld goes to his pharmacy and picks up a special prescription, supplied to him by the U.S. government: a canister containing roughly 10 ounces of marijuana in pre-rolled cigarettes.

Rosenfeld, a Boca Raton, Florida stockbroker, suffers from a rare illness called multiple congenital cartilaginous exostosis, a painful genetic disease that causes tumors to grow at the ends of his long bones, causing unbelievable pain. He is also one of four surviving patients receiving government-supplied medical marijuana, in a program that was closed to new applicants by President George H.W. Bush in 1992.

That program marks its 30th anniversary May 10. That's right, our government has been supplying medical marijuana to a small number of patients -- the program peaked at 34 approved participants in 1991 -- for three full decades.

This may seem puzzling. After all, hasn't White House Drug Czar John Walters called medical marijuana "snake oil," a "con," a "farce," and even compared it to "medicinal crack"? Surely if our government really thinks marijuana is useless and dangerous, it wouldn't supply it to sick people?

A better question might be: Why is our government working so hard to avoid learning that marijuana can be a safe and effective medicine?

The federal medical marijuana program, begun on May 10, 1978 as part of the settlement to a lawsuit filed by glaucoma patient Robert Randall, is officially a research program. Randall, Rosenfeld and the other participants were required to sign a consent document specifically referring to it as a "study."

But there has been no study of these patients, at least not by the government. While shipping literally hundreds of pounds of marijuana to these patients over the course of 30 years, the federal government never lifted a finger to find out whether it was helping or hurting.

In frustration, a handful of the patients worked with researchers a few years ago to organize and fund a study of four of the eight still alive in 2001 (the others were either too ill to participate or chose to remain anonymous). Each was subjected to an exhaustive battery of medical tests, including immunological and endocrine assays, MRI scans of the brain, pulmonary function tests, neuropsychological tests and more.

The study, published in 2002, found, "Results demonstrate clinical effectiveness [of marijuana] in these patients in treating glaucoma, chronic musculoskeletal pain, spasm and nausea, and spasticity of multiple sclerosis. All 4 patients are stable with respect to their chronic conditions, and are taking many fewer standard pharmaceuticals than previously." The only meaningful side effect noted was "mild changes in pulmonary function" in two of the patients -- not surprising, given that investigators found the government's marijuana to be a "crude, low-grade product."

In testimony before the Illinois state legislature two years ago, Rosenfeld called himself "living proof that [marijuana] works well. I'm also living proof that the government doesn't want to know how well it works. If they want to do research, all they have to do is contact me."

Federal officials claim they have no bias against medical marijuana research. The government has indeed allowed a handful of small pilot studies to proceed, and the ones published so far have consistently found marijuana to be safe and effective at relieving symptoms such as pain and appetite loss.

Typically in science, successful pilot studies lead to larger, more advanced trials. And there is a group of researchers at the University of Massachusetts who want to do just that: grow specially selected strains of marijuana for studies in treating specific conditions, designed to develop marijuana as an FDA-approved prescription drug.

The government is blocking them.

Instead of learning from the private study of the federal medical marijuana patients and the handful of other medical marijuana trials it has permitted, federal officials have chosen to bury their heads in the sand, repeating, "Marijuana is not a medicine," as if saying so would make it true.

The hypocrisy and dishonesty continue, and patients -- except for those four lucky survivors -- continue to suffer.

Bruce Mirken is director of communications for the Marijuana Policy Project.

House Blocks DEA From Targeting Medical Marijuana

Posted: 05/30/2014

WASHINGTON -- Reflecting growing national acceptance of cannabis, a bipartisan coalition of House members voted early Friday to restrict the Drug Enforcement Administration from using funds to go after medical marijuana operations that are legal under state laws.
An appropriations amendment offered by Rep. Dana Rohrabacher (R-Calif.) prohibiting the DEA from spending funds to arrest state-licensed medical marijuana patients and providers passed 219-189. The Senate will likely consider its own appropriations bill for the DEA, and the House amendment would have to survive a joint conference before it could go into effect.

Rohrabacher said on the House floor that the amendment "should be a no-brainer" for conservatives who support states' rights and argued passionately against allowing the federal government to interfere with a doctor-patient relationship.

"Some people are suffering, and if a doctor feels that he needs to prescribe something to alleviate that suffering, it is immoral for this government to get in the way," Rohrabacher said, his voice rising. "And that's what's happening."

The debate pitted three House Republicans who also are doctors against one another. Rep. Andy Harris (R-Md.) and Rep. John Fleming (R-La.) opposed the amendment, while Rep. Paul Broun (R-Ga.) supported it.

Harris insisted that there were no medical benefits to marijuana and that medical marijuana laws were a step toward legalizing recreational pot.

"It's the camel's nose under the tent," said Harris. He cited piece of anti-marijuana propaganda published by the DEA this month that claimed medical marijuana was just "a means to an end" -- the eventual legalization of marijuana for recreational purposes. The taxpayer-funded report uses scare quotes around the word "medical."

"I don't think we should accept at all that this is history in the making," said Fleming, who lamented earlier this month that it wasn't realistic to make alcohol illegal.

Broun said there were "very valid medical reasons" to use marijuana extracts or products. "It's less dangerous than some narcotics that doctors prescribe all over this country," Broun said. He said medical marijuana was a states' rights issue and Congress needed to "reserve the states' powers under the Constitution."

Rep. Sam Farr (D-Calif.) co-sponsored the amendment with Reps. Rohrabacher, Don Young (R-Alaska), Earl Blumenauer (D-Ore.), Tom McClintock (R-Calif.), Steve Cohen (D-Tenn.), Paul Broun (R-Ga.), Jared Polis (D-Colo.), Steve Stockman (R-Texas), Dina Titus (D-Nev.), Justin Amash (R-Mich.) and Barbara Lee (D-Calif.).

"The conflicting nature of state and federal marijuana laws has created an untenable situation," Blumenauer said prior to the House debate. "It's time we take the federal government out of the equation so medical marijuana business owners operating under state law aren't living in constant fear of having their doors kicked down in the middle of the night."

Under the Obama administration, the DEA and several U.S. attorneys have raided marijuana dispensaries that complied with state laws. The DEA still classifies marijuana as a Schedule I substance with "no currently accepted medical use," and the agency has engaged in an aggressive public relations campaign to diminish medical benefits.

Currently, 22 states and the District of Columbia have legalized marijuana for medical use. Five other states -- Alabama, Kentucky, Mississippi, Utah, and Wisconsin -- have legalized CBD oils, a non-psychoactive ingredient in marijuana that may treat epilepsy.

A number of studies in recent years have shown the medical potential of cannabis. Purified forms may attack some forms of aggressive cancer. Marijuana use also has been tied to better blood sugar control and may help slow the spread of HIV. Legalization of the plant for medical purposes may lead to lower suicide rates, according to one study.

Thursday's vote follows changing public sentiment toward the government's failed war on drugs. A recent Pew survey found that 67 percent of Americans support drug policies that focus on providing treatment, rather than an arrest and prosecution. An overwhelming majority of Americans also support the legalization of marijuana for medical purposes -- a recent CBS News poll found 86 percent think doctors should be able to prescribe marijuana to seriously ill patients.

"Those who suffer under current policies are not faceless," Blumenauer said. "They are not statistics. They are our neighbors and live in our communities. They are the owners of small businesses that are so important to our economy, and patients with conditions -- often desperate and painful -- who have turned to medical marijuana to help them get through each day. They're not the enemy, and it's time we stopped treating them like it."

UPDATE: 12:38 a.m. -- Tom Angell, chairman of Marijuana Majority, issued this statement:

"This historic vote shows just how quickly marijuana reform has become a mainstream issue. The last time a similar amendment came up it didn't come very close to passing but, since then, more states have passed medical marijuana laws and a couple have even legalized marijuana for all adults. More states are on this way later this year and in 2016, and it's clear that more politicians are beginning to realize that the American people want the federal government to stop standing in the way. If any political observers weren't aware that the end of the war on marijuana is nearing, they just found out."

Dear Long Beach Mayor & City Council Feb 3, 2015

RE: LB Citizens Need Medical Marijuana

Most people live in the delusion that tragedy happens to other people. They find it hard to believe it is possible that their child would be infected with some unspeakable disease or that a loved one might perish from cancer or a myriad of other afflictions. That is, of course, until it happens to them. Hope springs eternal.

However, reality remains constant. Accidents happen; people become disabled. We will all die at some time. And, there is a very high probability that we will suffer from something that could be helped with medical cannabis. We should do all that is within our reach to lessen the suffering of those in need.

Our forefathers used marijuana for a myriad of things—clothing, rope, paper, and most importantly—medicine. In fact, when Thomas Jefferson was President, the growing of hemp was required of farmers for the good of the nation. Cannabis was a time-honored agricultural product until newspaper magnate William Randolph Hearst and synthetic-fabric producer Dupont came to the realization that it had the potential of cutting into their millions of dollars of profit. Together, with their cronies in Congress, they pressed for its illegality. And, the rest has become history.

Since California's Proposition 215 passed allowing for the medical use of marijuana, the population has become much more enlightened. A staggering amount of anecdotal and scientific evidence points to the usefulness of this herb for a myriad of ailments, pain and even post-traumatic stress disorder (PTSD). Unfortunately, the "government" is lagging behind the voters in their understanding of this miracle medicine. The obscene profits garnered by a mercenary "government," in terms of asset forfeiture, has provided the incentive for them to maintain status quo.

As responsible citizens we must call or write our representatives (especially our Long Beach Councilmembers & Mayor) and demand that the infirmed and disabled have a right to reasonable access to marijuana. Don't wait until you need it; it may be too late.

Yours truly,
Diana Lejins
Chair - Advocates for Disability Rights
Chair - Long Beach Medical Marijuana Task Force
POB 15027
LB, CA 90815

Legalizing marijuana is civil rights issue, California NAACP says - CNN.com
By Liane Membis , CNN
July 7, 2010 3:20 p.m. EDT CNN.com

(CNN) -- Legalizing marijuana is a civil rights issue, according to one of California's most prominent African-American advocacy groups.

The California State Conference of the National Association for the Advancement of Colored People, led by President Alice Huffman, recently announced its "unconditional endorsement" for Proposition 19, a legislative initiative on the November ballot that would legalize the recreational use of marijuana in California.

Huffman said African-Americans are disproportionately affected by the criminalization of marijuana which makes passing the law a civil rights issue.

"We have empirical proof that the application of the marijuana laws has been unfairly applied to our young people of color," Huffman said in an official statement.

"Justice is the quality of being just and fair and these laws have been neither just nor fair."

Police departments in California have made more than 60,000 marijuana possession arrests in 2008, three times more than in 1990, according to a recent study released by the Drug Policy Alliancean organization that says it promotes policies to end the war on drugs. Although blacks and Latinos make up less than 44 percent of the state's population, together both ethnic groups constitute up to 56 percent of arrests that are made for marijuana possession in California, according to the study. Furthermore, the U.S. Department of Health and Human Services has found that African-Americans use marijuana at lower rates than white Americans across the country.

The study said arrests in California are "racially-biased" and have led to a "system-wide phenomenon, occurring in every county and nearly every police department in California, and elsewhere."

Hilary O. Shelton, vice president of advocacy for the NAACP, said these numbers make it a civil rights issue.

"We are usually conservative in terms of the issues that we support, but disproportionate prosecution of [African-Americans for] drug-related offenses for marijuana has called us to fight for decriminalization in our community."

"If the law on drug possession was being enforced correctly, then the number of arrests and prosecutions and prison sentences would be proportionate to our society across the board," Shelton said.

"Sadly, that's not the picture."

But some African-Americans don't think the solution to the problem is to legalize marijuana.

Bishop Ron Allen, an outspoken leader of the International Faith-Based Coalition and member of the NAACP, is outraged by the endorsement.

He, along with 24 other faith- and activist-based organizations held a press conference in California Wednesday, calling for the resignation of Alice Huffman, claiming the California NAACP's endorsement of marijuana legislation is selling out the African-American community.

"If you think you are a civil rights leader, you should know better than anyone not to open the door to laws that will poison our community," Allen said.

But Huffman's endorsement has been backed by other organizations that support civil rights, including LEAP, the Law Enforcement Against Prohibition.

However, Allen believes that by supporting this initiative, Huffman is giving the NAACP "a black eye."

"We agree that the disproportionate arrests should change, but legalizing marijuana is not the way," Allen said.

"What it will create is for more incarceration, more drug babies, and more crime on the street. This is not a civil rights issue."

Allen, a former drug addict, said marijuana is a gateway drug that causes violence in poor communities and impedes the education of African-American youth.

The California NAACP "does not speak for the majority of the African-American community in this country," Allen said.

"What we need to do is support initiatives that help the black male progress in education and job placement."

"How do you educate a mind that is intoxicated?"

In addition, Allen said, revenue raised from legalizing and taxing marijuana sales would not end up serving is community.

"To raise the $100 billion that would be needed to fund education in this state, the use of marijuana would have to increase by 20 to 40 percent," he said. "This is a smokescreen and it's blood money."

But Shelton said Huffman's stand against criminalization supports NAACP founding principles.

"What the California state conference is trying to do is simply what is rooted in our mission: to eliminate racial prejudice wherever it may be," Shelton said.

"If members of our own community are able to see this as not just a drug issue, but a civil rights issue, I think individuals across the nation will reconsider their views on the marijuana legislation."

The decision on Proposition 19 will be made in California in November.

Long Beach Marijuana Task Force

Long Beach Marijuana Task Force
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September 17, 2014 DRAFT DRAFT DRAFT

Honorable Board of Planning Commissioners
City of Long Beach
333 West Ocean Blvd., 3rd Floor
Long Beach, California 90802

Honorable Members of the Long Beach Planning Commission:

At the last meeting of the Planning Commission, in order to guide the Commission in its decision-making process, the Chief of Police was asked to provide his expert opinion relative to the impact of medical marijuana dispensaries in Long Beach. In doing so, the Chief provided the Commission with the near exact statements of those he made before the City Council, at the time the Council was considering the ban on dispensaries, many months earlier.

Those making contributions to this letter each read a transcript of the Chief's testimony before the Planning Commission on July 17, 2014. The underlined quotes in this letter depict the Chief's testimony taken from a transcript of the Commission hearing.

One of the first statements the Chief made to the Commission was, *"To begin as a foundation, my own personal feeling and I think that of members of the police department is in support of the Compassionate Use Act as it was intended and originally written."*

His statement is an improper foundation by which an officer sworn to uphold the law and the will of the people should chose to offer his expertise to the Commission.

As originally written, the Compassionate Use Act is not the current state of the law. There have been volumes of court decisions over the past 18 years since passage of Proposition 215. Nick Morrow, a retired Los Angeles Deputy Sheriff and court qualified expert on medical marijuana law stated, after reading the Chief's introductory testimony, *"How can you "support' what you do not understand?"* That is the purpose of this letter - - to point out what the Chief does not understand, or is not willing to accept as a matter of law.

The Chief's testimony before the Commission and the City Council was consistent with the volumes of misinformation published state-wide by the California Narcotic Officer's Association, an organization whose life blood depends upon maintaining the drug war status quo.

His statements also mirrors the testimony of a LBPD drug unit detective testifying in superior court during a voir dire examination when he stated that all of his drug enforcement related training is provided by the Narcotic Officer's Association and that, *"my department has never once provided me with drug enforcement training."* That case was eventually dismissed.

So, who within the LBPD is providing the Chief with the information that he in turn provides to those who are making the decisions on this vitally important issue?

Subsequent to the Chief's testimony before the City Council last year, Amanda Reinman, the Policy Manager for the Drug Policy Alliance wrote him a letter stating that many of the claims he made before the City Council are not

Supported by research. In her letter she undertook to educate and inform the Chief on the issues so that medical cannabis patients and the citizens of Long Beach and California might be better served.

Ms. Reiman took issue with his statements that medical marijuana facilities always have a negative impact on communities and pointed out how, in fact, they provide alternative health care, especially among lower income individuals, and backed her statement up with university research to which she referred the Chief.

As to the Chief's statement that the *"Compassionate Use Act already provides for caregivers to grow and share cannabis "and "Allowing dispensaries in is not the answer to help those who are ill, " Ms*. Reinman quite logically and compassionately informed him that *"Cannabis cultivation, especially in an urban area can be impossible for many patients, especially those who are seriously ill."*

She pointed out that the "vast number of hours" allegedly spend by LBPD dealing with the issue stems not from the actions of the dispensaries, but rather the lack of local regulation that sets out a framework for dispensary operations and community relations. Ms. Reinman provided the Chief with examples of municipalities that are proactive rather than reactive to the issue of medical cannabis and demonstrated how their regulations*, "ease the burden of policing, create stability within the patient community and allow dispensaries to become positive fixture in their communities."*

In spite of the "education" provided by Ms. Reinman in her letter to the Chief there was virtually no change between the Chief's testimony before the City Council and the Planning Commission many months later.

Other elements of the Chief's testimony before the City Council and the Commission included his statements that there was a negative impact upon the quality of life and a steady stream of complaints from residents and businesses.

Yet, when asked by a council member to provide the study that supported his statement, he testified that the information was confidential. Thus, our own governing body was prevented from accessing information related to important decision making. To this day, the Chief has not supported his allegation that dispensaries are "magnets for crime."

The Chief testified that a murder was linked to a medical marijuana dispensary, but did not say how it was linked. Information received from within the medical marijuana community, as reported by sheriff's veteran Nick Morrow, is that, *"the killing was a money and theft issue and the individual person was targeted separate from any dispensary operation."* Morrow also posited, *"How many alcohol, gang, and domestic violence related homicides were reported during the same time period? One incident does not a trend make.*

Superior Court Judge James P. Gray (ret), after having read the Chief's testimony, said, "*we also have problems with alcohol and liquor stores. But many times fewer problems, because liquor stores are licensed and able to have bank accounts. This means that they report crimes when they are victimized, their workers are paid wages that are reported and taxed, the customer knows the strength of the alcohol being purchased, and there is not nearly such a temptation for people to rob the liquor stores because there is not as much cash on hand. Furthermore, during the time of Alcohol Prohibition the problems with impurities in the product, as documented by hospital emergency room visits, were enormous. But that problem almost completely disappeared when the 21st Amendment repealed Alcohol Prohibition. The same thing will happen when we come to our senses and repeal Drug Prohibition.*

Additionally, a public records request reveals that between the year 2000 and 2013 the number of calls for service to the police department declined from 200,980 to 176,210 and that there is no public record that records calls for service to medical marijuana dispensaries, banks or other financial institutions, or liquor and convenience stores.

Therefore, the Chief's testimony cannot possibly be evidence based.

Cynical fear mongering blights our city more than actual crime. Rather than cultivate a fear of crime in opposing effective regulation and control of medical marijuana, the Chief should have studied Ms. Rieman's facts and

recognized that his representations to the City Council were inconsistent with the findings of other police departments and research institutions in the Los Angeles region.

The LAPD's Chief of Police conducted studies and made the results public. He concluded that despite neighborhood complaints, most medical marijuana clinics are not typically the magnets for crime that critics often portray. He said, *"Banks are more likely to get robbed than medical marijuana dispensaries."*

The LAPD Chief's findings are also consistent with those of the Rand Corporation whose study found that crime rates rose in surrounding neighborhoods when dispensaries were shut down when compared to areas where dispensaries were allowed to stay open. Yet we have seen no studies from the LBPD that examines this condition, one way or another.

In response to his reading of Chief McDonnell's testimony before the Planning Commission, Dale Gieringer, an expert in dispensary operations across California and director of Cal NORML, stated, *"I don't know the particulars of these complaints, but aren't they similar to those for liquor outlets and other businesses? What makes medical marijuana so different that the police are uniquely incapable of dealing with these activities? In Oakland and San Francisco, which have had regulated dispensaries for years, there are no public or police complaints about their operation."*

Commenting upon the Chief's testimony that *"enforcement has been challenging because dispensaries have repeatedly been closed down only to open up within a few days,"* Gieringer said, *"Does the Chief think that a broad-scale ban will solve this problem? Other cities with supposed bans have scores of dispensaries operating illegally. Illegal dispensaries aren't a major problem in Oakland, where the city has licensed a select number of (8) operators. These legal operators are adequate to discourage illegal competitors, and pay millions in taxes to the city each year. Long Beach voters approved a 6% tax on marijuana dispensaries. At present, Weedmaps lists 4 storefront dispensaries and 47 delivery services in Long Beach. I'll bet dollars to dounuts that the delivery services are not paying taxes. With an adequate number of licensed dispensaries, the city could expect to pick up millions in revenues.*

Superior Court Judge James P. Gray (ret), after having read the Chief's testimony said in part, *"Issues about some so-called dispensaries quickly appearing, disappearing and re-appearing raised by the Chief certainly are certainly troubling. But these issues no longer particularly exist with liquor stores, and, as the market is increasingly regulated, these problems will begin to disappear for the sale of marijuana as well. This is what has happened in places like Denver, where the local government officials have worked closely with the medical marijuana community, and, from my first-hand observations, their system is working quite well for all concerned. So if the Chief and other city leaders would like to visit to those dispensaries and see their operations first hand, I would be happy to arrange a tour for them."*

Other relevant considerations for the Commission to consider when include these facts:

- A 2010 report from the Denver Police Department stated that medical marijuana dispensaries in Denver were robbed at a rate of 16.8% per year, which is lower than banks (33.7%) and liquor stores (19.7%).

- In 2009, the Los Angeles Police Department received reports of 71 robberies at the more than 350 banks in the city, compared to 47 robberies at the more than 800 medical marijuana dispensaries.

- A recent research report from the UCLA School of Public Affairs found no relationship between the density of dispensaries and violent or property crime.

- Dispensaries can also be a conduit to other services, such as health services, counseling and substance abuse treatment, and can provide for patients with little or no income. In a recent survey research study of 303 medical marijuana patients 62% indicated a desire to participate in free clinical services at their dispensary. Approximately 20% indicated interest in participating in dispensary-based social services. .

- Mere months after two US states legalized marijuana sales, five Nobel Prize-winning economists released a UN report recommending that countries end their war on drugs finding that US marijuana legalization has

already weakened Mexican Cartels and predicted that violence will decline. Legal sales clearly weaken the black market, which dries up street corner sales and territorial violence.

Other elements of the Chief's testimony demonstrate unfamiliarity with the law. In one statement he said, *"Any person suffering serious illness that obtains a legitimate recommendation from an above board doctor can appoint the primary care giver to grow marijuana."*

This is not the case. In 2007, in People V. Mentch, the court established that there is no caregiver status afforded to marijuana cultivators or collectives. The Chief then went on to say that, *"It cannot, as mentioned, be a dispensary that does no more than provide the marijuana."*

Thus, the Chief implies that he would rather have hundreds of non-controlled, non-licensed, possibly unsafe, "caregiver grows" than reasonably regulated dispensaries providing quality, tested and non-illicit market cannabis to their member patients.

Following this the Chief told the Commission that dispensaries don't really care for the seriously ill and that money rather than compassion is their aim adding that, *"we've conducted numerous investigations. And in every one we've seen young, able bodied people riding skateboards, bikes, and walking to buy marijuana."*

Again, is Long Beach so unique that studies from the 2013 National Survey on Drug Use and Health of 70,000 Americans aged 12 and older don't apply?

The study indicates that illicit drug use is down significantly and that teen use of marijuana, ***"a contentious topic now that several states have legalized marijuana sales,"*** is also on the decline." Added to that, the State of Colorado, in their six month performance report announced that inspection audits related to sales to minors revealed 100% compliance.

In answering a question from Commissioner Christoffels, the Chief said, *"we see an awful lot of resale of product brought in a dispensary - - we see it in schools. The high schools, the middle schools the wrappers are found in - - in those types of locations and other locations. People who won't normally go to buy are kids who can't get a card. They'll buy it from someone else who was able to get a card."*

What the Chief was speaking to is diversion. Diversion is illegal. It is illegal regulated for marijuana, just as it is for alcohol and tobacco. The Chief continued, *"And we've seen - - medically we've seen a tremendous uptick in emergency room visits. It's the- - the - - in the - - in the country last year, there were just under 500,000 emergency room visits strictly due to marijuana ingestion.*

The data collection the Chief refers to is flawed as well as the reporting. A marijuana mention in an ER visit does not directly relate to marijuana being the reason or cause of the visit. Standard patient questioning entails an admission of any use of marijuana regardless of the reason for the visit. A positive toxicology result obtained as a result of a completely unrelated injury will satisfy a "mention" for purposes of data collection. Closer examination of the Drug Abuse Warning Network (DAWN) study findings from which the Chief quoted show a much lower "actual" ER visit number where marijuana is the sole cause of the Visit.

Law enforcement, especially the Narcotic Officer's Association, promote the idea that medical marijuana is a "con job" and that it is too easy to get a doctor's recommendation. But, none of them have seemed to have actually talked to the Medical Board of California, which oversees doctors.

As reported in the East Bay Express, Cassandra Hockenson, public affairs manager for the Medical Board said the so-called scourge of doctors recommending pot is a non-issue. The board doesn't even track pot-specific complaints. *"The word "marijuana' has not been mentioned once in the 2012-2013 Medical Board enforcement report."*

Californians mostly complain to the board about physicians who over-prescribe opioids, which can kill you, while marijuana has no overdose level. Hockenson added that*, "If somebody feels — whether it's police officer or whoever — that*

somebody is not acting appropriately and they feel like [recommendations] are being handed out like Chiclets and proper exams aren't being done, then they need to notify the medical board and we will look into it."

The Chief mirrored even more of the Narcotic Officer Association's propaganda when he said, *"And we've sat on places for hours. And over and over again it is, I would say, extremely rare to see anybody who could be interpreted as being seriously ill walk in and make these purchases. They're young people, able bodied people."*

Is the Chief so callous that he cannot believe that those "able bodied people" suffer anxiety symptoms, pain, cancer, glaucoma, AIDS, and all of the other maladies defined and allowed by law to purchase medical marijuana?

Ask him to look out over Council Chambers, or even among the Commissioners and tell us who is and who is not suffering one or more of those ailments. Just because one does not see a wheelchair, chemotherapy symptoms, a baldhead, or a colostomy bag, doesn't mean they are not suffering from a serious illness.

There is no requirement in the law that a patients illness and suffering be visible to law enforcement, or anyone else. If the patient is legally qualified, the patient is qualified. That was the decision of the people of the state of California, so why does law enforcement continue to raise this false flag of impunity?

Commissioner Van Horik raised questions about non-profits and income taxes paid and the Chief responded that allegedly, there is no payroll tax, because volunteers work in dispensaries and that they are not *"registered with the government to pay income tax because it's supposed to be not for profit."* And that *"we've seen - - in - -in every case we've seen that that is truly not the case."*

Again, the Chief clearly has no command of the subject. Some dispensary staff are volunteers, most are not. Legitimate dispensaries up and down the state make payroll, pay roll taxes, take payroll deductions and pay their bills like every other business in California. The Board of Equalization requires a seller's permit; State Law requires non-profit filings, business licenses, and adherence to local ordinances.

Complaining about the ineffectiveness of enforcement the Chief testified, "I'll give you an example. An operation called Nature Can up on Atlantic Boulevard it's been in operation for between two-and-a-half and three years. We've served, roughly, 15 search warrants during that time." Nick Morrow, a retired sheriff's deputy who has conducted hundreds of like investigations commented, *"Fifteen search warrants at least fifteen separate investigations using LBPD resources have not solved the problem? Why aren't the owners in jail? Why haven't there been successful prosecutions? When does it become clear their current tactic is not working?"*

The Chair of the Commission addressed the same question of ineffectiveness, asking rhetorically how, after closing more than 80 dispensaries following the ban, four could continue to remain open after multiple enforcement actions.

Matthew Pappas, a civil rights attorney who represented many of the legitimate dispensary operations as well as workers and clerks cited by police in those "four" dispensaries that remained open following the ban until just last week offered this answer the question of how and why they remained open:

"As the leading candidate for L.A. County Sheriff, the Chief should be more directly informed regarding Long Beach medical marijuana dispensaries. While working for their respective dispensaries, it is interesting that workers for the handful allegedly "too rich and powerful for the LBPD to shutdown" collectives were not arrested and taken to jail in raids conducted by police repeatedly. Periodically, there would be some arrests at these collectives. Oddly though, they were not subjected to utter destruction by officers during many of those raids as the other collectives long ago shutdown by police were. Indeed, the many collectives the LBPD did close down had to close because destructive raids were conducted where officers destroyed ATM machines, put holes in walls and destroyed virtually anything they could leaving the collectives unable to re-open. In those raids, every worker was arrested and subjected to "stay away" orders that prohibited them from going within 1000' of any dispensary in Long Beach. However, for this small handful of collectives, the "stay away" orders were only imposed on ex-workers who left or were fired. It seems Chief McDonnell is being fed limited information for a specific purpose by officers who may have interests that go beyond simply doing their jobs as safety officers for the city. The issue is more than the various inaccurate statements made by Chief McDonnell about medical marijuana and California's related laws, it is whether a person making those inaccurate

statements and who take as true reports about why dispensaries are remaining open when those reports -- reports he then repeats in public statements -- are illogical and don't make any sense at all. If the LBPD wants to close those last dispensaries, it need only engage the same tactics it employed with all the others it has closed in the past -- destroy tens of thousands of dollars of equipment and property, take all the medication, arrest all the workers and impose the stay away orders. The Chief should be able to detect there's more going on here considering he is seeking to be the County's lead law enforcement officer."

This past legislative season Law Enforcement and the League of Cities proposed legislation though Senator Lou Correa's SB 1282. The president of the California Chief's Association admitted they drafted and supported the bill because "we saw the handwriting on the wall." In short, they wanted to control the system, in spite of the fact that they abused, barricaded and propagandized the will of the People for the past 18 years.

Medical marijuana advocates worked hard with Senator Correa and Law Enforcement to re-work the proposed bill so that the unreasonable proposed by law enforcement could be made reasonable. Law enforcement would have no part of that. In the end the bill died only because SB 1262 left most patients isolated from access, while it disrupted the working medical cannabis regulations in Oakland, Berkeley, San Francisco, and elsewhere. In the end California NORML, the Drug Policy Alliance and Law Enforcement Against Prohibition opposed the bill. SB 1262's defeat was a stark rebuke for police lobbyists in Sacramento – a group that up until now got its way.

It was a strong message to politicians across California from the People and their advocates within the medical marijuana community.

Severe regulations that drive away legitimate collectives and dispensaries, while allowing the criminal element to flourish both on the street and in illegal dispensaries though violence and institutional corruption – as they do today - will not be compromised.

Reasonable regulations can be monitored and adjusted. Punitive, exacting and insensitive regulations will result in more of the same for Long Beach.

Judge Gray said it best when he finished reading Chief McDonnell's testimony, *"The only real question we should ask ourselves is: do we want the marijuana to be sold by regulated and licensed business people whose product is tested and the sales taxed, or by unlicensed criminals?"*

That will be up to your recommendations and the city council. It is time to listen to the people rather than the prohibitionists. It is time to look at what is successful rather than listen to the obstructionists. Consider the following in your deliberations:

****

Since Prop. 215 was passed in 1996, local jurisdictions in CA have struggled to determine the best model for regulation. Some cities, such as Berkeley and Oakland, developed regulations very early in the game, assuming control over the distribution of medical marijuana almost immediately. Other cities, such as San Francisco, were tasked with developing regulations amidst an already burgeoning market. This presented its own set of barriers. However, San Francisco was still able to implement a successful regulatory structure. These cities have developed frameworks for the density, location, size and structure of medical marijuana distribution, as well as methods to ensure program oversight. Although differences exist among these regulations, all were developed through the lens of their unique jurisdictions, and were developed to meet the specific needs of the communities they represent. Although the regulatory models developed by San Francisco, Berkeley and Oakland possess differences, there are unifying characteristics that have supported their success.

City Licensure Process

All of these cities require that facilities that dispense medical marijuana must obtain the proper permit. The permit application process varies from city to city. However, each locale requires that permitted facilities provide documents outlining their business plans, individuals who will be running the facility, and proof that the facility complies with local disability regulations and any operations and safety standards for medical marijuana that have been adopted by regulators. This vetting process allows cities to determine which facilities open and to ensure that open facilities are complying with local regulations.

A Cap on the Number of Dispensaries

Although it has been criticized for stifling entrepreneurship, Oakland, Berkeley and San Francisco have a limit of the number of licensed dispensaries that can exist in their jurisdictions. Berkeley's limit of three, Oakland's limit of four, and San Francisco's limit of X was designed to reflect the needs of the patient populations in those communities. This tight regulation can be loosened if the need arises. Both Berkeley and Oakland have increased the numbers of permitted dispensaries since crafting their original regulations.

An Oversight Committee

Another commonality of these city regulations is the presence of an oversight committee or task force to take on the intricacies of developing and carrying out medical marijuana regulation. These oversight committees prove most successful when staffed with members of the medical marijuana community and the greater community at large to provide a balance between the interests of the industry and the community.

Strict Zoning Laws

One of the complaints most often brought against the medical marijuana community is the presence of dispensaries in undesirable areas, such as neighborhoods, busy thoroughfares, etc. Although research does not suggest a link between dispensaries and crime, the concerns of the community are reflected in the strict zoning policies that some cities have adopted. These policies prevent dispensaries from being too close to each other, as well as vulnerable locations such as schools and parks.

Regulations that Work: Berkeley, Oakland and San Francisco

Cities such as those named above have enjoyed the benefits of pro-active medical marijuana regulation. The cities are consistently reviewing their policies and adapting them to the changing knowledge base around the uses and distribution of marijuana. Here are some key highlights from the different regulatory frameworks.

Berkeley

The latest iteration of Berkeley's Ordinance includes extensive details on the difference between a dispensary and collective, permissible quantities of medical marijuana, transportation of medical marijuana, medical marijuana paraphernalia, police procedures and training, and emergency distribution should the Federal government interfere. The ordinance also establishes a Medical Marijuana Commission to oversee the implementation of the ordinance.

Oakland

Oakland has been an epi-center for medical marijuana regulation and Federal action. Oakland's medical marijuana ordinance has also changed over the years to adapt to the changing marijuana landscape and the needs of the city, including the addition of a lowest priority law for adult use of marijuana. In a city where crime is high and police

resources are scarce, Oakland has decided to focus its efforts on violent crime, and to treat the medical marijuana issue as a planning and public health issue. Oakland's very first medical marijuana regulation came in 1996, shortly after Prop. 215 was passed, with resolutions occurring frequently in the 2000's.

San Francisco

San Francisco was not as pro-active around the development of medical marijuana regulation as the other two cities discussed. In 2005, there were close to 100 dispensaries in San Francisco, and they existed largely outside a regulatory framework. Worried about the impact this would have on the community, San Francisco declared a moratorium on the opening of new dispensaries until a permitting process could be put in place. They did not shut down the whole program and start from scratch, rather they decided what regulations would be best for San Francisco, and gave existing dispensaries the chance to meet those new requirements and become licensed entities. While this did cause some disruption for a short time, in the end, access to medicine was not abruptly discontinued. Today San Francisco's ordinance includes a lengthy application process, including a substantial fee, as well as rules about the vertical integration of products sold, as to minimize diversion.

Conclusion

Medical marijuana has been permitted in California for 18 years. In that time, the state has left it up to local communities to determine the best regulations for their medical marijuana programs. While many cities have struggled to determine appropriate regulations, they have found their way, and the patients and citizens who live in those cities have enjoyed numerous benefits as a result, including: tax revenue, enhanced safety, safe access to quality medicine, the neighborhood stability that comes with the longevity of a service organization, and the appropriate zoning and location for medical marijuana dispensaries. It's not too late. The success of cities like Berkeley, Oakland and San Francisco is built on determination and a willingness of public officials to put the well being of citizens ahead of hard work and uncertainty.

We still hold out the hope that Long Beach can do the same.

Sincerely,
Diana Lejins, Chair
Long Beach Medical Marijuana Task Force

Contributors to and Supporters of this letter include:

Judge James P Gray, Superior Court (ret)
Stephen Downing, Deputy Chief, LAPD (ret)
Diane Goldstein, Lt. Commander, Redondo Beach Police Department (ret)
Nick Morrow, Deputy, Los Angeles Sheriff's Department (ret)
Rosemary Chavez, Los Angeles City Prosecutor (ret)
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Studies claim medical marijuana may reduce suicide rates, traffic fatalities

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

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

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

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

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

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

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

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

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

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

10 Marijuana Myths and Facts:

1. **Marijuana is Not Medicine.**

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

2. **Marijuana is Addictive.**

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

3. **Marijuana is a "Gateway Drug".**

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

4. **Medical Marijuana Collectives Cause Crime.**

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

5. **Medical Marijuana Causes an Increase in Teen use.**

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

6. **Marijuana Causes Traffic Collisions.**

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

7. **Marijuana is Dangerous for Young Minds.**

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

8. **Marijuana is More Potent Now Than Ever Before.**

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

9. **Marijuana Causes People to be Lazy and Unproductive.**

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

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

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

Nick Morrow 2014
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Marijuana Legalization Supported By A Growing Majority Of Americans, Survey Shows

09/03/2014 Huffington Post

A broad new survey shows that a majority of American adults continue to support marijuana legalization in the United States, and that support appears to be growing.

The survey, released last week from online polling data company CivicScience, asked more than 450,000 U.S. adults over the last two years this question: "Would you support or oppose a law in your state that would legalize, tax, and regulate marijuana like alcohol?"

Fifty-eight percent of respondents said they support marijuana legalization -- with 39 percent saying they "strongly support" and 19 percent saying they "somewhat support" reformed marijuana laws in their states. Thirty-five percent oppose legalization of marijuana -- with 29 percent "strongly" opposing and 6 percent "somewhat" opposing laws that would regulate marijuana like alcohol. Seven percent of respondents had no opinion on the issue.

CivicScience then broke out the data from just the last three months of responses -- from May to August -- and saw an increase in support and decrease in opposition to the regulation of marijuana like alcohol. Of those who responded most recently, 61 percent said they strongly or somewhat support marijuana legalization, while only 30 percent were opposed.

Men were found to be slightly more in favor of legalization than women were, by 60 to 55 percent, according to CivicScience's survey data. Support for legalization was strongest among people ages 25-34; the only age group in which the majority of people opposed legalization was those over 65.

The question, asked between November 2012 and August 2014, was hosted on as many as 400 different websites across the U.S. Each respondent was anonymous and answered the question "just for fun," according to CivicScience.

Jennifer Sikora, a spokesperson for CivicScience, explained to The Huffington Post that although the survey was online, the company uses browser cookies to keep respondents from answering the question more than once. In order to further hedge against a person answering the same question multiple times, the question is part of a pool of more than 1,000 rotating questions on multiple websites to further decrease the possibility that a respondent might happen upon the same question again. Still, Sikora says, there is a very small percentage of respondents who do repeat the answer (after all, cookies can be deleted), but the 453,653 U.S. adults in this survey are unique.

"This huge poll is yet another indication that marijuana legalization is officially a mainstream issue," Tom Angell, chairman of Marijuana Majority, told HuffPost. "With ending prohibition polling better with voters than most elected officials do these days, it'll be really interesting to see which 2016 contenders realize that supporting marijuana reform is good politics and which still don't get it."

This isn't the first recent poll to show a majority of Americans supporting marijuana legalization. In April, a survey from Pew found that 54 percent of Americans support legalizing marijuana use, and about three-quarters of Americans told Pew that if marijuana use isn't legalized, those found in possession of small amounts of the substance should not go to jail. Just last year, Gallup found for the first time that a clear majority of Americans -- 58 percent -- say marijuana should be legalized.

To date, 23 states and the District of Columbia have legalized marijuana for medical purposes and two states -- Colorado and Washington -- have legalized marijuana for adult, recreational use. Voters in three states and our nation's capital will also decide on new marijuana laws in November. Oregon and Alaska voters will decide on the legalization of recreational marijuana, while voters in Florida will decide on a medical marijuana ballot measure. D.C. voters will decide on a measure that would legalize the adult possession of small amounts of marijuana as well as limited home cultivation; however, the sale of marijuana would still be prohibited under the measure.

NAACP Backs Marijuana Federalism

Jacob Sullum|Nov. 12, 2013 4:25 pm

The National Association for the Advancement of Colored People (NAACP) recently endorsed a bill that would make the federal ban on marijuana inapplicable to people who grow, possess, or distribute cannabis in compliance with state law. H.R. 1523, the Respect State Marijuana Laws Act of 2013, would essentially repeal (or at least limit) federal pot prohibition in the 21 states that allow medical or recreational use of the drug. So far the bill, which was introduced by Rep. Dana Rohrabacher (R-Calif.), has 20 cosponsors, including five more Republicans: Justin Amash (Mich.), Dan Benishek (Mich.), Don Young (Alaska), Duncan Hunter (Calif.), and Steve Stockman (Texas).

The NAACP resolution endorsing H.R. 1523, which was adopted by its board of directors at a meeting last month, notes that "even though numerous studies demonstrate that whites and African Americans use and sell marijuana at relatively the same rates, studies also demonstrate that African Americans are, on average, almost 4 times more likely to be arrested for marijuana possession, and in some jurisdictions Blacks are 30 times more likely to be arrested for marijuana possession than whites." The NAACP, which in recent years has highlighted the racially disproportionate impact of marijuana prohibition and condemned the war on drugs, last year supported the successful legalization initiatives in Colorado and Washington, so it's not surprising that the organization wants the feds to step back and let those experiments proceed. But Tom Angell, chairman of Marijuana Majority, argues that the NAACP's willingness to stand up for state's rights is significant given the group's history of battling segregationists who (erroneously) waved that banner:

For obvious historical reasons, many civil rights leaders who agree with us about the harms of marijuana prohibition still remain reluctant to see the states chart their own courses out of the failed "war on drugs." Having the NAACP's support for a states' rights approach to marijuana reform is going to have a huge impact and will provide comfort and cover to politicians and prominent people who want to see prohibition end but who are a little skittish about states getting too far ahead of the feds on this issue.

As I've argued in *Reason*, there is nothing inherently right-wing about the Constitution's division of powers between the states and the federal government. Properly understood, federalism was never a license for violating rights protected by the 14th Amendment, and today it can profitably be employed by progressives to further their own causes. Ending the war on drugs should be at the top of the list.

New York: Advocates Mourn Death of Child at Center of Medical Marijuana Battle

Submitted by steve elliott on Wed, 07/23/2014

Death Fuels Demand for Emergency Access to Medical Marijuana for Critically Ill Patients in New York

Anna Conte, a nine-year-old from Orchard Park, New York, who died last week after falling into a coma following a severe seizure, was laid to rest on Wednesday. Anna suffered from Dravet syndrome, a life-threatening seizure disorder that has been treated with medical marijuana in states where it is legal. Medical marijuana has dramatically reduced the number of seizures in many children with similar seizure disorders.

In an effort to help their daughter, the Conte family joined the successful fight to pass a medical marijuana bill in New York. The Contes travelled repeatedly to Albany, persuading several powerful New York senators to support the bill and generating thousands of phone calls and emails to Albany leadership. Advocates around the state came to know and love Anna and her family and admire their selfless advocacy which was always accompanied with a sense of humor.

Tragically, Anna Conte did not live long enough to benefit from the law that her family helped pass. Governor Cuomo, who signed the bill into law just days before Anna's passing, has said that it will take 18 months or longer for New York to implement the law and develop the full medical marijuana patient access system.

Families and advocates are urgently calling upon Governor Cuomo to take immediate action establishing expedited access to medical marijuana for those patients and families, like the Conte's, who cannot wait until the full system is up and running. "After nine years of fighting, her little body just had enough," said Anna's mom, Wendy Conte, reports the *Buffalo News*. "She did more in her nine years than what many people do in a lifetime."

"We are deeply saddened by the death of Anna Conte and two other New York children with severe seizure disorders who have died since New York's medical marijuana bill was signed into law," said Julie Netherland of the Drug Policy Alliance (DPA). "Anna and her family played a central role in passing New York's medical marijuana law.

"Our hearts go out to the Conte's and the other patients and families during this time of tragedy," Netherland said. "Part of Anna's legacy is having changed history to benefit thousands of seriously ill New Yorkers.

"These deaths have made even clearer what we already knew -– the 18-month or longer timeline for implementing New York's recently passed medical marijuana law is simply too long for some patients who face life-threatening or terminal illnesses," Netherland said. "These patients and their caregivers, including the parents of children with severe seizure disorders, have been at the forefront of the fight to create safe and legal access to medical marijuana. In fact, at the bill signing ceremony, Governor Cuomo stood with a young girl who suffers from Dravet Syndrome, the same life-threatening seizure disorder that tragically took Anna Conte's life.

"Unfortunately, several more children are likely to die waiting for New York to implement its medical marijuana program," Netherland said. "While not all of these deaths can be prevented by medical marijuana, we have a moral obligation to make this medicine available as soon as possible.

"Because implementation of the full medical marijuana patient access system will take 18 months, Governor Cuomo and leaders in Albany must work swiftly to establish a temporary emergency program for expediting access to medical marijuana for those with life-threatening or terminal illnesses," Netherland said. "By establishing a temporary, interim emergency access program, patients with life-threatening or terminal illnesses won't have to wait 18 months or longer for the full system to come online.

"We can immediately save lives and ease suffering at the end of life by establishing emergency, expedited access," Netherland said. "New York cannot stand by while more people die needlessly."

Photo of mother Wendy Conte and daughter Amy, then 8: *Buffalo News*

Attorney For Patients In Pack Vs. Long Beach Speaks Out

August 23, 2012

Earlier today **we told you about the California Supreme Court throwing out *Pack v. City of Long Beach***, and now the **attorney representing patients in that case is speaking out about it**.

"The patients in Pack won at the appellate court level," **Matthew Pappas** said in a statement. "The excessive permit fee, permitting, and permit lottery parts of 5.87 were deemed invalid by the appellate court. It was the City of Long Beach that asked the Supreme Court to review the Pack appellate decision—not the patients. When the City repealed Chapter 5.87, the issue the City had spent huge amounts of money asking the Supreme Court to review became moot. As a result, the City's Petition was dismissed. The patients won at the appellate court level and they won today when the Supreme Court dismissed the City's petition for review.

"Long Beach should have, following the decision by the appellate court in Pack, severed the few provisions of Chapter 5.87 that were deemed illegal. Instead, it asked for review and then made moot its own case before the Supreme Court by repealing 5.87. This is further evidence of the incompetence in the City Attorney's office as well as the outrageous behavior of council members who care more for themselves and their political aspirations than the citizens they are supposed to be serving.

"How many of the absolutely horrible roads in Long Beach could have been repaired using the millions of dollars the City has spent on just this issue? How many school books could have been purchased with the thousands of dollars spent by the City Attorney trying to get the Supreme Court to grant review? How many dollars will taxpayers have to pay out because Shannon and the police engaged outrageous tactics raiding collectives, destroying cameras, and injuring patients? Why was all of that money spent when Long Beach has a medical marijuana tax law—LBMC Chapter 3.80.260? Under 3.80.260 (which taxes medical cannabis at 15%), Long Beach could be generating much needed tax dollars for road repairs or schools or public safety. Instead, it has spent money it doesn't have making utterly incompetent decisions. It has also exposed future millions of tax dollars because of discriminatory actions it has taken against patients."

Advocates in Long Beach say that the city should now reinstate the original ordinance governing dispensaries, the one the city abandoned after the appellate court ruling in *Pack v. City of Long Beach*. "The rationale is that review is not needed because [Matthew] Pappas [viz. the attorney who filed the *Pack* case] withdrew its argument that 5.87 is preempted by federal law, and also because 5.87's repeal made the review of its legality moot," writes Carl Kemp, spokesperson for the Long Beach Collective Association (LBCA) in a release. "What this means is that the federal preemption argument is now moot. The Court of Appeals decision, which was already depublished and therefore not good law anyway, was based solely on the federal preemption. And since that was an argument made by Pappas, when Pappas withdrew his argument, that effectively means no more federal preemption. So there is NOTHING standing in the way now for the City Council to REINSTATE 5.87!"

All of this legal maneuvering basically means that cities that based dispensary bans based on the appellate decision in *Pack* now have no legal precedent for their actions. And it likely means that the battle between officials and patients in Long Beach will continue.

– ***Joe Klare***

ORDINANCE NO.

AN ORDINANCE OF THE CITY COUNCIL OF THE CITY OF LONG BEACH AMENDING THE LONG BEACH MUNICIPAL CODE BY ADDING CHAPTER 5.91 TO ESTABLISH RESTRICTIONS AND PROHIBITIONS ON THE ESTABLISHMENT AND OPERATION OF MEDICAL MARIJUANA COLLECTIVES.

WHEREAS, California voters approved the Compassionate Use Act ("CUA") in 1996 to exempt seriously ill patients and their primary caregivers from criminal liability for possession and cultivation of marijuana for medical purposes; and

WHEREAS, the Medical Marijuana Program Act of 2003 ("MMPA") provides for the association of primary caregivers and qualified patients to cultivate marijuana for specified medical purposes and also authorizes local governing bodies to adopt and enforce laws consistent with its provisions; and

WHEREAS, Medical Marijuana collectives / cooperatives / associations provide valuable services to qualified patients who, by virtue of disease or disability status, or personal circumstances, cannot cultivate medical marijuana for themselves; and

WHEREAS, Medical Marijuana collectives / cooperatives / associations provide safe, efficient, and reliable access to medical marijuana for qualified patients; and

WHEREAS, medical marijuana that has not been collectively or personally grown may constitute a unique health hazard to the public because, unlike other ingestibles, marijuana is not currently regulated, inspected, or analyzed for contamination by State or Federal governmental agencies and may contain

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Original creation date: 04-20-2014
Rev. Date 05182014

harmful chemicals that could further endanger the health of persons already seriously ill; and

WHEREAS, the City of Long Beach has a compelling interest in protecting the public health, safety and welfare of its residents and businesses, in preserving the peace and public safety of the neighborhoods in which medical marijuana collectives operate, and in providing compassionate access to medical marijuana to its seriously ill residents;

NOW, THEREFORE, the City Council of the City of Long Beach ordains as follows:

SECTION 1. Chapter 5.89 of the Long Beach Municipal Code is hereby repealed. Chapter 5.91 is added to the Long Beach Municipal Code to read as follows:

Chapter 5.91 MEDICAL MARIJUANA COLLECTIVES

5.91.010 Purpose and intent.

It is the purpose and intent of this Chapter to restrict and set forth prohibited activities related to the collective cultivation of medical marijuana in order to ensure the health, safety and welfare of the residents of the City of Long Beach. The restrictions and prohibitions in this Chapter, in compliance with the State Compassionate Use Act and the State Medical Marijuana Program Act ("State Law"), do not interfere with a patient's right to use medical marijuana as authorized under State Law, nor do they criminalize the possession or cultivation of Medical Marijuana by specifically defined classifications of persons, as authorized under State Law. Medical marijuana collectives shall comply with all provisions of the Long Beach City Municipal Code ("LBMC"), State Law, and all other applicable local and state laws. Nothing in this Chapter permits activities that are illegal under Federal, State, or local law.

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5.91.020 Definitions.

Unless the particular provision or the context otherwise requires, the definitions and provisions contained in this Section shall govern the construction, meaning, and application of words and phrases as used in this Chapter:

A. “Attending Physician” shall have the same definition as given such term in California Health and Safety Code Section 11362.7, as may be amended, and which defines “Attending Physician” as an individual who possesses a license in good standing to practice medicine or osteopathy issued by the Medical Board of California or the Osteopathic Medical Board of California and who has taken responsibility for an aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient and who has conducted a medical examination of that patient before recording in the patient’s medical record the physician’s assessment of whether the patient has a serious medical condition and whether the medical use of marijuana is appropriate.

B. “Chief of Police” as used in this Chapter is defined to mean the Chief of the Long Beach Police Department or her/his designee.

C. “Concentrated Cannabis” shall have the same definition as given such term in California Health and Safety Code Section 11006.5, as may be amended, and which defines “Concentrated Cannabis” as the separated resin, whether crude or purified, obtained from marijuana.

D. “Business Licensing division” as used in this Chapter is defined to mean the department within the City that reviews, issues and manages business licenses.

E. “Edible Medical Marijuana” as used in this Chapter is defined to mean any article used for food, drink, confectionery, condiment by human beings whether such article is simple, mixed or compound, which contains a quantity of Medical Marijuana or active ingredients contained within the marijuana plant.

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F. “Identification Card” shall have the same definition as given such term in California Health and Safety Code Section 11362.7, as may be amended, and which defines “Identification Card” as a document issued by the State Department of Health Services which identifies a person authorized to engage in the medical use of marijuana, and identifies the person’s designated primary caregiver, if any. It shall be further recognized the State Identification card program is voluntary and the required physician recommendation shall have the same weight in terms of access to medical marijuana by qualified patients.

G. “Management Member” means a Medical Marijuana Collective member with responsibility for the establishment, organization, registration, supervision, or oversight of the operation of a Collective, including but not limited to members who perform the functions of president, vice president, director, operating officer, financial officer, secretary, treasurer, or manager of the Collective.

H. “Marijuana” shall have the same definition as given such term in California Health and Safety Code Section 11018, as may be amended, and which defines “Marijuana” as all parts of the Cannabis plant, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or resin. It does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound , manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination.

I. “Medical Marijuana” means Marijuana used for medical purposes in accordance with California Health and Safety Code Sections 11362.5, *et seq.*

J. “Medical Marijuana Collective” (“Collective”) means an incorporated or unincorporated association, non-profit mutual benefit corporation,

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agricultural/consumer cooperative as defined in the state Corporations Code, or other business entity type that is composed of ten (10) or more Qualified Patients and their designated Primary Caregivers who associate at a particular location or Property within the boundaries of the City of Long Beach to collectively or cooperatively cultivate Marijuana for medical purposes or distribute said Medical Marijuana to Collective members and Management Members, in accordance with California Health and Safety Code Sections 11362.5, *et seq.* and 11362.7, *et seq.* For purposes of this Chapter, the terms "cooperative" and "dispensary" shall have the same meaning as Medical Marijuana Collective. A properly formed non-profit group under California law with fewer than ten (10) Qualified Patients or Primary Caregiver members shall be deemed a "patient garden club" and shall be exempt from this Chapter.

K. "Business License" as used in this Chapter is defined to mean a Business License issued by the City pursuant to the provisions of this Code. City issued Business Licenses are provided solely for revenue purposes.

L. "Primary Caregiver" shall have the same definition as given such term in California Health and Safety Code Sections 11362.5 and 11362.7 (as set forth in Appendix A of this Chapter), as may be amended, and which define "Primary Caregiver" as an individual, designated by a Qualified Patient, who has consistently assumed responsibility for the housing, health, or safety of that Qualified Patient.

M. "Property" as used in this Chapter means the location or locations within the boundaries of the City of Long Beach at which the Medical Marijuana Collective members and Management Members associate to collectively or cooperatively cultivate or distribute Medical Marijuana exclusively for the Collective members and Management Members.

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N. “Qualified Patient” means a person who is entitled to the protections of Health and Safety Code Section 11362.5 for patients who obtain and use marijuana for medical purposes upon the recommendation of an Attending Physician, whether or not that person has voluntarily applied for and received a valid Identification Card issued pursuant to State Law.

O. “Reasonable Compensation” means compensation commensurate with wages and benefits paid to employees or management staff of IRS-qualified non-profit organizations who have similar job descriptions and duties, level of education and experience, prior individual earnings history, and number of hours worked.

P. “State Law” means the state regulations set forth in the Compassionate Use Act and the Medical Marijuana Program Act, codified in California Health and Safety Code Sections 11362.5 and 11362.7, *et seq.* and the provisions set forth in Section IV of the Ca. Attorney General Guidelines for the Safety and Non-Diversion of Marijuana Grown for Medical Use and applicable case law.

5.91.030 Medical Marijuana Collective – Business License.

No Medical Marijuana Collective, Management Member or member shall carry on, maintain or conduct any Medical Marijuana Collective related operations in the City without first obtaining a Business License and Occupancy Permit issued by the City pursuant to the provisions of the Municipal Code. Issuance of an Occupancy Permit by the City is solely to ensure the general fitness of a proposed facility for occupancy by persons and does not constitute authorization of any activity by the permit holder. Issuance of a Business License by the City is for revenue purposes only as set forth in Chapter 3.80 of this Code. A City business license does not convey any authorization or approval of activities conducted by the holder thereof. This Chapter does not

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convey to any Medical Marijuana Collective that has received an Occupancy Permit and Business License from the City any purported or actual authorization to conduct medical marijuana activities but rather provides solely for regulatory limits on the conduct of such activities within the City.

5.91.040 Medical Marijuana Collective – Supplemental Business License Information Form Required.

Any Medical Marijuana Collective desiring a Business License, prior to initiating operations, shall complete and file a Supplemental Business License Information Form, which shall be supplied by the City, and shall submit with the completed application payment of the standard Business License application fee, as set from time to time by the City. Business licenses in the City are for revenue purposes only and do not authorize, permit, or regulate any activity.

A. Filing. On a form provided by the City, the Medical Marijuana Collective shall provide the following supplementary information prior to issuance of a Business License by the City:

1. The address of the Property or Properties where the proposed Medical Marijuana Collective will operate.

2. A site plan describing the Property with fully dimensioned interior and exterior floor plans including electrical, mechanical, plumbing, and disabled access compliance pursuant to Title 24 of the State of California Code of Regulations and the federally mandated Americans with Disabilities Act.

3. Exterior photographs of the entrance(s), exit(s), street frontage(s), parking, front, rear and side(s) of the proposed Property.

4. Photographs depicting the entire interior of the proposed Property.

5. If the Property is being rented or leased or is being purchased under contract, a copy of such lease or contract.

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6. If the Property is being rented or leased, written proof that the Property owner, and landlord if applicable, were given notice that the Property will be used as a Medical Marijuana Collective, and that the Property owner, and landlord if applicable, agree(s) to said operations.

7. The name, address, telephone number, title and function(s) of each Management Member.

8. For each Management Member, a fully legible copy of one (1) valid government issued form of photo identification, such as a State Driver's License or Identification Card. Acceptable forms of government issued identification include, but are not limited to: Drivers licenses or photo identity cards issued by state Department of Motor vehicles (or equivalent), a passport issued by the United States, U.S. Military ID cards (active duty or retired military and their dependents), or a Permanent Resident card.

9. Written confirmation as to whether the Medical Marijuana Collective, as a California Secretary of State registered non-profit entity, previously operated in this or any other county, city or state under a similar license/permit, and whether the Collective applicant ever had such a license/permit revoked or suspended and the reason(s) therefore.

10. If the Medical Marijuana Collective is a corporation, a certified copy of the Collective's Secretary of State Articles of Incorporation, Certificate(s) of Amendment, Statement(s) of Information and a copy of the Collective's Bylaws.

11. If the Medical Marijuana Collective is an unincorporated association, a copy of the Articles of Association.

12. The name and address of the applicant's current Agent for Service of Process.

13. A copy of the City's Acknowledgment of Medical Marijuana Collective Operating Limits and Restrictions, listed in Section 5.91.050, containing a

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statement dated and signed by each Management Member, under penalty of perjury, that they read, understand and shall ensure compliance with the aforementioned operating limitations and restrictions.

14. A copy of the City's Acknowledgment of Prohibited Activities, listed in Section 5.91.090, containing a statement dated and signed by each Management Member, under penalty of perjury, that they read, understand and shall ensure that neither the Collective nor its members and Management Members shall engage in the aforementioned prohibited activities.

15. A statement dated and signed by each Management Member, under penalty of perjury, that the Management Member has personal knowledge of the information contained in the application, that the information contained therein is true and correct, and that the application has been completed under the supervision of the Management Member(s).

16. Whether Edible Medical Marijuana products will be prepared at the proposed Property. Such activities will be conducted under existing LA County Health Department policies and procedures relating to the production of edible products.

17. The Property address where any and all Medical Marijuana will be collectively cultivated by the Collective members and Management Members within the City of Long Beach, if any.

18. A statement signed under penalty of perjury by each Managing Member that the compensation paid to any person or entity by the Collective shall be limited to Reasonable Compensation as set forth in Section 5.91.020, Subsection O of this Chapter.

B. No earlier than thirty (30) days following the effective date of this Chapter, the Business Licensing division of the City shall:

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1. Within ten (10) business days of receipt of a Business License application, Supplemental Business License Information Form, Acknowledgment of Medical Marijuana Collective Operating Limits and Restrictions, and Acknowledgment of Prohibited Activities, except where circumstances beyond the control of the City justifiably delay review, determine whether the application and supporting documentation is complete.

2. If it is determined the application is incomplete, the applicant shall be notified in writing within ten (10) business days of the date the application is determined to be incomplete, except where circumstances beyond the control of the City justifiably delay such response, that the application is not complete and the reasons therefore, including any additional information necessary to render the application complete.

3. The Applicant shall have thirty (30) calendar days from the date of notice set forth above in Subsection 5.91.040(B), Subsection (2) to complete the application. Failure to do so within the thirty (30) day period shall render the application null and void.

4. Within ten (10) business days following the receipt of an amended application and supplemental information, except where circumstances beyond the control of the City justifiably delay such response, the Business Licensing Division shall again determine whether the application is complete in accordance with the procedures set forth above. Evaluation and notification shall occur as provided above until such time as the application is found to be complete or in the alternative null and void.

5. Once the application is found to be complete, the applicant shall be notified within ten (10) business days, except where circumstances beyond the control of the City justifiably delay such response.

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6. All notices required by this Chapter shall be deemed issued upon the date they are either deposited in the United States mail or the date upon which personal service of such notice is provided.

C. No later than ten (10) days following determination that a Business License application, Supplemental Business License Information form, and the required acknowledgments are complete, the Business Licensing division shall review the application and ensure the applicant and location meet all of the provisions set forth in Section 5.91.050 of this Chapter. The Business License division shall, in a written report, identify each subpart of Section 5.91.050 and report if the applicant meets the requirements or complies with the restrictions of that subpart.

1. When a completed application and corresponding Supplemental Business License Application form for a Collective meets all of the requirements and restrictions set forth in Section 5.91.050 of this Chapter, the City shall issue to the applicant a City Business License that shall be valid for twelve (12) months.

2. Should a Business License be denied under this subpart, the reasons for denial specifically setting forth the subparts of Section 5.91.050 of this Chapter the applicant has failed to comply with and/or meet the restriction requirements of shall be provided in writing to the applicant(s). Within ten (10) days of the date of mailing plus two (2) days for mail service, the applicant(s) may appeal the decision denying the Business License to the City Council. The request for appeal shall be in writing, shall set forth the specific ground(s) on which it is based and shall be submitted to the Business Licensing division with a copy submitted to the clerk of the City Council. The applicant shall, along with the appeal requested submitted to the Business Licensing division, include an appeal deposit in an amount of $1,000.00.

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G. The City Council shall conduct a hearing on the appeal or refer the matter to a hearing officer, pursuant to hearing provisions of this Code, within thirty (30) business days from the date the completed request for appeal was received by the Business Licensing division, except where good cause exists to extend this period. The appellant shall be given at least ten (10) business days written notice of such hearing. The hearing and rules of evidence shall be conducted pursuant to the hearing this Code. The determination of the City Council on the appeal shall be final.

5.91.050 Medical Marijuana Collective Operating Restrictions and Prohibitions.

All person(s) or entities operating as a Medical Marijuana Collective in the City shall comply with the following Operating Restrictions and Prohibitions. A Business License issued by the City for a Medical Marijuana Collective does not authorize or permit the operation of such entities. The sole purpose of this Chapter is to limit and restrict the operations of such entities.

A. The Property location of a Medical Marijuana Collective or any entity that provides medical marijuana pursuant to any provision of state law is restricted to commercial and industrial zones as defined in this Code.

B. A Medical Marijuana Collective shall not be 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 preschool, kindergarten, elementary, middle or junior high school except that a Medical Marijuana Collective that was issued a Business License by the City before a private school is located or built within the distance provisions of this Section shall not be subject to the aforementioned distance limitations. Should the distance limitations set forth herein be less than any state law distance limitation, the State distance limitations shall apply. The distances specified in this

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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.

C. A Medical Marijuana Collective shall not be located within a one thousand foot (1,000') radius of any other Medical Marijuana Collective. The distance specified in this subdivision shall be determined by the horizontal distance measured in a straight line from the property line of any other Medical Marijuana Collective, to the closest property line of the lot on which the Medical Marijuana Collective is located, without regard to intervening structures.

D. The exterior building and parking area lighting at the Property where a Medical Marijuana Collective is located shall be in compliance with all applicable provisions of this Code.

E. Any exterior or interior sign visible from the exterior of a Medical Marijuana Collective shall be unlighted with the exception of an optional 18" by 18" or smaller lighted green cross with no lettering or additional symbols or markings that may be placed on a window or door that is visible from the exterior of the Property.

F. Windows and roof hatches at the Property of a Medical Marijuana Collective shall be secured so as to prevent unauthorized entry, and shall be equipped with latches that may be released quickly from the inside to allow exit in the event of emergency and are in compliance with all applicable building code provisions.

G. The Property where a Medical Marijuana Collective is located shall provide sufficient sound absorbing insulation so that noise generated inside the premises is not audible anywhere on the adjacent property or public rights-of-

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way, or within any other building or other separate unit within the same building as the Medical Marijuana Collective.

H. The Property where a Medical Marijuana Collective is located shall have a sufficient and functional odor absorbing ventilation and exhaust system so that offensive odors generated inside the Property are not detected outside the Property, or public rights-of-way, or within any other unit located within the same building as the Medical Marijuana Collective.

I. A Medical Marijuana Collective shall be monitored at all times by closed-circuit television for safety and security purposes. The camera and recording system must be of adequate quality, and resolution to allow the ready identification of an individual on or adjacent to the Property. The recordings shall be maintained at the Property or other secure location for a period of not less than thirty (30) days. For patient privacy reasons, no remote access by law enforcement or the City will be allowed. Access to these recordings by law enforcement or City Officials shall be pursuant to a order issued by a competent court based upon probable cause or by specific written and detailed request for such information.

J. The Property where a Medical Marijuana Collective is located shall have a centrally-monitored fire and burglar alarm system that is functional and operating at all times.

K. A Medical Marijuana Collective shall post a sign in a conspicuous location advising:

1. “A video monitoring and recording device is in operation at this facility”.

2. “The illegal sale of marijuana and the diversion of marijuana for non-medical purposes are violations of State Law. Your membership in

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this patient group will be terminated if you are caught diverting marijuana in a manner that violates State law".

3. "The use of marijuana may impair a person's ability to drive a motor vehicle or operate heavy machinery".

4. "Loitering at the location of a Medical Marijuana Collective for an illegal purpose is prohibited by California Penal Code Section 647(h)."

L. "Edible Medical Marijuana shall not be provided to any person who is not a Qualified Patient member, Caregiver member or Qualified Patient Management Member of the Collective, in compliance with all applicable state and local laws".

M. The Medical Marijuana Collective shall meet all applicable state and local laws to ensure that the operations of the Collective are consistent with the protection of the health, safety and welfare of the community, Qualified Patients and their Primary Caregivers, and will not adversely affect surrounding uses.

N. No Collective shall operate for profit. Cash and in-kind contributions, reimbursements, and reasonable compensation provided by Management Members and members towards the Collective's actual expenses of the growth, cultivation, and provision of Medical Marijuana shall be allowed provided that they are in compliance with State Law. Profit shall be determined by best and customary practices of Certified Public Accountants, Forensic Accountants and/or persons with sufficient training and expertise in California non-profit structures and related laws and procedures to conduct such examinations.

O. Collective cultivation of Medical Marijuana by a Medical Marijuana Collective shall not be done by any person who is not a Producing member, Caregiver member or Management Member of that Medical Marijuana Collective / Cooperative / Association.

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P. Medical Marijuana, including any derivative for which an exception to State marijuana criminal liability is provided for under State law, shall not be made available to or provided to any person who is not a patient member or authorized patient member Caregiver of any Medical Marijuana Collective. No marijuana, including any derivative for which an exception to state marijuana criminal liability is provided for under state law, that was not cultivated by the members, authorized Caregivers, and/or Management Members of a Medical Marijuana Collective or that was not provided by a properly operating Medical Marijuana Agricultural or Consumer Cooperative shall be provided by a Medical Marijuana Collective.

Q. Delivery Services. It shall be acknowledged that delivery services are a customary and common activity related to the operation of lawful collectives, cooperatives, and associations throughout the State. Distribution of Medical Marijuana to qualified patients and collective members is necessary for those patients who cannot access public transportation or by virtue of disease and/or disability status. Responsibilities for safety, security and non-diversion of medical marijuana shall be consistent with other sections of this chapter. Procedures and policies shall be adopted to insure compliance with State Law and customary business practices.

R. Should any independently enacted tax measure governing city fees and taxes on marijuana be deemed invalid, every Medical Marijuana Collective shall file, on the fifteenth day of every February, May, August, and November the then effective City Supplemental Quarterly Collective Business License Fee form and shall pay a Supplemental Business License Fee of $50.00 of every $1,000.00 received by the Medical Marijuana Collective during the preceding three (3) month period, including but not limited to donations, contributions, sales, and/or

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membership fees. This section shall be deemed inapplicable upon enactment and implementation by the voters of any marijuana tax measure.

S. An application for a new Business License or renewal of a Business License for a Medical Marijuana Collective shall be denied if:

1. One or more of the Managing Members of an applicant was the Managing Member of a Medical Marijuana Collective issued a Business License by the City that, following enactment of this Chapter, was either convicted of a misdemeanor for failing to comply with any provision of this Chapter or was, after administrative hearing, deemed liable for failing to submit any Supplemental Quarterly Collective Business License Fee form and/or pay Supplemental Business License Fees required under Section 5.91.050, Subsection R or any properly enacted and effective marijuana tax measure.

2. The applicant failed to submit any required Supplemental Quarterly Collective Business License Fee form and/or pay Supplemental Business License Fees required under Section 5.91.050, Subsection R, if applicable.

3. The applicant, through administrative, civil, or criminal proceeding, was determined by a judge, jury, or hearing officer to have previously violated any provision of this Chapter.

4. The applicant, through administrative, civil, or criminal proceeding, was determined by a judge, jury, or hearing officer to have operated a Medical Marijuana Collective in the City without a Business License following enactment of this Chapter.

T. Medical Marijuana provided to Collective members shall not be provided without labeling that complies with all State and local laws.

U. At all times, a Medical Marijuana Collective shall not operate on a for-profit basis nor shall it operate without fully complying with current State Law.

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V. Compensation paid to any person or entity by a Medical Marijuana Collective is limited to Reasonable Compensation.

W. Medical Marijuana Collectives shall not be open to patient or caregiver members or operate to provide Medical Marijuana between the hours of 10:00 P.M. and 10:00 A.M.

X. There shall be no more than one (1) Business License issued under this Chapter for every fifteen thousand (15,000) residents of the City based on the official population of the City as provided by the U.S. Census Bureau. The Total number of dispensaries shall further be limited by City and Planning Commission regulations dictating location distances from away places defined and described previous in this ordinance.

Y. No medical marijuana collective shall be open to member patients without a properly licensed security guard present on the premises. No licensed security guard (armed or unarmed) shall handle, possess or use any Medical Marijuana while on duty.

5.91.060 Business License –Non-transferable.

A Business License issued pursuant to this Chapter shall become null and void upon the cessation of the Collective or non-profit organization as licensed under this ordinance. Within 30 days of the resignation or replacement of any of the Managing Members set forth in the Supplemental Business License Information form submitted by the applicant and/or the relocation of the Collective to a different Property information provided to the City will be provided with updated information and copies of identification as required under this ordinance.

A. The following shall be deemed a change in location:

1. Any relocation or expansion that includes a separate piece of property or parcel of land from the Property identified in the Supplemental Business License Information form submitted by the applicant.

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2. Any expansion of the Property identified in the Supplemental Business License Information form which represents a greater than fifty percent (50%) increase in the square footage of space devoted to public access or occupancy.

B. A Business License issued to a Medical Marijuana Collective shall not be transferred to any other person or entity.

C. The holder of a Business License issued under this Chapter shall not allow others to use or rent the Property for purposes not described in the Business license application.

5.91.070 Inspection Authority.

Upon proper issuance of an Inspection Warrant as defined in Section 1822.50 of the Ca. Code of Civil Procedure, City representatives may enter and inspect the Property of every Medical Marijuana Collective between the hours of 10:00 A.M. and 10:00 P.M., to ensure compliance and enforcement of the provisions of this Chapter, except that the inspection and copying of private medical records shall be made available to the Police Department only pursuant to a properly executed search warrant, subpoena, or court order. It is unlawful for any Property owner, landlord, lessee, Medical Marijuana Collective member or Management Member or any other person having any responsibility over the operation of the Medical Marijuana Collective to refuse to allow, impede, obstruct or interfere with an inspection. No information or records maintained by the City as a result of an inspection conducted pursuant to this Section or otherwise provided by a Medical Marijuana Collective, Managing Members, or members to the City under this Chapter or as a result of any investigation shall be provided to the federal government unless a court of competent jurisdiction issues an order requiring such disclosure. The City shall, at all times, give meaning and effect to California law and shall not enforce federal law related to marijuana.

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5.91.080 Existing Medical Marijuana operations.

A. Any existing Medical Marijuana Collective, dispensary, operator, establishment, or provider that does not comply with the requirements of this Chapter must immediately cease operation until such time, it complies fully with the requirements of this Chapter. Except as provided for in Subsections B or C of this Section, no Medical Marijuana Collective, dispensary, operator, establishment, or provider that existed prior to the enactment of this Chapter shall be deemed to be a legally established use or a legal non-conforming use under the provisions of this Chapter or the Code.

B. Any Medical Marijuana Collective that was successful in the October, 2010 permit lottery conducted by the City under former Chapter 5.87 of this Code shall have sixty (60) days from the date of the enactment of this Chapter to conform with the provisions of this Chapter and to apply for a Business License and shall have priority in the granting of Business Licenses under this Chapter if application is made within the specified sixty (60) day period. No citation issued, convictions under, failure to comply with, or violations of former Chapters 5.87 or 5.89 of this Code shall be factors weighed in any decision granting or denying a Business License.

C. Any Medical Marijuana Collective established and operating within the City and in conformance with State Law, whether such operation was with or without a Business License or Occupancy Permit, prior to February 14, 2012, that the establishment and operation thereof would be subject to this Chapter shall, within sixty (60) days of the effective date of this Chapter, conform with all provisions of this Chapter, including but not limited to the location restriction to areas zoned industrial or commercial, and apply for and be issued a Business License or cease operations. No citation issued, convictions under, failure to

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comply with, or violations of former Chapters 5.87 or 5.89 of this Code shall be factors weighed in any decision granting or denying a Business License.

D. An application for a Business License under this Chapter by any preexisting Medical Marijuana Collective eligible under Subsections B and C of this Section shall have priority. Applications made by entities meeting the requirements of Subsection B of this Section shall have priority over applications made under Subsection C.

E. On the enactment date of this Chapter, any administrative or criminal actions filed and pending against a Managing Member, member, Qualified Caregiver, or Medical Marijuana Collective for violation of any current or former provision of this Code, including but not limited to alleged or actual violations of former Chapters 5.87 or 5.89, where such violation related solely to operating a Medical Marijuana Collective, shall be dismissed. A person convicted under any provision of former Chapters 5.87 or 5.89 of this Code shall have the right to move to set aside such conviction and any penalty assessed or sentence imposed thereunder and such conviction shall be set aside by the Court.

F. On the enactment date of this Chapter, any unpaid fines assessed, whether civil, administrative, or criminal, against a Managing Member, member, Qualified Caregiver, or Medical Marijuana Collective for violation of any current or former provision of this Code, including but not limited to former Chapters 5.87 or 5.89, resulting solely from operating a Medical Marijuana Collective in the City, shall be waived. An individual who or entity that has paid a fine or fee under former Chapters 5.87 or 5.89 shall have thirty (30) days following enactment of this Chapter to apply for a refund of such fines or fees. An application for refund shall be made in writing on the City's then effective refund request form and shall include documentation showing payment of any amount claimed. Within sixty

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(60) days of submission of a completed refund application and verification of fine or fee payment claimed, the City shall refund the fine or fee to the claimant.

G. On the enactment date of this Chapter, any unpaid fines assessed, whether civil, administrative, or criminal, against a landlord of any medical marijuana collective, dispensary, cultivation site, or business for violation of any current or former provision of this Code, including but not limited to former Chapters 5.87 or 5.89, resulting solely from leasing or renting to an operating Medical Marijuana Collective in the City, shall be waived.

H. The provisions of subsections E, F and G of this Section do not constitute admissions by the City of the invalidity of former Chapters 5.87 or 5.89.

5.91.090 Prohibited activities.

A. Any person or entity in full compliance with this Chapter and State Law shall not be subject to criminal, civil or administrative action by the City for violation of this Chapter.

B. It is unlawful for any person or entity to operate a Medical Marijuana Collective without a Business License issued by the City pursuant to the provisions of this Chapter.

C. It is unlawful for any person to knowingly make any false, misleading or inaccurate statement or representation in any form, record, filing or documentation required to be maintained, filed or provided to the City under this Chapter.

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 Qualified Patient Member.

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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 or at the Medical Marijuana Collective or areas in control or responsibility of the Collective.

F. No cultivation of Medical Marijuana at the Property shall be visible with the naked eye from any area accessible to the public, nor shall cultivated Medical Marijuana or dried Medical Marijuana be visible from the building exterior. No cultivation shall occur at the Property unless the area devoted to the cultivation is secured from public access by means of a locked gate, controlled access, and/or any other reasonable security measures necessary to prevent unauthorized entry.

G. No person or entity shall manufacture Concentrated Cannabis at the Collective location in a manner that violates California Health and Safety Code Section 11379.6.

H. No Medical Marijuana Collective shall be open to or provide Medical Marijuana to its members or Management Members between the hours of 10:00 P.M. and 10:00 A.M.

I. No person under the age of eighteen (18) shall be allowed at the Property, unless that minor is a Qualified Patient and is accompanied by his or her licensed Attending Physician, or parent(s) or documented legal guardian.

J. No Medical Marijuana Collective shall possess Medical Marijuana that was not collectively cultivated by its Management Members or members. There is no requirement that Medical Marijuana be cultivated solely within the City of Long Beach or at any specific location.

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K. Unless otherwise provided for by state or federal law, a Medical Marijuana Collective shall not possess or provide marijuana grown outside of the State of California.

L. No Medical Marijuana Collective, Management Member or member shall cause or permit the sale, dispensing, or consumption of alcoholic beverages, as defined by the California Alcoholic Beverage Control, on the Property or in areas under the control or responsibility of the Collective.

M. Dried Medical Marijuana shall be stored at the Property outside approved business hours in secure, locked structures, safes and/or vaults to prevent inappropriate access and theft.

N. 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, which include:

1. Any place where smoking is prohibited by law;

2. Within one thousand feet (1,000') of the grounds of a school, recreation center, or youth center;

3. While on a school bus; or

4. While in a motor vehicle that is being operated.

O. No marijuana medication or derivative thereof provided by a Medical Marijuana Collective shall contain pesticides, mold, fungus or spider mites. Frequent, competent testing and sufficient quality and purity assurance procedures relating to any medical marijuana product shall be encouraged.

P. No marijuana collective shall operate in a facility that is not compliant with the architectural requirements of the Americans with Disabilities Act [ADA] (42 U.S.C. § 12101, *et seq*.) and California Disabled Persons Act [DPA] (Cal. Civ. Code § 54). An individual diagnosed with one of the conditions enumerated

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in Cal. Health & Safety Code § 11362.7(h)(1) through 11362.7(h)(12) who is a patient with a valid physician recommendation for medical marijuana and who suffers injury or sustains actual damages, including but not limited to injuries or damages caused by inaccessibility or reduced access caused by failure to comply with provisions of the ADA or CDPA or injuries or damages caused by discrimination under Title II of the ADA, shall have a private right of action for damages and injunctive relief under this section. The provisions of 42 U.S.C. § 12210(D) shall not prevent a medical marijuana patient from seeking relief or obtaining recovery in an action brought pursuant to this section. Should later enacted state law provide for access to and use of marijuana for recreational and non-medical purposes, this section shall not apply to individuals using or accessing marijuana for non-medical reasons.

5.91.100 Violation and enforcement.

A. Any person violating any provision of this Chapter or knowingly or intentionally misrepresenting any material fact in procuring a Business License under this Chapter, shall be deemed guilty of a misdemeanor punishable by a fine of not more than one thousand dollars ($1,000.00) or by imprisonment for not more than twelve (12) months, or by both such fine and imprisonment. Each and every day a violation occurs shall be considered a separate violation.

B. Any person who engages in any Medical Marijuana Collective operations after a Business License application has been denied, or a Business License has been suspended or revoked, and before a new Business License is issued, shall be guilty of a misdemeanor punishable by a fine of not more than one thousand dollars ($1,000.00) or by imprisonment for not more than twelve (12) months, or by both such fine and imprisonment.

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C. Any person who or entity that facilitates the operation of a Medical Marijuana Collective without a Business License shall be guilty of a misdemeanor punishable by a fine of not more than one thousand dollars ($1,000.00) or by imprisonment for not more than twelve (12) months, or by both such fine and imprisonment.

D. As a nuisance per se, any violation of this Chapter shall be subject to injunctive relief, revocation of the Certificate of Occupancy for the property, disgorgement and payment to the City of any and all monies unlawfully obtained, costs of abatement, costs of investigation, attorney fees, and any other relief or remedy available at law or equity. The City may also pursue any and all remedies and actions available and applicable under local and state law for any violations committed by the Medical Marijuana Collective, it's Management Members, members or any person related or associated with the Medical Marijuana Collective.

E. Any violation of the terms and conditions of this Chapter, State Law, or of applicable local or state regulations and laws may be grounds for Business License revocation.

F. In addition to the remedies set forth herein, the City may, at its sole discretion, issue administrative citations pursuant to the provisions of this Code and any other applicable state law for any violation of this Chapter.

G. Any complaints received by the City about any Medical Marijuana Collective or activities related thereto shall be memorialized in writing by the City in a form that shall be retained by the Office of the City Prosecutor for no less than five (5) years that shall include the location of the Medical Marijuana Collective that is the subject of the complaint, the date and time of the incident resulting in the complaint, the name, address, and phone number of the person or entity making the complaint, the date of the complaint, the specific complaint

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made, actions taken in response to the complaint and the City official or employee recording the complaint. The Office of the City Prosecutor may investigate complaints made or may deem complaints invalid at its sole discretion following review thereof. On or before January 30 of each year, the Office of the City Prosecutor shall prepare a summary of the number of complaints received for each Medical Marijuana Collective for the prior calendar year. Complaints deemed invalid by the City Prosecutor shall not be included in the annual summary. No City official or employee shall make public statements or claims while acting in his or her official capacity that suggest crime is caused by Medical Marijuana Collectives without providing specific and accurate statistics provided by the City's Police Department and without referencing the latest annual summary of complaints report published by the City Prosecutor.

H. No Management Member or Medical Marijuana Collective shall make or cause to be made a false complaint about any other Medical Marijuana Collective to the City or any City employee, officer or official.

I. Corrective Action Allowed. Any collective found in violation or of any finding of a failure to comply with this chapter shall be allowed a reasonable period of time to correct the specific violation and provide documentation to the City documenting such correction. Additional inspection(s) shall be allowed to confirm such correction.

5.91.110 Appeal process.

A. If a City department determines that a Business License holder has failed to comply with any provision of this Chapter, or with any other provision or requirement of law, the Business License Division shall revoke or suspend the Business License in accordance with the provisions of this Code governing business licenses.

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B. The Business License Division shall notify the holder of the Business License of the revocation or suspension by dated written notice. Such notice shall advise the Business License holder of the right to appeal the decision to the City Council. The request for appeal shall be in writing, shall set forth the specific ground(s) on which it is based and shall be submitted to the Business License Division within ten (10) calendar days from the date the notice was mailed along with an appeal deposit in the amount of $1,000.00.

C. The City Council shall conduct a hearing on the appeal or refer the matter to a hearing officer, pursuant to the hearing provisions of this Code, within thirty (30) business days from the date the completed request for appeal was received by the Business License Division, except where good cause exists to extend this period. The appellant shall be given at least ten (10) business days written notice of such hearing. The hearing and rules of evidence shall be conducted pursuant to the hearing provisions of this Code. The determination of the City Council on the appeal shall be final.

D. Whenever a Business License has been revoked or suspended under this Chapter, no other such permit application shall be considered for a period of one (1) year from either the date notice of the revocation or suspension was mailed, or the date of the final decision of the City Council, whichever is later.

5.91.120 Operative date.

This ordinance will become effective ninety (90) days following its passage and adoption. The Business License Division will accept completed Business License applications and the required supplemental documents set forth herein thirty (30) days before the effective date of this Chapter.

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5.91.130 Severability.

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.

5.91.140 Review of Regulations.

On or before the first anniversary of the effective date of this Chapter, the City Council shall review the effectiveness of these regulations, and shall enact modifications, if necessary.

SECTION 2. The City Clerk shall certify to the passage of this Ordinance by the City Council and cause it to be posted in three conspicuous places in the City of Long Beach, and it shall take effect on the thirty-first (31st) day after it is approved by the Mayor.

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

Forbes.com July 2011

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

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

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

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

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

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

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

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

Prescription painkiller deaths fall in medical marijuana states

REUTERS

- Aug 25, 2014

By Kathryn Doyle

NEW YORK (Reuters Health) – Researchers aren't sure why, but in the 23 U.S. states where medical marijuana has been legalized, deaths from opioid overdoses have decreased by almost 25 percent, according to a new analysis.

"Most of the discussion on medical marijuana has been about its effect on individuals in terms of reducing pain or other symptoms," said lead author Dr. Marcus Bachhuber in an email to Reuters Health. "The unique contribution of our study is the finding that medical marijuana laws and policies may have a broader impact on public health."

California, Oregon and Washington first legalized medical marijuana before 1999, with 10 more following suit between then and 2010, the time period of the analysis. Another 10 states and Washington, D.C. adopted similar laws since 2010.

For the study, Bachhuber, of the Philadelphia Veterans Affairs Medical Center and the University of Pennsylvania, and his colleagues used state-level death certificate data for all 50 states between 1999 and 2010.

In states with a medical marijuana law, overdose deaths from opioids like morphine, oxycodone and heroin decreased by an average of 20 percent after one year, 25 percent by two years and up to 33 percent by years five and six compared to what would have been expected, according to results in JAMA Internal Medicine.

Meanwhile, opioid overdose deaths across the country increased dramatically, from 4,030 in 1999 to 16,651 in 2010, according to the Centers for Disease Control and Prevention (CDC). Three of every four of those deaths involved prescription pain medications.

Of those who die from prescription opioid overdoses, 60 percent have a legitimate prescription from a single doctor, the CDC also reports.

Medical marijuana, where legal, is most often approved for treating pain conditions, making it an option in addition to or instead of prescription painkillers, Bachhuber and his coauthors wrote.

In Colorado, where recreational growth, possession and consumption of pot has been legal since 2012 and a buzzing industry for the first half of 2014, use among teens seems not to have increased (see Reuters story of July 29, 2014 here: http://reut.rs/1o040NI).

Medical marijuana laws seem to be linked with higher rates of marijuana use among adults, Bachhuber said, but results are mixed for teens.

But the full scope of risks, and benefits, of medical marijuana is still unknown, he said.

“I think medical providers struggle in figuring out what conditions medical marijuana could be used for, who would benefit from it, how effective it is and who might have side effects; some doctors would even say there is no scientifically proven, valid, medical use of marijuana,” Bachhuber said. “More studies about the risks and benefits of medical marijuana are needed to help guide us in clinical practice.”

Marie J. Hayes of the University of Maine in Orno co-wrote an accompanying commentary in the journal.

“Generally healthcare providers feel very strongly that medical marijuana may not be the way to go,” she told Reuters Health. “There is the risk of smoke, the worry about whether that is carcinogenic but people so far haven’t been able to prove that.”

There may be a risk that legal medical marijuana will make the drug more accessible for kids and smoking may impair driving or carry other risks, she said.

“But we’re already developing Oxycontin and Vicodin and teens are getting their hands on it,” she said.

If legalizing medical marijuana does help tackle the problem of painkiller deaths, that will be very significant, she said.

“Because opioid mortality is such a tremendously significant health crisis now, we have to do something and figure out what’s going on,” Hayes said.

The efforts states currently make to combat these deaths, like prescription monitoring programs, have been relatively ineffectual, she said.

“Everything we’re doing is having no effect, except for in the states that have implemented medical marijuana laws,” Hayes said.

People who overdose on opioids likely became addicted to it and are also battling other psychological problems, she said. Marijuana, which is not itself without risks, is arguably less addictive and almost impossible to overdose on compared to opioids, Hayes said.

Adults consuming marijuana don’t show up in the emergency room with an overdose, she said. “But,” she added, “we don’t put it in Rite Aid because we’re confused by it as a society.”

SOURCE: http://bit.ly/1pYZf8d JAMA Internal Medicine, August 25, 2014

Reduction of Teen Marijuana Use

- diana lejins
- May 9, 2014

To

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

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

Further Reduce Teen Marijuana Use

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

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

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

Restrictive Marijuana Laws Hurt the Most Vulnerable - Children

September 30, 2014 - By Julie Netherland

Those who would perpetuate the failed drug war claim they want to protect the children.

But nothing could be further from the truth. The drug war overall, and marijuana prohibition specifically, hurts young people.

Restrictive marijuana policies and limited medical marijuana laws have simultaneously kept very sick children from getting the medicine they need and saddled tens of thousands of young people with criminal records that severely limit their future chances in life. Our marijuana policies are hurting, and in some cases, killing our youth.

The situation is so dire in New York that the Cuomo Administration recently sent a letterto the U.S. Department of Justice, following up on an earlier letter to U.S. Attorney General Holder sent on August 13. Both letters asked the DOJ to extend a narrow, time-limited exception to federal law to allow the importation of certain strains of medical marijuana from other states for use by children in New York with severe forms of epilepsy. Senators Schumer and Gillibrand followed suit with their own letter asking DOJ for relief.

Since New York's medical marijuana bill was signed, at least three New York children with severe seizure disorders have died. Medical marijuana has dramatically reduced life-threatening seizures in other children with similar conditions, but families in New York are facing an eighteen-month wait until the new medical marijuana law is implemented.

Cuomo has urged the Department of Health to expedite access to medical marijuana for these children, but a web of outdated and draconian laws have made it impossible for these critically-ill children to get the medicine they need. Each day these parents are forced to wait knowing that their children are losing ground and may die. And this isn't just a problem in New York. Many states have never passed any medical marijuana law, leaving thousands of vulnerable patients, including children, to needlessly suffer.

Meanwhile, marijuana prohibition is destroying other young lives all over the country. In New York, which decriminalized the possession of marijuana in 1977, a loophole in the law has resulted in tens of thousands of young people – predominantly African American and Latino young men – are arrested for possessing small amounts of marijuana. Worse, the law is being enforced unfairly and creating enormous racial disparities. And that doesn't even get to the tragic loss of young life that sometimes occurs when the police enforce marijuana prohibition. It is a nation-wide problem.

How are these policies protecting our kids? They aren't.

They keep medicine from sick children and sweep thousands of other young people –the vast majority of whom have no previous arrests-- into the criminal justice system, while doing nothing to improve public safety. If we really want to protect our kids, we need to do away with policies like these that do more harm than good.

No one wants to see more young people using marijuana, but we can work to protect young people from the potential harms of marijuana through sensible policies that don't simultaneously prevent sick children from getting needed medicine or criminalize thousands of young people of color.

In New York, we can start by creating an emergency access program for medical marijuana for the sickest New Yorkers and passing the Fairness and Equity Act, which would help end unlawful marijuana arrests of young people of color.

Our kids do deserve protection. So let's protect them by putting an end to destructive marijuana policies and enacting sensible, humane reforms.

Julie Netherland is the New York deputy state director for the Drug Policy Alliance.

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

5.91.090

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

1. Any place where smoking is prohibited by law;

2. Within one thousand feet (1,000') of the grounds of a school, recreation center, or youth center;

3. While on a school bus; or

4. While in a motor vehicle that is being operated.

For American Military Veterans, Transition Has Been Hell

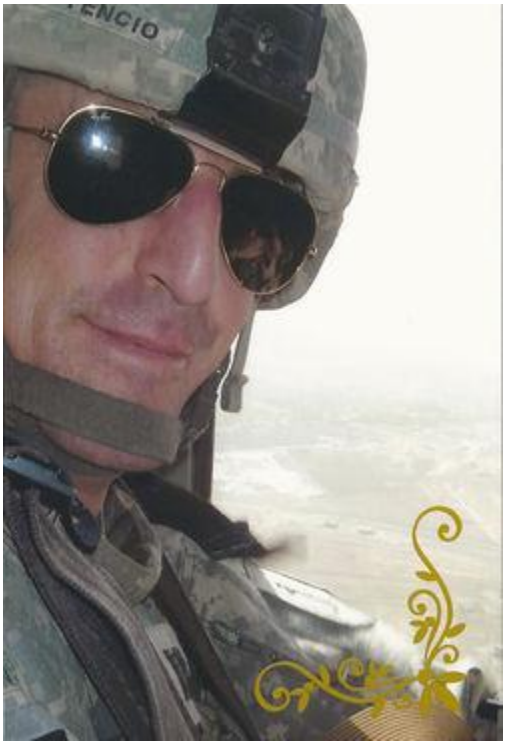
On average, 22 vets kill themselves every day in the U.S. On Jan. 18, one of them was my friend Chris

By ANTHONY PIGNATARO

published: May 22, 2014 OC Weekly

- **Angie Thompson**

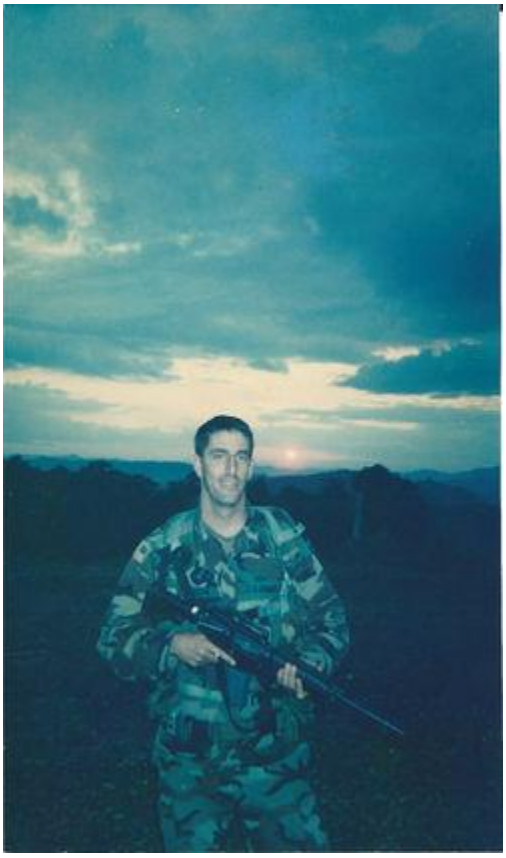
Anthony Pignataro (left) with Chris Atencio on Maui, 2013

- 

Atencio in Iraq, date unknown

- 
  Atencio in Iraq, 2009
- 

  Atencio with a care package sent by Pignataro, 2009

- 
  Atencio representing his favorite Newport Beach bar, date unknown
- 
  Atencio as a second Lieutenant, 2004
- 
  Atencio (left), Pignataro and Andy Greene at a 2003 party

Details:
Chris Atencio's family has asked friends and well-wishers to donate to the Jimmy Miller Foundation, which uses surfing to help people cope with physical and mental illness. For more information, go to[Jimmymillerfoundation.org](Jimmymillerfoundation.org).

If you're a veteran who's contemplating suicide, or you know one who is, call the Veterans Crisis Line at (800) 273-8255.

For more information on the Orange County Veterans Service Office, call (714) 480-6555, or go toVeterans.ocgov.com. Andy Greene was in Mammoth when the phone rang. It was 1:30 in the morning on Saturday, Jan. 18, and the Long Beach resident was sleeping, so the call went to voice mail. After the sun rose, Greene checked his phone. The message was from Chris Atencio.

Greene met Atencio more than a decade earlier when they were sales clerks at the North Face in Costa Mesa. In 2002, Atencio joined the U.S. Army, but the two had remained in contact. When the Army discharged Atencio in July 2013, he moved back to Orange County. Atencio and Greene had seen each other a few times since then and had traded emails just 10 days earlier.

"Andy? This is Chris Atencio," the voice mail began. "I'm happy as fuck that you got married, but I'm bummed as fuck that you've called me one and a half times since I've been home in six months. Ummm, I'm struggling, so if I die in the next God knows what, then we've got an issue up in heaven. I'll talk to you soon."

The message disturbed Greene immediately. Atencio had often drunk-dialed Greene, but this was different. Greene played the message for Vu Pham, a friend staying with him who'd also worked with Atencio at North Face.

"Whoa," Pham told Greene. "That's not good."

"What should I do?" Greene asked.

"Call him," Pham said. "Tell him you love him, you're there for him."

Greene made the call. Atencio didn't pick up, but Greene left a long message, saying all the things Pham suggested. Greene didn't hear back from Atencio that day. On Sunday night, Atencio's mother, Jane, called Greene; he wasn't able to pick up. It wasn't until Monday afternoon that Greene talked to her and learned that Atencio killed himself Saturday afternoon—just a few hours after Greene called him back.

"She was obviously in shock," Greene recalled. He told Jane that Atencio phoned him just a few hours before he died.

"I'm so sorry," she told Greene. "He did that with a number of his friends."

Chris Atencio was a good friend of mine. He and I met about 14 years ago, not long after he moved next door to me. We were living in tiny, drafty studio apartments built on the Balboa Peninsula in the 1920s, but they were also just a few yards from the beach. We ate pizza while watching surf videos, flirted with girls and traded books. When he got his private pilot's license, we rented a Cessna and flew to Catalina and back.

Right from the beginning, Atencio seemed different from your typical Newport Beach resident. He was part of the Wedge Crew of surfers who found a home in those nasty waves at the end of the Balboa Peninsula, but he was more than that. He was a world traveler, endlessly curious about how people everywhere lived. He and I talked for hours about all manner of subjects. I often asked him about his experiences overseas, and he in turn asked me questions about writing.

He'd traveled to and lived in dozens of countries, including South Africa, Israel, the Dominican Republic, Australia, Mauritius, Germany, Japan and Russia. He spoke Japanese, French, German, Spanish and even American Sign Language. A year or two ago, when he was applying for a security clearance, an investigator with the U.S. Office of Personnel Management dropped by my office in Maui, Hawaii, and asked me, among other questions, how many people Atencio knew overseas. I could only shrug my shoulders. "Who knows?" I told him. "Dozens? Hundreds?"

"He had a key to my apartment, and I had a key to his condo," said Craig Plitt, a Newport Beach boat captain who knew Atencio for more than 20 years. "He was a great, true friend. He had honesty, reliability, sincerity."

Atencio was also deeply troubled, though I knew nothing of it until Greene called me shortly after he got off the phone with Atencio's mother. I knew nothing of the medications he was taking for depression, or that he was suffering from crippling nightmares. I didn't know he had spent months at U.S. Department of Veterans Affairs (VA) medical clinics talking with doctors, nurses and specialists. I had no idea that just a few days before he died, he had started the process of getting the VA to acknowledge he suffered from post-traumatic stress disorder (PTSD). Doing so could have resulted in the government paying for his medical care for the rest of his life, but the process required filling out lengthy forms, describing in detail all the "stressful incidents" that plagued him during his time in the service.

Two days after he finished filling out those forms—finished reliving all the pain and frustration he'd dealt with—Atencio hanged himself in his garage. It was his mother's birthday.

"I don't know," Jane Atencio said when I asked why her son would kill himself on that day. It was an impossible question, but I had to ask it. "He was very good with my birthday. He knows I can't remember dates. I actually chuckle every time I have to give the day he died. This way, I have to remember."

* * *

Atencio's desire to put on the uniform began, as with so many, on Sept. 11, 2001. In fact, he woke me up that morning to tell me the news of the attacks.

"Dude, airplanes just hit the World Trade Center and the Pentagon," he had said. His mom had called him, but he didn't have a TV set to see for himself. So we sat in silence on the floor of my apartment as the second World Trade Center tower collapsed.

Christopher Andrew Atencio was born in Oregon on Nov. 7, 1971, but he grew up in Newport Beach. He went to Corona del Mar High School, then graduated from UC Santa Cruz in 1995. Although he had a degree in linguistics, he was doing odd jobs when I met him: selling action-sports gear and clothing at North Face, checking IDs at Cal Beach Sushi in Newport, tending bar at the restaurant in the Balboa Pavilion.

Not long after 9/11, Atencio decided he wanted to be an intelligence officer. First, it was the Marines, but he was too old (31) and couldn't get an age waiver. Then he moved on to the Army, which accepted him.

I didn't like the idea. If he really wanted to travel the world on the government's dime, then the U.S. State Department seemed far more suited to his interests and skills. But even that was a stretch. While Atencio at first glance seemed to be a lighthearted, easygoing OC surfer—a friend once compared him to Crush, the green sea turtle in *Finding Nemo*—inside, he was high-strung and completely intolerant of bullshit in all its forms.

Rather than confront Atencio head-on with my concerns, which I figured he'd reject out of hand, I tried something more indirect. That's how my story "My Friend Chris," which ran in the *Weekly*'s Sept. 12, 2002, issue came about. It's a brief story of a local guy who had a whole world of options to choose from, but decided at 31 to join the Army. I packed the story with quotes from vets, including my father, who all (as I had hoped) offered the same advice: "Just keep your mouth shut."

But what I didn't realize at the time was that Atencio wanted the structure and bureaucracy of the Army, even if he couldn't really articulate it. He thought he could deal with all the tiny empires that sprout in the service. He wanted the order that came from the Army's rules, but he didn't understand that each rule might also have a waiver.

"Chris was a people person," said Katie Marsh, Atencio's girlfriend for much of the latter half of 2013. "He had a temper, didn't really like taking orders, couldn't keep his mouth shut and had a high idea of how people should act. He bounced

around the world. But [in 2000], he felt his life was going nowhere. After 9/11, he found direction. He didn't have to identify the direction because someone else would."

* * *

Although getting into combat is the ultimate goal of pretty much everyone who volunteers for military service, it wasn't easy for Atencio. After basic training—where, after being told to name his rifle, he chose Amelie—and officer-candidate school, the Army assigned him to artillery school. He spent years serving in Oklahoma, Korea and Germany before he was able to transfer to intelligence.

Going to "spy school" at Fort Huachuca in Arizona was Atencio's dream. But it was only after he committed suicide that I learned how traumatic his time there had been.

"At Fort Huachuca, they accused him of taking notes out of the building," his mother said. "It scared him shitless. He called me in tears, saying the MPs were coming to get him. He didn't do it, but they could have sent him to Leavenworth."

Atencio never told me about his near-arrest at Huachuca—his honorable discharge and active security clearance indicate it didn't hurt his career—but he made pointed references to it on forms he was filling out for VA mental-health benefits that friends found after his death.

By 2008, he was part of an American unit advising an Iraqi brigade. He was based at Combat Outpost (COP) Shocker, located near the Iraq-Iran border. Though such an assignment had been his goal since he first took the oath back in 2002, he told me—in emails, personal chats and old-fashioned letters—that his experiences there were often as frustrating as the war itself.

"Army stuff amazes me here," he emailed me on Nov. 19, 2008, not long after arriving in Iraq. "We are deployed, but we put on the best dog-and-pony show for a deployed team/task force I have ever heard of, much less been in. . . . Times like this make me want to jump ship ASAP. Still holding out for some programs and real training where I can get a job and apply it. I never thought the army would be that hard when it comes to that. Otherwise it's MSU (Make shit up) and OJT (on the Job Training), for fuck's sake.

"We were just left a veritable shit storm of crap [because] the guys we replaced did a half-ass job," he continued. "Typical. I am completely disillusioned [with] how many people in the army actually know their shit. Not very many, based on dudes having to create a PowerPoint presentation to translate all the maintenance reports so it looks pretty for 'higher' to read. It goes downhill from there."

PowerPoints. The Army lives and dies by those things. Years later, when Atencio spent time with me in Maui, he showed me a PowerPoint he'd created in Iraq. It was Arab History 101 stuff, but he had to do it because though the U.S. Army had been fighting in Iraq for the previous five years, none of the other officers in his unit had what he thought was passable knowledge of even rudimentary Middle East history.

That was such an Atencio move—attempting to teach others, including his superiors, what he thought they should know. Sure, he was right, but it was no way to make friends. That's why I wasn't surprised to hear, a few weeks after his November email, that he'd gotten into trouble again.

On Dec. 19, 2008, Atencio emailed me, saying that his boss, a colonel, had forbidden him from checking out locals who were living just 200 meters from the base's gate. "We have no idea who is around us, and thus [they] could send shit into the COP at their luxury like our neighbor FOB [Forward Operating Base] has had to the south," Atencio wrote. The colonel's reason, Atencio said, for preventing him from talking with the locals? "He's good at forming relationships, and we don't want to do that." In other words, it wasn't in their mission to find out who those people were, and Atencio needed to stick to the mission.

This was tough for Atencio. He personally craved talking to people. It was what he was best at.

"People are cool, and it doesn't take much to show if you are a decent person or not," he emailed me on Dec. 17, 2008. "One judged overseas is judged by how he treats himself and others. Write that down [because] I wrote that."

Atencio didn't talk about the reprimand from his commanding officer in Iraq much in his letters and emails home, but I later learned it had killed his career. His commanding officer gave him a bad Officer Evaluation Report (OER). Given the Army's zero tolerance for just about anything deemed bad by the top brass, a single negative OER could doom an officer. From late 2008 onward, Atencio would never rise above captain. After his year in Iraq, his superiors sent him to Japan, considered a backwater post by soldiers. He never again held a command and ended up marking time until the Army decided it was through with him.

* * *

I last saw Atencio toward the end of June 2013, right around the time of his discharge, and he seemed fine. Well, mostly fine. He was getting out of the Army when he emailed me, saying he wanted to stop on Maui and say hi and asked if he could crash on my couch. Since I hadn't seen him in at least eight years (he'd spent some leave while in active duty to visit Hawaii), that wouldn't be a problem.

In typical Atencio fashion, I found him in Kahului Airport's baggage claim, trying to help fellow passengers find their luggage. I wasn't surprised to see a skateboard strapped to his bag.

At home, he showed me and my girlfriend slides of some of his travels. One night when we were out for sushi, he demonstrated his special technique for mixing wasabi into soy sauce. Later, he gave us special chopsticks he'd bought in Japan. While I was away at work, he rode his skateboard down to the beach and snorkeled with green turtles. On his last day, I took him to the *Maui Time Weekly* office, and he talked easily with my colleagues—even flirted with our summer intern.

He also showed me his DD-214 (his military discharge/separation document), which served as a kind of résumé of all his duty stations and assignments. Atencio's discharge from the service was honorable, and his security clearance was still good. He could write his own ticket for a solid civilian job.

But there were darker moments during his visit. He was quieter, less effusive than I recalled. At the time, I attributed it to his long flight over from Japan, as well as a general fatigue that comes from making big life transitions. But he also admitted something odd just a couple of hours after arriving.

"I've gotten so racist," he said. "Especially toward Filipinos."

It was a shocking admission, made almost matter-of-factly. Here was a guy who spent his entire adult life traveling the world, and now he was telling me he couldn't rise above racism. Something was wrong, but I did nothing.

Not sure what to say, I just frowned and shook my head. Soon we were talking about other things, but I didn't forget his comment. Though I never saw him say or act in a racist manner, the admission gnawed at me for the rest of his visit. It still does.

* * *

When Atencio arrived in Orange County last July, he immediately reconnected with his old Wedge Crew pals. They surfed, went dirt-bike riding and even took up skydiving. Though Atencio had earned his jump wings in the Army, Plitt said he loved jumping "just for fun." He had time to relax and have fun, it seemed, and no one complained.

"When he moved back, he seemed like Chris," Plitt said. "The first day I saw him was the Fourth of July. We hopped on bikes and cruised the boardwalk, going from bar to house party to bar to house party. Pretty much every day after that, the three of us were hanging out—jumping out of planes, body surfing, eating sushi, drinking beers."

But deep down, Atencio wasn't well. He had money and a secure place to live (the condo in which he lived belonged to his mother), but he didn't have a job and didn't seem to know what he wanted to do.

The Army calls what Atencio went through "transition"—the time when a soldier finally trades in his or her uniform for civilian clothes. Regardless of promises of future health benefits, job counseling and paid college tuition, it's a rough time. In 2012, the Army even mandated that all personnel leaving active duty participate in "transition services" that included job counseling and other practical assistance. But as far as transitioning a soldier's mind to civilian life, the former grunt is pretty much alone.

"The system is full of bureaucracy," said John Parent, interim service officer for the Orange County Veterans Service Office (VSO) in Santa Ana. Since 1929, it has helped vets such as Atencio navigate the complex, maddening world that is the VA. About 6,500 veterans visit the office every year, and it ends up helping about 4,500 of them. "In a year, we may see a veteran three times," he said. "Last December, we helped a client who first came here in 1946.

"It can be overwhelming and confusing to a lot of people," Parent added. "If you say a certain thing to the VA, that will generate a certain response. A lot of times, the veteran gets so frustrated, but by law, the VA has certain due processes that they have to do. The VA is trying to be veteran-friendly, and they've implemented some policies that allow you to apply online, but if you read the fine print, it says to seek help from a veteran services organization."

Parent said that his office assists veterans in a variety of ways, including talking to them about their claims and filling out the forms for them. "The VA can be generous, if you provide them with a well-grounded claim," he said. "Getting the word out to veterans is not easy, but it's gotten better. A lot of people [leaving the service] may get a general briefing on their benefits, but that's about it."

* * *

On Feb. 1, 2013, the VA released a study showing that veterans are killing themselves at the rate of about 22 per day—that's more than 8,000 vets per year. "The report indicates that the percentage of veterans who die by suicide has decreased slightly since 1999, while the estimated total number of veterans who have died by suicide has increased," the VA announced when the report came out.

A VA spokesperson told the *Weekly* the department does its best to get care to the vets who seek help, and the toll-free Veterans Crisis Line is posted throughout its facilities. "If any veteran comes into any medical center and claims he's a danger, he can get medical care," said VA public-affairs officer Ndidi Mojay. "If you go to a VA medical center, they should be able to point you in the right direction."

Should. Critics of the VA say that's fine, but sometimes people get lost in the bureaucracy.

"There's also a lot of variation between the various VA facilities," said Dr. Tom Berger, the executive director of the Veterans Health Council of the organization Vietnam Veterans of America. "As the saying goes, if you've seen one VA, you've seen one VA."

The VA's data shows a number of trends, some good, others not so much. In January 2014, the Veterans Health Administration (VHA) noted that vets in the system—such as Atencio—killed themselves at a rate of not quite 30 per 100,000 in 2010, while those outside the system took their lives at a rate of nearly 45 per 100,000.

But Berger noted something else in the data. "The VA report shows that 70 percent of suicides are veterans [older than] 50 years old," he said. "It's significant—Vietnam vets and older veterans are killing themselves at a higher and faster rate than younger people."

Another telling stat comes from the Veterans Crisis Line. Created in 2007 as the National Veterans Suicide Prevention Hotline (officials changed the name in 2011 as a way of telling friends and family members they could call, too), the service has so far taken 1.1 million calls. Of those, the organization says it has made "more than 35,000 life-saving rescues."

In early 2013, the VA announced it had "increased the capacity of the Veterans Crisis Line by 50 percent," also noting that the department was "currently engaged in an aggressive hiring campaign" to deal with the rise in suicides. At the same time, 98 members of Congress secured an additional $40 million appropriated specifically for suicide prevention and outreach.

On paper, those new staffing figures and dollar amounts seem like a lot. But when you think of the facts this nation has approximately 22 million veterans and that the VA's budget is nearly $100 billion per year, they suddenly seem woefully inadequate.

"It is a tragedy that our country loses more veterans and service members to suicide than to hostile fire or enemy action," Representative Tulsi Gabbard (D-Hawaii), who is a captain in the Hawaii National Guard and an Iraq War veteran, told the *Weekly* through her spokesperson. "They represent less than 1 percent of Americans who have carried the burden of the battles fought in Iraq and Afghanistan, and [they] are paying the physical and psychological price. We owe them our gratitude and so much more."

Vets such as Chris.

* * *

In mid-September, Atencio started going to the VA for help.

"We don't know what Chris told the VA," Jane said. "But I have his VA medical records. And I know for a fact that he wasn't taking his meds regularly because he told me. He was also drinking, which you're not supposed to do when taking the meds."

In late October, Jane said she and her son had a blowup. She was moving to Las Vegas, and it was a stressful time for both. After that, she said, Jane asked some of her son's friends to keep an eye on him. Plitt and others began periodically checking in on Atencio.

"I always found him to be fine, and we'd have a good time," Plitt said.

Atencio went to the VA a lot, Marsh said. Often, he would vent to her about his frustrations. Sometimes, he went multiple times per week. VA doctors prescribed him the antidepressants Citalopram and Trazodone. In late December, an acupuncturist told him he had fibromyalgia, brought on by PTSD. By January, he was also undergoing sleep tests to deal with constant nightmares.

"He wasn't really sleeping," Plitt said. "You sleep, but you don't get rest. You don't get your batteries recharged."

On Jan. 6, Greene—who met up with Atencio a couple of times since his return—heard part of an NPR story titled "Army Takes On Its Own Toxic Leaders." It was a well-researched, 13-minute report on how the Army was looking into whether inept commanding officers may "have contributed to soldiers' mental-health problems."

Recalling his own talks with Atencio about some of the commanding officers who'd given him grief, Greene found the story online when he got home and emailed it to Atencio. Jane heard the story, too, and she also sent it to her son.

"Colonels and generals adored Chris," said Jane, who counted numerous senior officers as family friends who followed her son's military career closely. "It was majors who didn't really like him."

In any case, Atencio thanked Greene for the story three days later.

"You know how to hit the nail on the head, my friend," Atencio said in an email. "I'm right there and had two amazingly fucked-up, toxic people in key leadership positions."

Then Atencio shared some of his current frustrations with both the VA and his mother.

"Hoping we can hang out sometime," he wrote. "I'm at the VA next Tues[day] and Wed[nesday]. Home has sucked. Transition has been hell."

Around that time, Atencio decided to file a disability claim with the VA for PTSD. If the VA accepted the claim, it would pay for his medical care for the rest of his life. But making the claim required him to complete VA Form 21-0781 (Statement in Support of Claim for Service Connection for PTSD) and VA Form 21-4138 (Statement in Support of Claim). Both are monuments to the massive bureaucratic forces that treat soldiers like machines and so frustrated Atencio.

The forms required him to describe in detail each "stressful incident" that happened to him in the service. They included spaces to list the names of service members involved in the stressful incidents and helpful checkoff boxes to mark in case those service members were "killed in action" or merely "wounded in action." They even included time elements, specifically saying how much time it should take the depressed soldier to complete the form.

"That was the worst thing ever," Jane said. "He had to enumerate everything he felt was contributing to his PTSD. They sent him home with these forms, and he had to fill them out by hand. It came to nine pages. Most of it I knew, but it was horrifying for him to relive it. He filled out the forms but didn't send them in.

"He filled out forms on PTSD on the Thursday before he died," she added. "There's no doubt in my mind that that's what pushed him over the edge."

Jane said she last talked with her son a couple of days before his suicide. They talked about her upcoming birthday and planned a visit for early February. When Atencio didn't call her on her birthday—something she said he was very good about doing every year—she became concerned.

Plitt went by the condo to check on his friend, as he'd done in the past. "When I found him, he was clean-shaven, well-dressed," Plitt said. "He had the appearance of being ready to go out. He looked like he was ready to go out and have fun."

Chris Atencio was 42 years old.

* * *

Nearly 300 people showed up at the Balboa Pavilion on Feb. 1, 2014, for Atencio's celebration of life. It was a good venue choice—back in 2001 or so, I'd spent many weekend afternoons in the Pavilion's restaurant, sitting with locals, fishermen and the odd tourist at the bar while Atencio mixed drinks for us all.

Jane said friends of her son came from the West Coast, the East Coast, Alaska, Canada and Japan. Another 86 people went to the Wedge for a paddle out. Friends in Japan held a separate paddle out for him.

I wasn't able to make it. The last time I saw him was when I dropped him off at Kahului Airport. He was headed to Oahu for a couple of days to see a few friends there before returning to OC. On the drive over, we talked about his future, mostly—the possibility of him getting a job as a contractor, starting his own business or even going back to school. I told him he had tons of options, that I had no fear that he'd do all right for himself.

We traded a couple of brief emails after, but that day back in June 2013 was pretty much the last time we really talked. It was pleasant but entirely unmemorable, which I guess makes me fortunate. Others, such as Andy Greene, have very different final memories of our friend.

"I still have the voice mail message," Greene said recently. "I don't know why. Maybe because it's his voice. My wife wants me to delete it. I'll let go of it at some point—it's a tough one to swallow. But I'll be honest with you: I feel a little bit better that I wasn't the only one who got one."

At the celebration, Jane placed hundreds of photos of her son from throughout his life on tables and told everyone gathered to take home what they thought important and special. Knowing I couldn't be there, Greene sifted through them until he found a few with me; he mailed them a few days later. One image, taken at a 2003 going-away party before I moved to Maui, showed the three of us. Atencio, his head freshly shaven—he was on leave after finishing basic training, I believe—had his arm around us and some shiny fake lei around his neck.

Years ago, I had mailed the photo to Atencio, and he'd filed it away, with practically everything else he ever owned. On the back, for reasons I've long forgotten, I had scribbled the following quotation from Emerson, which I'd found in the novel *From Here to Eternity*:

"The Sphinx must solve her own riddle. If the whole of history is in one man, it is all to be explained from individual experience."

Anthony Pignataro is the editor of Maui Time Weekly*. He was a staff writer for* OC Weekly *from 1996 to 2003.*

Why suicide rate among veterans may be more than 22 a day

By **Moni Basu**, CNN
updated November 14, 2013

Leon Panetta, the former defense secretary, called the suicide rate among service members an epidemic.

STORY HIGHLIGHTS

- The data the suicide rate is based on are incomplete
- Examples of uncounted: "suicide by cop," by overdoses and by vehicle crashes
- "There's probably a tidal wave of suicides coming"
- VA makes appeal for more uniform reporting of suicide data

(CNN) -- Every day, 22 veterans take their own lives. That's a suicide every 65 minutes. As shocking as the number is, it may actually be higher.

The figure, released by the Department of Veterans Affairs in February, is based on the agency's own data and numbers reported by 21 states from 1999 through 2011. Those states represent about 40% of the U.S. population. The other states, including the two largest (California and Texas) and the fifth-largest (Illinois), did not make data available.

Who wasn't counted?

People like Levi Derby, who hanged himself in his grandfather's garage in Illinois on April 5, 2007. He was haunted, says his mother, Judy Casper, by an Afghan child's death. He had handed the girl a bottle of water, and when she came forward to take it, she stepped on a land mine.

When Derby returned home, he locked himself in a motel room for days. Casper saw a vacant stare in her son's eyes. A while later, Derby was called up for a tour of Iraq. He didn't want to kill again. He went AWOL and finally agreed to an "other than honorable" discharge.

Derby was not in the VA system, and Illinois did not send in data on veteran suicides to the VA.

Experts have no doubt that people are being missed in the national counting of veteran suicides. Luana Ritch, the veterans and military families coordinator in Nevada, helped publish an extensive report on that state's veteran suicides.

Veteran confronts rape and suicide

Part of the problem, she says, is that there is no uniform reporting system for deaths in America. It's usually up to a funeral director or a coroner to enter veteran status and suicide on a death certificate. Veteran status is a single question on the death report, and there is no verification of it from the Defense Department or the VA. "Birth and death certificates are only as good as the information that is entered," Ritch says. "There is underreporting. How much, I don't know."

Who else might not be counted?

A homeless person who has no one who can vouch that he or she is a veteran, or others whose families don't want to divulge a suicide because of the stigma associated with mental illness; they may pressure a state coroner to not list the death as suicide

If a veteran intentionally crashes a car or dies of a drug overdose and leaves no note, that death may not be counted as suicide.

An investigation by the Austin American-Statesman newspaper last year revealed an alarmingly high percentage of veterans who died in this manner in Texas, a state that did not send in data for the VA report. "It's very hard to capture that information," says Barbara van Dahlen, a psychologist who founded Give an Hour, a nonprofit group that pairs volunteer mental-health professionals with combat veterans.

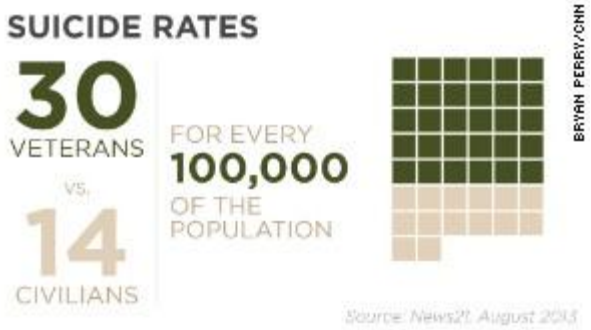
Nikkolas Lookabill had been home about four months from Iraq when he was shot to death by police in Vancouver, Washington, in September 2010. The prosecutor's office said Lookabill told officers "he wanted them to shoot him." The case is one of many considered "suicide by cop" and not counted in suicide data.

Carri Leigh Goodwin enlisted in the Marine Corps in 2007. She said she was raped by a fellow Marine at Camp Pendleton and eventually was forced out of the Corps with a personality disorder diagnosis. She did not tell her family that she was raped or that she had thought about suicide. She also did not tell them she was taking Zoloft, a drug prescribed for anxiety.

Her father, Gary Noling, noticed that Goodwin was drinking heavily when she returned home. Five days later, she went drinking with her sister, who left her intoxicated in a parked car. The Zoloft interacted with the alcohol, and she died in the back seat of the car. Her blood alcohol content was six times the legal limit.

Police charged her sister and a friend in Goodwin's death for furnishing alcohol to an underaged woman: Goodwin was 20. Noling says his daughter intended to drink herself to death. Later, Noling went through Goodwin's journals and learned about her rape and suicidal thoughts.

A recent analysis by News21, an investigative multimedia program for journalism students, found that the annual suicide rate among veterans is about 30 for every 100,000 of the population, compared with the civilian rate of 14 per 100,000. The analysis of records from 48 states found that the suicide rate for veterans increased an average of 2.6% a year from 2005 to 2011 -- more than double the rate of increase for civilian suicide.



Nearly one in five suicides nationally is a veteran, even though veterans make up about 10% of the U.S. population, the News21 analysis found.

The authors of the VA study, Janet Kemp and Robert Bossarte, included many cautions about the interpretation of their data, though they stand by the reliability of their findings. Bossarte said there was a consistency in the samples that allowed them to comfortably project the national figure of 22.

But more than 34,000 suicides from the 21 states that reported data to the VA were discarded because the state death records failed to indicate whether the deceased was a veteran. That's 23% of the recorded suicides from those states. So the study looked at 77% of the recorded suicides in 40% of the U.S. population.

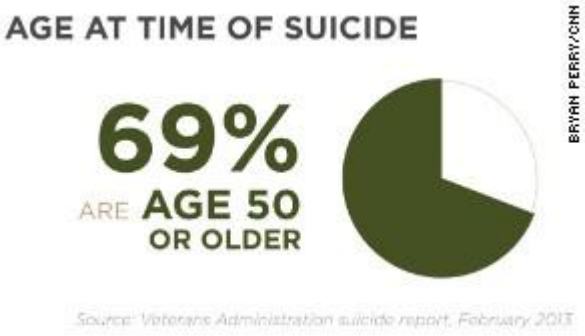
The VA report itself acknowledged "significant limitations" of the available data and identified flaws in its report. "The ability of death certificates to fully capture female veterans was particularly low; only 67% of true female veterans were identified. Younger or unmarried veterans and those with lower levels of education were also more likely to be missed on the death certificate."

"We think that all suicides are underreported. There is uncertainty in the check box," says Steve Elkins, the state registrar in Minnesota, which has one of the best suicide data recording systems in the country.

Websites become tool for stopping suicide

VA Secretary Eric Shinseki requested collaboration from all 50 states to improve timeliness and accuracy of suicide reporting, key to improving suicide prevention. At the time the VA released its last suicide report, at least 11 states had not made a decision on data collaboration.

Combat stress is just one reason why veterans attempt suicide. Military sexual assaults are another. Psychologist Craig Bryan says his research is finding that military victims of violent assault or rape are six times more likely to attempt suicide than military non-victims.



More than 69% of all veteran suicides were among those 50 and older. Mental-health professionals said one reason could be that these men give up on life after their children are out of the house or a longtime marriage falls apart. They are also likely to be Vietnam veterans, who returned from war to a hostile public and an unresponsive VA. Combat stress was chalked up to being crazy, and many Vietnam veterans lived with ghosts in their heads without seeking help.

Even though more older veterans are committing suicide, it's difficult to predict what the toll of America's newest wars will be. A survey by the Iraq and Afghanistan Veterans of America showed that 30% of service members have considered taking their own life, and 45% said they know an Iraq or Afghanistan veteran who has attempted suicide.

"There's probably a tidal wave of suicides coming," says Brian Kinsella, an Iraq war veteran who started Stop Soldier Suicide, a nonprofit group that works to raise awareness of suicide. Between October 2006 and June 2013, the Veterans Crisis Line received more than 890,000 calls. That number does not include chats and texts.

President Barack Obama says there is a need to "end this epidemic of suicide among our veterans and troops." In August 2012, he signed an executive order calling for stronger suicide prevention efforts. A year later, he announced $107 million in new funding for better mental health treatment for veterans with post-traumatic stress and traumatic brain injury, signature injuries of the wars in Afghanistan and Iraq.

The Truth About Driving While Stoned
By *Abby Haglage* 15 hours ago The Daily Beast
June 2014

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The Truth About Driving While Stoned
Nathan Palmer was headed to his job at a Peoria, Illinois, Pizza Hut in July 2011 when his car crossed the median and struck a motorcycle, instantly killing its driver. Despite the smell of marijuana, the 33-year-old told police he hadn't smoked in a week, and that the crash was the result of "losing consciousness."

In Illinois, which houses some of the tougher DUI laws in the nation, even smoking a joint a week before can implicate you. Authorities found trace amounts of THC (the psychoactive chemical in marijuana)—enough to send Palmer to prison. But after months in court, the judge dropped charges against Palmer, citing evidence that hypoglycemia—low blood sugar—was the likely cause.

The story captures the disorder that still pervades the stoned-driving debate today. Without a "weed breathalyzer" or any tool to measure recent marijuana use, the line between anecdote and fact has been indelibly blurred. Had hypoglycemia not been a factor, Palmer's case would have come down to whether or not the THC in his system was impairing him at the time. A loaded question with no easy answer.
It's an issue further complicated this week by a piece in USA Today which details a "new" study that allegedly proves marijuana DUIs tripled nationwide in one year. The concept is not only inaccurate, it's recycled—similar to an article titled *Pot Fuels Surge in Drugged Driving Tests,* published by NBC in January. The report claim not only that the study measured for cannabis and risk of accident, but that it was a sampling of national data.
It was neither.
The study's authors never intended to imply that marijuana caused the accidents, nor suggest that their sample was nationally representative. Analyzing the toxicology reports from 24,000 driving fatalities in six states during 2010, the authors found that 12 percent of those killed had marijuana in their system—triple what the number was in 1999.

But the study didn't analyze whether marijuana *caused* the fatal accidents—only that it was present at the time of death. Since THC is fat soluble, it stays in the system much longer than alcohol. The Centers for Disease control estimates that, in some users, it can be detected up to two weeks after use. It is impossible to know whether the 12 percent with marijuana in their system smoked an hour or 14 days before their fatal crash.
Marijuana may have contributed to many of these accidents—perhaps all of them. But the study's authors are disbelieving of that notion. "The prevalence of non-alcohol drugs reported in this study should be interpreted as an indicator of drug use, not necessarily a measurement of drug impairment," the authors write. One of the study's authors, Guohua Li, elaborated on the point in a February story in the Denver Post. "The most likely explanation [for the rise] is that use of

marijuana in the general driver population has been increasing, which may reflect increased use in the overall population," Li said.

The truth is, after decades of analysis, we still don't have a firm grasp on how THC impairs driving.

Laboratory studies have confirmed that THC (officially, Delta-9-tetrahydrocannabinol) impairs many motor skills necessary for driving. But actual driving simulation studies have not mimicked these results. One sound example is a 2004 study in which three researchers found THC to inhibit attention, reaction time, hand-eye coordination, short-term memory, time and distance perception, and concentration.

But when tested in actual driving simulation, the authors found the results did not "replicate" their laboratory evidence. In other words, researchers were able to prove that THC *should*, technically, impair driving, but not that it *does*. Their explanation for the discrepancy: Drivers with THC are likely cognizant of their impairment and are thus able to "compensate...by driving more slowly and avoiding risky driving maneuvers."

Dr. Paul Armentano, the deputy director of NORML (a nonprofit lobbying organization for marijuana reform) who has written extensively in peer-reviewed literature on the subject of cannabinoids' influence on psychomotor performance, calls reports on the paper "highly" misleading. "[This] paper itself sought to draw no conclusions in regard to whether cannabis was a likely cause of accident or whether crashes in which cannabis played a causal role are increasing," Armentano tells The Daily Beast. "It simply measured cannabis prevalence."

He further suggests that applying this study to the nation as a whole is irresponsible: "[The authors] reviewed data from six states only—four of which were Hawaii, New Hampshire, West Virginia, and Rhode Island—hardly the states one would assess if you were doing a random sampling of the country."

Kevin Sabet, executive director of SAM (Smart Approaches to Marijuana), says the study does hold importance. "This is further evidence...that marijuana is harmful for driving. It is directly related to car crashes," he tells The Daily Beast. "I think it's reflective of the growing acceptance of marijuana and the growing ignorance about its harms, especially for drivers. Many teens today think driving while stoned is safe."

In Sabet's eyes, it's anything but safe. "Science has determined that cannabis intoxication doubles your risk of a car crash. Despite this scientifically valid fact, people are not getting this message," he says. One commonly referenced example, a 2012 paper from the British Medical Journal, looked at close to 3,000 studies on the topic. Their analysis found drivers who had consumed cannabis twice as likely to be involved in a traffic accident.

The National Institute on Drug Abuse (NIDA) echoed Sabet's sentiments in a paper released this week about the risks associated with marijuana and driving. In relation to the study, the agency told The Daily Beast: "The bottom line is that we are seeing broader use of more potent cannabis, thus we can expect more serious outcomes."

But NIDA's claim that marijuana use increases the likelihood of an accident is contradicted in some of the government's own research. One, a U.S. Department of Transportation study from 2000, measured the effects of a low dose of THC with and without alcohol on driving proficiency of recreational users of marijuana and alcohol. The results showed that while THC and alcohol combined impaired driving, THC had only a negligible effect on driving. "Low doses of marijuana (THC 100 µg/kg) taken alone, did not impair city driving performance and did not diminish visual search frequency for traffic at intersections in this study," the study reads.

Another, published in 2012 by the Journal of Accident Analysis and Prevention, found that the odds ratio for the likelihood of a marijuana positive driver being culpable in a traffic accident compared to a drug-negative driver to be on par with penicillin and antihistamines.

Mark Kleiman, a drug policy expert and professor at UCLA, says driving stoned is hazardous, but much less hazardous than driving drunk. Marijuana, according to a 2013 Columbia University

case study, holds a relative risk of 1.83—meaning that driving 10 miles stoned is equally dangerous to driving 18 sober. This number falls significantly below those of other factors. In the same study, texting is shown to have a relative risk of 4, alcohol 12, and alcohol + something else, 23. “You shouldn’t be driving stoned," says Kleiman. “But there are many things that will degrade driving just as much if not more—having a 4-year-old in your back seat, sleepiness, texting.”
Beyond the relative risk associated with marijuana, Kleiman says blood is not a good proxy for how stoned you are. “It’s almost impossible not to be guilty of driving while stoned if you smoke. The fact that THC is fat soluble and then comes back out in your bloodstream means you can be THC positive when you’re not impaired at all,” he says. “There’s no way to tell if you’re breaking the law—that seems unjust.” Kleiman says THC mouth swabs are being tested that could present a viable solution to the drugged-driving debate.

In the meantime, the two states where recreational marijuana is already legal are ignoring the buzz and focusing on keeping the streets safe.
“Marijuana has been around for a long time,” Colorado State Trooper Nate Reid tells The Daily Beast. “State troopers across the country have been stopping people for marijuana for a long time. Now that it’s legal recreationally you still aren’t allowed to drive on it." According to data from the Colorado State Patrol, 374 out of the 2,314 DUIs statewide already this year—12 percent—have been due to marijuana.

But without data from years past to compare it to Reid is hesitant to claim this as an increase: “It's too soon,” he says.
A noble attempt to change the landscape of the marijuana DUI debate—where fiction often precedes fact.

****
I'm not proud of this but I have driven drunk, stoned and drunk and stoned when I was younger. I no longer drink and drive, I barely drink. Due to medications I take for chronic pain I am "legally" impaired every time I drive a car, whether I use medical marijuana or not. I try not to drive as much as possible, if I have to drive, I wait an hour after vaporizing to let the worst of the impairment pass before driving. I know my reactions may be slowed due to medications and I allow for that in my driving behavior. I DO NOT text while driving, I don't make a phone call while driving and I try to avoid answering the phone when driving. My 47 yrs. of driving experience have convinced me that phone use while driving is more dangerous than anything I have consumed before driving!
Texting, eating, smoking, noisy kids and any other distraction that pulls your attention from the road are just as dangerous as using marijuana before driving!
drive. It may seem obvious but it seems to me that when you smoke weed you are smoking to deliberately get high, but many people who drink maybe do not intend to get hammered and so do not realize when they have gone to far--or at least I have heard them say so.

Thousands of Rapists Are Not Behind Bars Because Cops Focus on Marijuana Users

Drug Policy Alliance

A recent piece in the *Washington Post* highlights the growing backlog of untested rape test kits that are sitting in police storage units while rapists run free and victims suffer. Missing from the story, however, is one of the biggest contributors to this backlog, the enormous amount of police and tax resources spent targeting drug crimes, particularly marijuana possession.

The backlog is a disgrace. The total number of rape test kits that have never been sent to laboratories for testing exceeds 100,000. In some cases, the kits have been sitting in storage for decades. From the *Washington Post*:

> "In 2009, authorities found more than 11,000 unprocessed kits at the Detroit crime lab after it was closed for improperly handling weapons evidence. After testing the first 2,000 kits, authorities identified 127 serial rapists and made 473 matches overall to known convicts or arrestees, or to unknown people whose genetic material was found at crime scenes."

The real question is why does this backlog exist at all? Cities and states claim they don't have the money or other resources, but they sure do have plenty of time and money to arrest people for drugs.

About 1.5 million Americans are arrested for drugs annually – about 660,000 for nothing more than possession of marijuana for personal use. It takes up to three hours to process someone after an arrest. And since most arrests involve multiple officers in multiple police cars it's potentially dozens of lost police hours just to arrest one person for marijuana.

It costs an estimated $10,000 to arrest, process, and convict someone for marijuana possession. Then there's the cost of keeping thousands of drug task forces operational, most of which do nothing but bust people for marijuana or other low-level drug offenses. New York City claims to not have enough money to test all its rape test kits but spends millions each year randomly searching young people of color for marijuana.

Worse, police have a financial incentive to focus on drugs. Federal grant programs, such as the Edward J. Byrne Justice Assistance Grant (JAG) program, reward local and state police for the number of people they arrest. Through asset forfeiture laws police agencies are allowed to keep money, cars, houses and other proceeds from the drug trade. Busting nonviolent drug offenders allows them to line their own agency's coffers. They don't get anything for arresting rapists or other violent criminals.

When the Drug Policy Alliance did an asset forfeiture reform ballot measure in Utah that directed forfeiture proceeds to the state's general treasury instead of police budgets, police said that if the measure passed they would have no reason to go after drug offenders. The initiative passed and drug arrests and seizures decreased. Police eventually convinced the legislature to gut the initiative and let them return to profiting from drug cases.

At least one national policymaker gets the connection between the war on drugs and the increasing backlog in rape kit testing: Rep. Steve Cohen (D-TN). He recently offered an amendment on the U.S. House floor shifting $5 million from the Drug Enforcement Administration (DEA) to a rape test kit testing program. It passed overwhelmingly.

Polling shows that voters support legalizing or decriminalizing marijuana because they want to stop wasting police resources. They want police to focus on real crime, like rape, instead of ruining people's lives with an arrest record for marijuana possession. Unfortunately there are still politicians and police officers supporting the failed war on drugs. It's time we start calling them out.

Every dollar and police hour spent on nonviolent drug offenders is money and time not spent on real crime.

Bill Piper is the director of national affairs for the Drug Policy Alliance.

Top U.S. doctor says medical marijuana may help some conditions

REUTERS

By **Ian Simpson** Feb 4, 2015

By Ian Simpson

WASHINGTON (Reuters) - The United States' top doctor said that medical marijuana can help some patients in comments on Wednesday that may boost pressure on the Justice Department to redesignate the drug under federal law.

In an interview on "CBS This Morning," U.S. Surgeon General Vivek Murthy said the medical effectiveness of marijuana had to be shown scientifically and much more information about it was coming.

"We have some preliminary data showing that for certain medical conditions and symptoms, marijuana can be helpful," said Murthy, who became surgeon general in December.

"I think we have to use that data to drive policymaking, and I'm very interested to see where that data takes us."

The Justice Department designates marijuana as a Schedule I controlled substance, a category for drugs that have no accepted medical value and have a high potential for abuse.

Twenty-three states and the District of Columbia have legalized medical marijuana, according to the Drug Policy Alliance advocacy group.

Florida also allows a narrow use of medical marijuana. Two states, Washington and Colorado, have legalized marijuana for recreational use.

Tom Angell, chairman of Marijuana Majority, another advocacy group, said in a statement that Murthy's remarks mean that President Barack Obama should direct Attorney General Eric Holder to begin changing how the department categorizes marijuana.

"Dr. Murthy's comments add to a growing consensus in the medical community that marijuana can help people suffering from painful conditions," Angell said.

The Justice Department had no immediate response to Murthy's comments.

For Myself and Other Veterans Medical Marijuana is the Difference

November 11, 2014 | Patrick Seifert

Think about that number for a moment. **Sadly, a report from the Department of Veterans Affairs (VA) finds that 22 American lives are taken every single day as a result of military conflicts overseas. Except these men and women aren't dying on the battlefield, they are dying right here on American soil. From the tiniest towns to the biggest cities, mothers, fathers, brothers, sisters, sons and daughters are taking their own lives to end the pain and suffering.**

Let's put things into perspective. On average, there were close to 4,150 American troops killed during each year of the Vietnam War. In comparison, the VA estimates nearly twice as many veterans killed themselves in 2010, as a direct result of their military service. Most of these forgotten heroes are over 50 years old. Nearly all suffer from Post Traumatic Stress Disorder (PTSD) or have a Traumatic Brain Injury (TBI). The VA has struggled with these problems for over a decade. So, what if there was a medicine that could save just one of these American heroes. What if we could save more than that?

Findings of research released in January 2012 found the passage of medical marijuana laws are associated with a nearly 5% reduction in suicide rates among veterans of all ages. Similarly, a new study from UCLA found that THC, the psychoactive ingredient in marijuana, leads to a higher survival rate among victims of TBI's. Then there's the recent research to suggest cannabis can be used to lessen the dependence on painkillers, another undisputed factor in suicide rates among veterans.

True story. Just the other day, I got a text message from a veteran who completed three tours of duty in Afghanistan and Iraq. He was a decorated soldier who had been to the VA and tried every option they provided, but nothing worked. This young man in his early 30's was desperate to find a way out. Like all the others, I asked him to make one simple promise: not to do anything drastic for at least 24 hours. During that time, I set him up with a support system made up of several fellow veterans who were willing to lend an ear and we explained how medical marijuana might help. By the end of the weekend, my friends were able to set him up with a volunteer project helping other vets, which took his mind off things long enough to get him to a doctor and get him some medical cannabis. He is currently using it to help ease PTSD and curb thoughts of suicide, and is now doing well. This is one of three veterans who've desperately reached out to me, just in the past three weeks. I have helped every single one of them turn their lives around with medical cannabis.

Research unequivocally shows that cannabis should be considered a first-line defense against PTSD and anxiety disorders, yet out of 35 states where medical marijuana is legal, only 10 allow for use by patients with PTSD. That leaves 40 states where veterans can still go to jail for using cannabis, regardless of their reasoning for doing so. Something is wrong with this picture.

The U.S. recently declared war on ISIS for taking the lives of two American hostages. Yet today, on this day designed specifically to honor veterans, another 22 soldiers, sailors, airmen and marines will choose to end their own lives because our country has abandoned them in a time of need. When will the military declare a War on Suicide?

If we truly want to honor the sacrifices of men and women in uniform, we owe it to them to find out if medical marijuana can ease their suffering. We need to fight for researchers like Dr. Sue Sisley, who gained approval to conduct a study on the efficacy of medical marijuana for Veterans with PTSD, only to lose her job over the issue. We need to fight to make sure Veterans with TBI's, chronic pain, PTSD and other war wounds have the option to choose marijuana over addictive pharmaceuticals. We need to fight to make sure every single Veteran that we come in contact with knows beyond a shadow of a doubt that they are not alone. Only then can we truly celebrate on Veterans Day, because unless we make some serious changes soon, we will continue to lose 22 beloved American heroes each and every day.

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Patrick Seifert is founder of Rainier Xpress, a medical cannabis collective that serves approximately 5,000 veterans. He is an active ASA member and serves on the steering committee of ASA-Washington. Patrick has proven to be a fierce champion for patients' rights, logging dozens of hours at the Capitol and beyond, educating policymakers about veterans issues and how to improve Washington's medical marijuana law.

WHY IS HEMP REALLY ILLEGAL??

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

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

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

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

MEDIA MANIPULATION

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

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

LEGISLATION

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

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

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

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

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

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

WHO BENEFITS FROM MARIJUANA'S ILLEGALITY?

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

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

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

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

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

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

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

10 Marijuana Myths and Facts:

1. **Marijuana is Not Medicine.**

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

2. **Marijuana is Addictive.**

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

3. **Marijuana is a "Gateway Drug".**

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

4. **Medical Marijuana Collectives Cause Crime.**

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

5. **Medical Marijuana Causes an Increase in Teen use.**

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

6. **Marijuana Causes Traffic Collisions.**

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

7. **Marijuana is Dangerous for Young Minds.**

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

8. **Marijuana is More Potent Now Than Ever Before.**

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

9. **Marijuana Causes People to be Lazy and Unproductive.**

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

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

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

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For Myself and Other Veterans Medical Marijuana is the Difference

November 11, 2014 | Patrick Seifert

ıink about that number for a moment. **Sadly, a report from the Department of Veterans Affairs (VA) finds that 22 American lives ar .ken every single day as a result of military conflicts overseas. Except these men and women aren't dying on the battlefield, the 'e dying right here on American soil. From the tiniest towns to the biggest cities, mothers, fathers, brothers, sisters, sons and .aughters are taking their own lives to end the pain and suffering.**

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After California decriminalized marijuana, teen arrest, overdose and dropout rates fell

WASHINGTON POST **Oct 2014**

By Christopher Ingraham

A new report from the Center on Juvenile and Criminal Justice adds to the growing body of evidence that legalizing or decriminalizing marijuana does not lead to any number of doomsday scenarios envisioned by legalization opponents. Looking specifically at California, where full marijuana decriminalization went into effect on Jan. 1, 2011, the report finds that "marijuana decriminalization in California has not resulted in harmful consequences for teenagers, such as increased crime, drug overdose, driving under the influence, or school dropout. In fact, California teenagers showed improvements in all risk areas after reform."

Table 1. California's marijuana reform was followed by improvements in 15-19 year-olds' risk indexes, both absolutely and compared to teenagers elsewhere in the country

Index		Year before (2010)	Year after (2011)	2 years after (2012)	Change
Violent Deaths	California	28.5	27.4	24.7	**-4%**
	Rest of US	38.3	37.9	N/A	**-1%**
Drug Overdose Deaths	California	3.0	2.4	2.3	**-20%**
	Rest of US	3.9	4.0	N/A	**4%**
Suicide	California	5.3	5.8	4.6	**9%**
	Rest of US	7.8	8.7	N/A	**11%**
Criminal Arrest	California	9,505.3	7,712.0	6,612.2	**-30%**
	Rest of US	14,711.1	13,572.8	11,908.0	**-19%**
Drug arrests*	California	718.4	593.8	551.6	**-23%**
	Rest of US	2,013.7	1,794.0	1,734.4	**-14%**
Property crime arrests	California	2,272.1	1,996.1	1,708.0	**-25%**
	Rest of US	3,229.1	3,045.4	2,784.4	**-14%**
DWI, marijuana**	California	0.289	0.240	0.282	**-3%**
	Rest of US	0.119	0.131	0.129	**+9%**
School dropout rate	California	14.7%	13.1%	11.4%	**-22%**
	Rest of US	N/A	N/A	N/A	

Notes: Death and crime rates are per 100,000 population age 15-19. Change is 2011 versus 2010 for mortality measures, and 2012 versus 2010 for arrest and DWI measures. School dropout is those failing to graduate on time as a percent of all eligible students. DWI marijuana is the proportion of fatal accidents involving a driver under age 20 in which marijuana is found by test. Vital statistics are not available nationally for 2012, nor are comparable school dropout rates. Different measures may account for differences in California and national numbers. Sources: Centers for Disease Control (2014); California Department of Public Health (2014); Criminal Justice Statistics Center (2013); Federal Bureau of Investigation (2013); National Highway Traffic Safety Administration (2014); California Department of Education (2014). *Excluding marijuana possession arrests in California. **California drug-tests a substantially greater proportion of drivers than other states and therefore finds more drug involvement. The measure used here maximizes marijuana presence by treating multiple drug tests a separate when in fact they probably include testing the same drivers more than once.

Center on Juvenile and Criminal Justice

Most notable in the above table is the drop in school dropout rates. Recent studies have suggested links between heavy marijuana use and low school completion rates. But many experts question the direction of causality in this relationship, suggesting that there could be any number of confounding factors that account for this relationship. While it's still early

LONG BEACH MEDICAL MARIJUANA TASK FORCE

POB 15027
Long Beach, CA 90815

ır Mayor Robert Garcia and Honorable City Councilmembers October 2014

LB MEDICAL MARIJUANA (MMj) ORDINANCE DRAFT

at has been proven in numerous studies and anecdotal evidence is that cannabis/marijuana does have dicinal value and has helped many citizens across the world with various maladies, disabilities and pain. The gest concern before us is how to reasonably and compassionately distribute this medicine to those who need presented in the recent People v **Baniani** California Court of Appeals case (G04835), **"It would be cruel for th ose need for medical marijuana is the most dire to require that they devote their limited strength and effo he actual cultivation of the marijuana, and then wait months for it to grow so they can use it....."** In Peop rziceanu (CA App.4th), the court noted the Medical Marijuana Program Act (MMPA) was the Legislature's init ponse to the CUA's (Compassionate Use Act – Prop 215) call to provide a plan "for the *safe and affordable ribution* of marijuana to all patients in medical need of marijuana....."

rsonally experienced the painful, **prolonged deaths** of both my mother and other family members from canc not a pretty picture. At that time, cannabis was sadly not allowed as medicine. It is now, and we should do rything we can to alleviate the needless suffering in this world. We must never forget that a patient could be ır mother, your sister, your friend or your child. While "abuse" does happen, we don't deprive cancer patient ain meds because others abuse it. (Prescription drugs are the most abused drug group in the nation.)

people of Long Beach voted for the 1996 Prop 215 Compassionate Use Act, Proposition 19 (full legalization) LB Prop A MMj tax measure. The citizens of this fair City have spoken. Mirroring this sentiment, 60% of the ire nation wants legalization. And, as people become more informed and enlightened, that number continue ncrease.

City Attorney (CA) proposed Ordinance for Medical Marijuana collectives was written with little cern/compassion for sick patients and people with disabilities who rely on cannabis for their maladies and pa s CA draft is little more than a punitive, miserably failed 5.87 ordinance (2010) on steroids. It blatantly throw e process" out the window, repeatedly insults the United States Constitution, and shamelessly disregards the ıts of patients. Fraught with litigation landmines (5.87 earned over 30 lawsuits), it promotes a biased agenda deprives equal access those who do need it. By creating a non-workable ordinance, it only serves as a quasi without actually calling it so.

following is an **in-depth analysis** of the 9-11-14 version of the proposed City MMj ordinance (**A copy is ached herein.**) Page and line #s correlate accordingly. This was presented to the Planning Commission at the 14 meeting. Changes made on subsequent versions are minimal and not as consequential. While this is not a nplete list, it highlights some of the numerous stand-out problems with this draft.

equiring that every dispensary obtain a **conditional use permit (CUP)**, the new ordinance appears to have th ne flaw that the Appellate court disapproved of in the Pack Case (Pack v Superior Court - City of Long Beach

LONG BEACH MEDICAL MARIJUANA TASK FORCE

POB 15027
Long Beach, CA 90815

Dear Mayor Robert Garcia and Honorable City Councilmembers October 2014

RE: **LB MEDICAL MARIJUANA (MMj) ORDINANCE DRAFT**

What has been proven in numerous studies and anecdotal evidence is that cannabis/marijuana does have medicinal value and has helped many citizens across the world with various maladies, disabilities and pain. The biggest concern before us is how to reasonably and compassionately distribute this medicine to those who need it. As presented in the recent People v **Baniani** California Court of Appeals case (G04835), **"It would be cruel for those whose need for medical marijuana is the most dire to require that they devote their limited strength and efforts to the actual cultivation of the marijuana, and then wait months for it to grow so they can use it....."** In People v Urziceanu (CA App.4th), the court noted the Medical Marijuana Program Act (MMPA) was the Legislature's initial response to the CUA's (Compassionate Use Act – Prop 215) call to provide a plan "for the *safe and affordable distribution* of marijuana to all patients in medical need of marijuana....."

I personally experienced the painful, **prolonged deaths** of both my mother and other family members from cancer. It's not a pretty picture. At that time, cannabis was sadly not allowed as medicine. It is now, and we should do everything we can to alleviate the needless suffering in this world. We must never forget that a patient could be your mother, your sister, your friend or your child. While "abuse" does happen, we don't deprive cancer patients of pain meds because others abuse it. (Prescription drugs are the most abused drug group in the nation.)

The **people of Long Beach** voted for the 1996 Prop 215 Compassionate Use Act, Proposition 19 (full legalization) and LB Prop A MMj tax measure. The citizens of this fair City have spoken. Mirroring this sentiment, 60% of the entire nation wants legalization. And, as people become more informed and enlightened, that number continues to increase.

The **City Attorney (CA) proposed Ordinance** for Medical Marijuana collectives was written with little concern/compassion for sick patients and people with disabilities who rely on cannabis for their maladies and pain. This CA draft is little more than a punitive, miserably failed 5.87 ordinance (2010) on steroids. It blatantly throws "due process" out the window, repeatedly insults the United States Constitution, and shamelessly disregards the rights of patients. Fraught with litigation landmines (5.87 earned over 30 lawsuits), it promotes a biased agenda and deprives equal access those who do need it. By creating a non-workable ordinance, it only serves as a quasi-ban without actually calling it so.

The following is an **in-depth analysis** of the 9-11-14 version of the proposed City MMj ordinance (**A copy is attached herein.**) Page and line #s correlate accordingly. This was presented to the Planning Commission at the 9-18-14 meeting. Changes made on subsequent versions are minimal and not as consequential. While this is not a complete list, it highlights some of the numerous stand-out problems with this draft.

By requiring that every dispensary obtain a **conditional use permit (CUP)**, the new ordinance appears to have the same flaw that the Appellate court disapproved of in the Pack Case (Pack v Superior Court - City of Long Beach 2011). The City determines which collectives are permissible and those that are not. It then collects fees as a

LONG BEACH MEDICAL MARIJUANA TASK FORCE

POB 15027
Long Beach, CA 90815

Chairperson Diana Lejins * Ret LAC Sheriff Nick Morrow * Ret LA Prosecutor Rosemary Chavez * Judy Far
Gary Farris * Marla James * David James * Expert MMj Witness Bill Britt * Advocates for Disability Rights

ır CACOD Chair & Esteemed Members November 2014

ANALYSIS OF LB MEDICAL MARIJUANA (MMj) ORDINANCE DRAFT

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LONG BEACH MEDICAL MARIJUANA TASK FORCE

POB 15027
Long Beach, CA 90815

ır City of LB Medical Cannabis Task Force March 2015

ANALYSIS OF LB MEDICAL MARIJUANA (MMj) ORDINANCE DRAFT - Patient Perspective

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November 2014

Citizen Advisory Committee on Disabilities
City of Long Beach, CA

Dear CACOD Chair and Esteemed Members

Attention: Human Resources Officer Sherriel Murry and Administrative Aide Katherine Bussi

Thank you for your interest in the Medical Marijuana (MMj) issue that I presented in Public Comment at your meeting in Nov 13, 2014. I appreciate your willingness to put this on the Dec 11, 2014 Agenda. While there seemed to be some confusion regarding inviting someone to make a presentation, I have checked with several officials at City Hall and they assured me that you can place an item on your Agenda and invite a presenter without a formal letter. This happens at Council on a regular basis.

I will be happy to come to your meeting in Dec 2014, make a presentation, and answer any questions you may have. Additionally, if another member of our Long Beach Medical Marijuana Task Force is available, they would also be able to contribute.

In a separate email, I have attached a number of documents for you to review prior to that meeting. Included is a copy of the proposed (MMj) Ordinance, an analysis of that document, and other documents pertaining to this subject. This draft ordinance (Sep 2014) has been slightly updated but the pertinent segments remain the same and the reference numbers correlate with this draft. I have abbreviated the analysis to target ADA issues for your convenience. If there are other issues that especially concern you, please feel free to let me know and I can try to address them and/or send you further documentation.

*I would truly appreciate receiving a copy of the Nov 2014 meeting minutes and the Dec 2014 Agenda.

Yours truly

Diana Lejins, Chair
Advocates for Disability Rights &
Long Beach Medical Marijuana Task Force

POB 15027
Long Beach, CA 90815
Tele (562) 421-8012

Attachments:
Sep 2014 draft MMj Ordinance
Analysis of ordinance by LB MMj Task Force (condensed for CACOD)

CBS NEWS June 25, 2014

Can marijuana heal a wounded warrior?

Matt Kahl made it home after two tours in Afghanistan, but was wracked with pain from physical injuries, and on a host of anti-anxiety medication to try and treat his mental anguish.

"About ten months after I got back, I attempted suicide," Kahl told CBS News' Barry Petersen.

"I was completely hopeless," recalled the veteran, who said he was on about 15 different medications.

Until the day he tried marijuana.

"Suddenly, my extremely overactive, hyper-vigilant mind started to calm down," he told Petersen, "and my pain gradually started to go away, too. I needed less of these other medications, and shortly afterwards, I determined that I absolutely have to move to a state that allows this so that I can get my life back."

He moved his family to Colorado and now works with a group called Grow4Vets. He and other volunteers recently spent a day putting together bags of marijuana products that are given away on holidays, like Memorial Day.

P**TSD treatment inadequate, study shows**
Two recent studies confirm widespread veteran concern with VA mental health care.

The marijuana is meant to treat war wounds -- both the mental and the physical kind that doctors often treat with drugs like oxycontin. According to the VA, 20 percent of veterans returning from Afghanistan and Iraq suffer from post-traumatic stress. Current treatments range from therapy to prescription drugs, but the group wants to replace pills with pot, according to veteran and Grow4Vets founder Roger Martin.

"Anybody that's been on narcotic medication especially wants to get off of it," he said. "I really have not met anybody who just enjoys being in a drug stupor."

But because marijuana is still considered a Schedule 1 drug at the federal level, there has been very little research into the effects of pot and post-traumatic stress disorder. The House recently voted down a bill that would allow VA doctors to speak with patients about medicinal marijuana, even in states like Colorado where it's legal.

Soldiers and pot have been together since the Vietnam War, as pot shop owner Toni Fox knows well. Her father came home from Vietnam suffering from post-traumatic stress disorder. Marijuana helped but it was illegal, so not always available.

"He struggled his whole life," she said. "When I was 14 he ended up committing suicide, and it was directly related to the post-traumatic stress disorder from Vietnam."

Which is why she gives Grow4Vets marijuana from her crop area, and money from the shop's tip jar.

"I believe in my heart of hearts that, if he would have had access to cannabis, he would be alive today," said Fox.

Critics are still dubious, given the fact there is little to no scientific proof that pot actually helps with post-traumatic stress disorder.

"Why the hell not? Why don't we study it? Why don't we run these clinical trials?" said Kahl. "I'm absolutely convinced that it works."

For Matt and wife Aimeé, the relief he gets from marijuana means a second chance at healing from Afghanistan, and that's nothing less than a second chance at life.

ORDINANCE NO.

AN ORDINANCE OF THE CITY COUNCIL OF THE CITY OF LONG BEACH AMENDING THE LONG BEACH MUNICIPAL CODE BY ADDING CHAPTER 21.XX; AND BY REPEALING CHAPTER 5.89, ALL RELATING TO MEDICAL MARIJUANA

WHEREAS, the people of the State of California have enacted Proposition 215, the Compassionate Use Act of 1996 ("CUA") (codified in Health and Safety Code Section 11362.5, *et seq.*), which allows for the possession and cultivation of marijuana for medical use by certain qualified persons; and

WHEREAS, the CUA creates a limited exception from criminal liability for seriously ill persons who are in need of medical marijuana for specified medical purposes and who obtain and use medical marijuana under limited circumstances; and

WHEREAS, in 2004, the State of California enacted Senate Bill 420, the Medical Marijuana Program Act ("MMPA") (codified in California Health and Safety Code Section 11362.7 *et seq.*), which purports to clarify the scope of the CUA, and also which recognizes the right of cities and other governing bodies to adopt and enforce rules and regulations consistent with the MMPA; and

WHEREAS, notwithstanding the passage of the CUA and MMPA, the cultivation, possession, and distribution of marijuana is strictly prohibited by federal law and specifically by the Controlled Substances Act ("CSA") (codified in 21 U.S.C. Section 841); and Section 841 of the CSA makes it unlawful for a person to manufacture, distribute, dispense, or

OFFICE OF THE CITY ATTORNEY
CHARLES PARKIN, City Attorney
333 West Ocean Boulevard, 11th Floor
Long Beach, CA 90802-4664

California Democrats write marijuana legalization into party platform

Published: March 10, 2014

California Democrats voted overwhelmingly to add marijuana legalization to the state party's official platform on Sunday, marking a shift from current Gov. Jerry Brown's own position on the drug.

According to the Sacramento Bee, the issue was approved by a near-unanimous voice vote at the party's annual convention in California. As a result, the party platform for state Democrats will officially support *"the legalization, regulation and taxation of pot in a manner similar to that of tobacco or alcohol."*

Despite the move, however, the issue is not expected to be put up for a vote during the 2014 midterms. Instead, advocates have decided to wait until 2016, when a larger percentage of the population is engaged with the national election and when more money could be spent to push messages.

Speaking out in support of legalization, California's Lt. Gov. Gavin Newsom said the state has fallen behind public opinion since it first voted to approve medical marijuana, and the time has come to take the next step forward.

"It's time for all of us to step up and step in and lead once again in California, just as we did in 1996. We did just that with medical marijuana," he told convention attendees on Saturday, according to the Huffington Post. *"But for almost 20 years now, we've sat back admiring our accomplishment while the world, the nation, and states like Colorado and Washington have passed us by. ... It's time to legalize, it's time to tax, it's time to regulate marijuana for adults in California."*

Colorado and Washington both voted to legalize recreational marijuana use in 2012, becoming the first two states in the US to do so.

Newsom's comments, meanwhile, certainly fall in line with shifts in public opinion. According to a Public Polling Institute of California survey released in late 2013, 55 percent of residents support legalizing marijuana. Of that number, 47 percent support legalization with restrictions similar to those levied on alcohol, while 8 percent favor allowing anyone to purchase the drug.

Widespread support aside, Gov. Jerry Brown does not seem to agree with the state Democratic party at large. Speaking on NBC's "Meet the Press" in early March, Brown said he was concerned with the consequences of allowing anyone to purchase and smoke pot.

"The problem with anything, a certain amount is okay," he said, according to the Huffington Post. *"But there is a tendency to go to extremes. And all of a sudden, if there's advertising and legitimacy, how many people can get stoned and still have a great state or a great nation? The world's pretty dangerous, very competitive. I think we need to stay alert, if not 24 hours a day, more than some of the potheads might be able to put together."*

Outside of California, other states are also considering legalizing recreational pot use. As RT reported previously, Alaska is set to vote on the issue this August, while Oregon and Washington, DC, are also considering similar measures.

Last April, a nationwide Pew poll found marijuana supporters gaining steam, with a majority of Americans supporting legalization for the first time in the survey's history.

Denver Murder Rate Cut in Half After Marijuana Legalization. Coincidence?

The Free Thought Project
John Vibes
May 20, 2014

According to statistics recently released by the government in Denver, the amount of robberies and violent crimes significantly decreased since marijuana legalization went into effect. It is important to mention that this strong correlation is not definitive proof that legalization is the cause of this drop in crime, but it does strongly suggest that this is the case.

These statistics are especially convincing considering the short amount of time that this drastic reduction in crime has taken place. In just one short year the number of homicides dropped by 52.9%. Sexual assaults were reduced by 13.6%. Robberies were down by 4.8% and assaults were down by 3.7%.

The statistics measured the first few months of the year for both 2013 and 2014, and then compared those numbers with one another to determine whether they were higher or lower after legalization went into effect.

There are many different factors contributing to this drop in crime, and it is likely that marijuana legalization is a very big piece of the puzzle. Legalization has had a profound impact on local economies, and has created a large boom in new residents who have moved to the area to flee persecution. This increase in prosperity surely has some effect on the amount of robberies and burglaries that have taken place.

Additionally, marijuana is traditionally known to mellow people out and calm them down, making them far less likely to act out in anger or plan a murder.

One final possibility that comes to mind is the fact that possibly, police resources are being diverted towards serious crimes instead of nonviolent offenses. Unfortunately, they are still writing plenty of fines and locking up plenty of people for nonviolent offenses, but marijuana smokers and traders have been one of the largest group of persecuted nonviolent offenders for a very long time.

See the UCR Citywide Report

John Vibes is an author, researcher and investigative journalist who takes a special interest in the counter culture and the drug war. In addition to his writing and activist work he is also the owner of a successful music promotion company. In 2013, he became one of the organizers of the Free Your Mind Conference, which features top caliber speakers and whistle-blowers from all over the world. You can contact him and stay connected to his work at his Facebook page. You can find his 65 chapter Book entitled "Alchemy of the Timeless Renaissance" at bookpatch.com.

OPED: PSST... GOVERNMENT-SUPPLIED MARIJUANA PROGRAM TURNS 30

Each month Irvin Rosenfeld goes to his pharmacy and picks up a special prescription, supplied to him by the U.S. government: a canister containing roughly 10 ounces of marijuana in pre-rolled cigarettes.

Rosenfeld, a Boca Raton, Florida stockbroker, suffers from a rare illness called multiple congenital cartilaginous exostosis, a painful genetic disease that causes tumors to grow at the ends of his long bones, causing unbelievable pain. He is also one of four surviving patients receiving government-supplied medical marijuana, in a program that was closed to new applicants by President George H.W. Bush in 1992.

That program marks its 30th anniversary May 10. That's right, our government has been supplying medical marijuana to a small number of patients -- the program peaked at 34 approved participants in 1991 -- for three full decades.

This may seem puzzling. After all, hasn't White House Drug Czar John Walters called medical marijuana "snake oil," a "con," a "farce," and even compared it to "medicinal crack"? Surely if our government really thinks marijuana is useless and dangerous, it wouldn't supply it to sick people?

A better question might be: Why is our government working so hard to avoid learning that marijuana can be a safe and effective medicine?

The federal medical marijuana program, begun on May 10, 1978 as part of the settlement to a lawsuit filed by glaucoma patient Robert Randall, is officially a research program. Randall, Rosenfeld and the other participants were required to sign a consent document specifically referring to it as a "study."

But there has been no study of these patients, at least not by the government. While shipping literally hundreds of pounds of marijuana to these patients over the course of 30 years, the federal government never lifted a finger to find out whether it was helping or hurting.

In frustration, a handful of the patients worked with researchers a few years ago to organize and fund a study of four of the eight still alive in 2001 (the others were either too ill to participate or chose to remain anonymous). Each was subjected to an exhaustive battery of medical tests, including immunological and endocrine assays, MRI scans of the brain, pulmonary function tests, neuropsychological tests and more.

The study, published in 2002, found, "Results demonstrate clinical effectiveness [of marijuana] in these patients in treating glaucoma, chronic musculoskeletal pain, spasm and nausea, and spasticity of multiple sclerosis. All 4 patients are stable with respect to their chronic conditions, and are taking many fewer standard pharmaceuticals than previously." The only meaningful side effect noted was "mild changes in pulmonary function" in two of the patients -- not surprising, given that investigators found the government's marijuana to be a "crude, low-grade product."

In testimony before the Illinois state legislature two years ago, Rosenfeld called himself "living proof that [marijuana] works well. I'm also living proof that the government doesn't want to know how well it works. If they want to do research, all they have to do is contact me."

Federal officials claim they have no bias against medical marijuana research. The government has indeed allowed a handful of small pilot studies to proceed, and the ones published so far have consistently found marijuana to be safe and effective at relieving symptoms such as pain and appetite loss.

Typically in science, successful pilot studies lead to larger, more advanced trials. And there is a group of researchers at the University of Massachusetts who want to do just that: grow specially selected strains of marijuana for studies in treating specific conditions, designed to develop marijuana as an FDA-approved prescription drug.

The government is blocking them.

Instead of learning from the private study of the federal medical marijuana patients and the handful of other medical marijuana trials it has permitted, federal officials have chosen to bury their heads in the sand, repeating, "Marijuana is not a medicine," as if saying so would make it true.

The hypocrisy and dishonesty continue, and patients -- except for those four lucky survivors -- continue to suffer.

Bruce Mirken is director of communications for the Marijuana Policy Project.

USEFUL INFORMATION FOR APPLICANTS - LB Police Dept

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

Personal History Statement

Becoming an Exemplary Peace Officer

****

P.O.S.T. MINIMUM REQUIREMENTS:

- Be at least 21 years of age or older by September 30, 2015
- US High School Diploma or GED equivalency
- Have no physical or mental limitations that might prevent the completion of any duty assignment
- Have vision correctable to 20/20
- Possess a valid driver's license
- Be a United States citizen or a permanent resident alien who is eligible for and has applied for citizenship (1031.5 Government Code)
- Cannot be on court ordered probation at the time of application or hire
- No felony convictions

LONG BEACH POLICE DEPARTMENT DRUG POLICY

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

- **Marijuana -** any use of marijuana in the last **two-years** from the application deadline (July 3, 2014) will result in disqualification from the current hiring process. This is not a life time disqualification; just until a two-year period of no marijuana use has passed
- **Other illegal drug use** (other than marijuana or hard drugs listed below) in the last **three-years** from the application deadline (July 3, 2014), will result in disqualification from the current hiring process. This is not a life-time disqualification; just until a three-year period of no illegal drug use has passed.
- Any use of **hallucinogenic drugs (PCP, LSD, mushrooms, etc.),** illegal **intravenous drugs** (heroin, methamphetamine, etc.), or **bath-salts** is an automatic disqualification from this process. This is a **life-time** ban.

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

Marijuana Legalization Supported By A Growing Majority Of Americans, Survey Shows

09/03/2014 Huffington Post

A broad new survey shows that a majority of American adults continue to support marijuana legalization in the United States, and that support appears to be growing.

The survey, released last week from online polling data company CivicScience, asked more than 450,000 U.S. adults over the last two years this question: "Would you support or oppose a law in your state that would legalize, tax, and regulate marijuana like alcohol?"

Fifty-eight percent of respondents said they support marijuana legalization -- with 39 percent saying they "strongly support" and 19 percent saying they "somewhat support" reformed marijuana laws in their states. Thirty-five percent oppose legalization of marijuana -- with 29 percent "strongly" opposing and 6 percent "somewhat" opposing laws that would regulate marijuana like alcohol. Seven percent of respondents had no opinion on the issue.

CivicScience then broke out the data from just the last three months of responses -- from May to August -- and saw an increase in support and decrease in opposition to the regulation of marijuana like alcohol. Of those who responded most recently, 61 percent said they strongly or somewhat support marijuana legalization, while only 30 percent were opposed.

Men were found to be slightly more in favor of legalization than women were, by 60 to 55 percent, according to CivicScience's survey data. Support for legalization was strongest among people ages 25-34; the only age group in which the majority of people opposed legalization was those over 65.

The question, asked between November 2012 and August 2014, was hosted on as many as 400 different websites across the U.S. Each respondent was anonymous and answered the question "just for fun," according to CivicScience.

Jennifer Sikora, a spokesperson for CivicScience, explained to The Huffington Post that although the survey was online, the company uses browser cookies to keep respondents from answering the question more than once. In order to further hedge against a person answering the same question multiple times, the question is part of a pool of more than 1,000 rotating questions on multiple websites to further decrease the possibility that a respondent might happen upon the same question again. Still, Sikora says, there is a very small percentage of respondents who do repeat the answer (after all, cookies can be deleted), but the 453,653 U.S. adults in this survey are unique.

"This huge poll is yet another indication that marijuana legalization is officially a mainstream issue," Tom Angell, chairman of Marijuana Majority, told HuffPost. "With ending prohibition polling better with voters than most elected officials do these days, it'll be really interesting to see which 2016 contenders realize that supporting marijuana reform is good politics and which still don't get it."

This isn't the first recent poll to show a majority of Americans supporting marijuana legalization. In April, a survey from Pew found that 54 percent of Americans support legalizing marijuana use, and about three-quarters of Americans told Pew that if marijuana use isn't legalized, those found in possession of small amounts of the substance should not go to jail. Just last year, Gallup found for the first time that a clear majority of Americans -- 58 percent -- say marijuana should be legalized.

To date, 23 states and the District of Columbia have legalized marijuana for medical purposes and two states -- Colorado and Washington -- have legalized marijuana for adult, recreational use. Voters in three states and our nation's capital will also decide on new marijuana laws in November. Oregon and Alaska voters will decide on the legalization of recreational marijuana, while voters in Florida will decide on a medical marijuana ballot measure. D.C. voters will decide on a measure that would legalize the adult possession of small amounts of marijuana as well as limited home cultivation; however, the sale of marijuana would still be prohibited under the measure.

NAACP Backs Marijuana Federalism

Jacob Sullum|Nov. 12, 2013 4:25 pm

The National Association for the Advancement of Colored People (NAACP) recently endorsed a bill that would make the federal ban on marijuana inapplicable to people who grow, possess, or distribute cannabis in compliance with state law. H.R. 1523, the Respect State Marijuana Laws Act of 2013, would essentially repeal (or at least limit) federal pot prohibition in the 21 states that allow medical or recreational use of the drug. So far the bill, which was introduced by Rep. Dana Rohrabacher (R-Calif.), has 20 cosponsors, including five more Republicans: Justin Amash (Mich.), Dan Benishek (Mich.), Don Young (Alaska), Duncan Hunter (Calif.), and Steve Stockman (Texas).

The NAACP resolution endorsing H.R. 1523, which was adopted by its board of directors at a meeting last month, notes that "even though numerous studies demonstrate that whites and African Americans use and sell marijuana at relatively the same rates, studies also demonstrate that African Americans are, on average, almost 4 times more likely to be arrested for marijuana possession, and in some jurisdictions Blacks are 30 times more likely to be arrested for marijuana possession than whites." The NAACP, which in recent years has highlighted the racially disproportionate impact of marijuana prohibition and condemned the war on drugs, last year supported the successful legalization initiatives in Colorado and Washington, so it's not surprising that the organization wants the feds to step back and let those experiments proceed. But Tom Angell, chairman of Marijuana Majority, argues that the NAACP's willingness to stand up for state's rights is significant given the group's history of battling segregationists who (erroneously) waved that banner:

For obvious historical reasons, many civil rights leaders who agree with us about the harms of marijuana prohibition still remain reluctant to see the states chart their own courses out of the failed "war on drugs." Having the NAACP's support for a states' rights approach to marijuana reform is going to have a huge impact and will provide comfort and cover to politicians and prominent people who want to see prohibition end but who are a little skittish about states getting too far ahead of the feds on this issue.

As I've argued in *Reason*, there is nothing inherently right-wing about the Constitution's division of powers between the states and the federal government. Properly understood, federalism was never a license for violating rights protected by the 14th Amendment, and today it can profitably be employed by progressives to further their own causes. Ending the war on drugs should be at the top of the list.

New York: Advocates Mourn Death of Child at Center of Medical Marijuana Battle

Submitted by steve elliott on Wed, 07/23/2014

Death Fuels Demand for Emergency Access to Medical Marijuana for Critically Ill Patients in New York

Anna Conte, a nine-year-old from Orchard Park, New York, who died last week after falling into a coma following a severe seizure, was laid to rest on Wednesday. Anna suffered from Dravet syndrome, a life-threatening seizure disorder that has been treated with medical marijuana in states where it is legal. Medical marijuana has dramatically reduced the number of seizures in many children with similar seizure disorders.

In an effort to help their daughter, the Conte family joined the successful fight to pass a medical marijuana bill in New York. The Contes travelled repeatedly to Albany, persuading several powerful New York senators to support the bill and generating thousands of phone calls and emails to Albany leadership. Advocates around the state came to know and love Anna and her family and admire their selfless advocacy which was always accompanied with a sense of humor.

Tragically, Anna Conte did not live long enough to benefit from the law that her family helped pass. Governor Cuomo, who signed the bill into law just days before Anna's passing, has said that it will take 18 months or longer for New York to implement the law and develop the full medical marijuana patient access system.

Families and advocates are urgently calling upon Governor Cuomo to take immediate action establishing expedited access to medical marijuana for those patients and families, like the Conte's, who cannot wait until the full system is up and running. "After nine years of fighting, her little body just had enough," said Anna's mom, Wendy Conte, reports the *Buffalo News*. "She did more in her nine years than what many people do in a lifetime."

"We are deeply saddened by the death of Anna Conte and two other New York children with severe seizure disorders who have died since New York's medical marijuana bill was signed into law," said Julie Netherland of the Drug Policy Alliance (DPA). "Anna and her family played a central role in passing New York's medical marijuana law.

"Our hearts go out to the Conte's and the other patients and families during this time of tragedy," Netherland said. "Part of Anna's legacy is having changed history to benefit thousands of seriously ill New Yorkers.

"These deaths have made even clearer what we already knew -– the 18-month or longer timeline for implementing New York's recently passed medical marijuana law is simply too long for some patients who face life-threatening or terminal illnesses," Netherland said. "These patients and their caregivers, including the parents of children with severe seizure disorders, have been at the forefront of the fight to create safe and legal access to medical marijuana. In fact, at the bill signing ceremony, Governor Cuomo stood with a young girl who suffers from Dravet Syndrome, the same life-threatening seizure disorder that tragically took Anna Conte's life.

"Unfortunately, several more children are likely to die waiting for New York to implement its medical marijuana program," Netherland said. "While not all of these deaths can be prevented by medical marijuana, we have a moral obligation to make this medicine available as soon as possible.

"Because implementation of the full medical marijuana patient access system will take 18 months, Governor Cuomo and leaders in Albany must work swiftly to establish a temporary emergency program for expediting access to medical marijuana for those with life-threatening or terminal illnesses," Netherland said. "By establishing a temporary, interim emergency access program, patients with life-threatening or terminal illnesses won't have to wait 18 months or longer for the full system to come online.

"We can immediately save lives and ease suffering at the end of life by establishing emergency, expedited access," Netherland said. "New York cannot stand by while more people die needlessly."

Photo of mother Wendy Conte and daughter Amy, then 8: *Buffalo News*

ADVOCATES FOR DISABILITY RIGHTS
P.O. Box [illegible] • Long Beach, CA 90815

ORDINANCE NO.

AN ORDINANCE OF THE CITY COUNCIL OF THE CITY OF LONG BEACH AMENDING THE LONG BEACH MUNICIPAL CODE BY ADDING CHAPTER 5.91 TO ESTABLISH RESTRICTIONS AND PROHIBITIONS ON THE ESTABLISHMENT AND OPERATION OF MEDICAL MARIJUANA COLLECTIVES.

WHEREAS, California voters approved the Compassionate Use Act ("CUA") in 1996 to exempt seriously ill patients and their primary caregivers from criminal liability for possession and cultivation of marijuana for medical purposes; and

WHEREAS, the Medical Marijuana Program Act of 2003 ("MMPA") provides for the association of primary caregivers and qualified patients to cultivate marijuana for specified medical purposes and also authorizes local governing bodies to adopt and enforce laws consistent with its provisions; and

WHEREAS, Medical Marijuana collectives / cooperatives / associations provide valuable services to qualified patients who, by virtue of disease or disability status, or personal circumstances, cannot cultivate medical marijuana for themselves; and

WHEREAS, Medical Marijuana collectives / cooperatives / associations provide safe, efficient, and reliable access to medical marijuana for qualified patients; and

WHEREAS, medical marijuana that has not been collectively or personally grown may constitute a unique health hazard to the public because, unlike other ingestibles, marijuana is not currently regulated, inspected, or analyzed for contamination by State or Federal governmental agencies and may contain

Original creation date: 04-20-2014
Rev. Date 05152014

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

Forbes.com July 2011

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

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

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

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

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

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

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

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

City Prosecutor
City of Long Beach
333 West Ocean Boulevard, 2nd Floor
Long Beach, CA 90802
Telephone: (562) 570-5600
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MEETING REQUEST

☐ We would like to invite the City Prosecutor to speak to our group on:

Date: _____

Time: _____

☐ We would like to meet the City Prosecutor in his office. Requested dates and times are:

1st choice: _____

2nd choice: _____

Explain meeting topic in detail:

EVENT/CONTACT INFORMATION:

Your name (first and last): _____

Your Phone Number: _____

Your Email: _____

Name of Group or Organization: _____

How many people do you expect will attend? _____

Please tell us something about your group:

(Please attach your business card or any additional information you have about your event, group, or meeting topic.)

Thank you for assisting us by completing this form! Please email this form to Sherri.Seldon@Longbeach.gov, or fax it to (562) 570-7140. Someone will contact you to confirm or coordinate with you regarding your request.

Restrictive Marijuana Laws Hurt the Most Vulnerable - Children

September 30, 2014 - By Julie Netherland

Those who would perpetuate the failed drug war claim they want to protect the children.

But nothing could be further from the truth. The drug war overall, and marijuana prohibition specifically, hurts young people.

Restrictive marijuana policies and limited medical marijuana laws have simultaneously kept very sick children from getting the medicine they need and saddled tens of thousands of young people with criminal records that severely limit their future chances in life. Our marijuana policies are hurting, and in some cases, killing our youth.

The situation is so dire in New York that the Cuomo Administration recently sent a letterto the U.S. Department of Justice, following up on an earlier letter to U.S. Attorney General Holder sent on August 13. Both letters asked the DOJ to extend a narrow, time-limited exception to federal law to allow the importation of certain strains of medical marijuana from other states for use by children in New York with severe forms of epilepsy. Senators Schumer and Gillibrand followed suit with their own letter asking DOJ for relief.
Since New York's medical marijuana bill was signed, at least three New York children with severe seizure disorders have died. Medical marijuana has dramatically reduced life-threatening seizures in other children with similar conditions, but families in New York are facing an eighteen-month wait until the new medical marijuana law is implemented.
Cuomo has urged the Department of Health to expedite access to medical marijuana for these children, but a web of outdated and draconian laws have made it impossible for these critically-ill children to get the medicine they need. Each day these parents are forced to wait knowing that their children are losing ground and may die. And this isn't just a problem in New York. Many states have never passed any medical marijuana law, leaving thousands of vulnerable patients, including children, to needlessly suffer.
Meanwhile, marijuana prohibition is destroying other young lives all over the country. In New York, which decriminalized the possession of marijuana in 1977, a loophole in the law has resulted in tens of thousands of young people – predominantly African American and Latino young men – are arrested for possessing small amounts of marijuana. Worse, the law is being enforced unfairly and creating enormous racial disparities. And that doesn't even get to the tragic loss of young life that sometimes occurs when the police enforce marijuana prohibition. It is a nation-wide problem.

How are these policies protecting our kids? They aren't.

They keep medicine from sick children and sweep thousands of other young people –the vast majority of whom have no previous arrests-- into the criminal justice system, while doing nothing to improve public safety. If we really want to protect our kids, we need to do away with policies like these that do more harm than good.

No one wants to see more young people using marijuana, but we can work to protect young people from the potential harms of marijuana through sensible policies that don't simultaneously prevent sick children from getting needed medicine or criminalize thousands of young people of color.

In New York, we can start by creating an emergency access program for medical marijuana for the sickest New Yorkers and passing the Fairness and Equity Act, which would help end unlawful marijuana arrests of young people of color.

Our kids do deserve protection. So let's protect them by putting an end to destructive marijuana policies and enacting sensible, humane reforms.

Julie Netherland is the New York deputy state director for the Drug Policy Alliance.

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

5.91.090

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

1. Any place where smoking is prohibited by law;

2. Within one thousand feet (1,000') of the grounds of a school, recreation center, or youth center;

3. While on a school bus; or

4. While in a motor vehicle that is being operated.

Why suicide rate among veterans may be more than 22 a day

By **Moni Basu**, CNN
updated November 14, 2013

Leon Panetta, the former defense secretary, called the suicide rate among service members an epidemic.

STORY HIGHLIGHTS

- The data the suicide rate is based on are incomplete
- Examples of uncounted: "suicide by cop," by overdoses and by vehicle crashes
- "There's probably a tidal wave of suicides coming"
- VA makes appeal for more uniform reporting of suicide data

(CNN) -- Every day, 22 veterans take their own lives. That's a suicide every 65 minutes. As shocking as the number is, it may actually be higher.

The figure, released by the Department of Veterans Affairs in February, is based on the agency's own data and numbers reported by 21 states from 1999 through 2011. Those states represent about 40% of the U.S. population. The other states, including the two largest (California and Texas) and the fifth-largest (Illinois), did not make data available.

Who wasn't counted?

People like Levi Derby, who hanged himself in his grandfather's garage in Illinois on April 5, 2007. He was haunted, says his mother, Judy Casper, by an Afghan child's death. He had handed the girl a bottle of water, and when she came forward to take it, she stepped on a land mine.

When Derby returned home, he locked himself in a motel room for days. Casper saw a vacant stare in her son's eyes. A while later, Derby was called up for a tour of Iraq. He didn't want to kill again. He went AWOL and finally agreed to an "other than honorable" discharge.

Derby was not in the VA system, and Illinois did not send in data on veteran suicides to the VA.

Top U.S. doctor says medical marijuana may help some conditions

REUTERS

By **Ian Simpson** Feb 4, 2015

By Ian Simpson

WASHINGTON (Reuters) - The United States' top doctor said that medical marijuana can help some patients in comments on Wednesday that may boost pressure on the Justice Department to redesignate the drug under federal law.

In an interview on "CBS This Morning," U.S. Surgeon General Vivek Murthy said the medical effectiveness of marijuana had to be shown scientifically and much more information about it was coming.

"We have some preliminary data showing that for certain medical conditions and symptoms, marijuana can be helpful," said Murthy, who became surgeon general in December.

"I think we have to use that data to drive policymaking, and I'm very interested to see where that data takes us."

The Justice Department designates marijuana as a Schedule I controlled substance, a category for drugs that have no accepted medical value and have a high potential for abuse.

Twenty-three states and the District of Columbia have legalized medical marijuana, according to the Drug Policy Alliance advocacy group.

Florida also allows a narrow use of medical marijuana. Two states, Washington and Colorado, have legalized marijuana for recreational use.

Tom Angell, chairman of Marijuana Majority, another advocacy group, said in a statement that Murthy's remarks mean that President Barack Obama should direct Attorney General Eric Holder to begin changing how the department categorizes marijuana.

"Dr. Murthy's comments add to a growing consensus in the medical community that marijuana can help people suffering from painful conditions," Angell said.

The Justice Department had no immediate response to Murthy's comments.

WHY IS HEMP REALLY ILLEGAL??

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

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

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

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

MEDIA MANIPULATION

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

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

LEGISLATION

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

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

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

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

Report: Suicide rate spikes among young veterans

By Leo Shane III
Stars and Stripes
Published: January 9, 2014

- Death rate unusually high for young veterans
- Report: VA's mental health efforts fall short now, won't keep pace in the future
- Report: Stigmas stop veterans in need from seeking health care

WASHINGTON -- The number of young veterans committing suicide jumped dramatically from 2009 to 2011, a worrying trend that Veterans Affairs officials hope can be reversed with more treatment and intervention.

New suicide data released by the department on Thursday showed that the rate of veterans suicide remained largely unchanged over that three-year period, the latest for which statistics are available. About 22 veterans a day take their own life, according to department estimates.

But while older veterans saw a slight decrease in suicides, male veterans under 30 saw a 44 percent increase in the rate of suicides. That's roughly two young veterans a day who take their own life, most just a few years after leaving the service.

"Their rates are astronomically high and climbing," said Jan Kemp, VA's National Mental Health Director for Suicide Prevention. "That's concerning to us."

Reasons for the increase are unclear, but Kemp said the pressures of leaving military careers, readjusting to civilian life and combat injuries like post-traumatic stress disorder all play a role in the problems facing young male vets.

Female veterans saw an 11 percent increase in their suicide rate over the same span. Overall, suicide rates for all veterans remain significantly above their civilian counterparts.

The good news, according to the report, is that officials have seen decreases in the suicide rates of veterans who seek care within the VA health system. Of the 22 deaths a day, only about five are patients in the health system.

"What we're seeing is that getting help does matter," Kemp said. "Treatment does work."

Now, she said, the challenge is expanding that outreach. Persuading younger veterans to seek care remains particularly problematic, because of stigma associated with mental health problems.

VA officials have boosted their mental health personnel and suicide hotline staff in recent years, but the outdated data doesn't reflect those changes.

The report also notes that national rates of suicide have remained steady or increased slightly in recent years, indicating the issue is a larger national health problem, not simply a military and veterans issues.

The Veterans Crisis Hotline is staffed 24 hours a day, 7 days a week, at (800)-273-8255, press 1.

shane.leo@stripes.com
Twitter: @LeoShane

IN OUR MAILBOX: Letters To The Editor

Tweet

Posted: Thursday, October 23, 2014 12:15 am

IN OUR MAILBOX: Letters To The Editor **Reader Submissions**

Send your letters to the editor to editor@gazettes.com.

Miracle Herb

To The Editor,

What if there was a cure for many types of cancer?

What if we could save lives with the cure, but the government wouldn't let us? What if the powers-that-be were so entrenched in the monetary value of continuing the "war on drugs" that they let people suffer and die to sate their appetites?

These greedy entities include big pharmaceuticals, tobacco and alcohol corporations, and government sectors that have become dependent on asset forfeiture and keeping our prison populations the highest in the world.

That's exactly what is happening today, here and now.

Medicinal marijuana is that miraculous herb that might have saved my father and many other of my friends and relatives from cancer. It is that medicine that helps adults and children plagued with seizures.

Chronic pain has been treated for eons with this panacea. There are so many other maladies responsive to cannabis that there is not enough space here to elaborate.

So, if we truly desire an honest look at an "old" cure, we need to legalize marijuana, allow for medical research, and stop wasting money on a prohibitionist agenda. It's a matter of life and death.

David Zink

Long Beach

House Blocks DEA From Targeting Medical Marijuana

Posted: 05/30/2014

WASHINGTON -- Reflecting growing national acceptance of cannabis, a bipartisan coalition of House members voted early Friday to restrict the Drug Enforcement Administration from using funds to go after medical marijuana operations that are legal under state laws.
An appropriations amendment offered by Rep. Dana Rohrabacher (R-Calif.) prohibiting the DEA from spending funds to arrest state-licensed medical marijuana patients and providers passed 219-189. The Senate will likely consider its own appropriations bill for the DEA, and the House amendment would have to survive a joint conference before it could go into effect.

Rohrabacher said on the House floor that the amendment "should be a no-brainer" for conservatives who support states' rights and argued passionately against allowing the federal government to interfere with a doctor-patient relationship.

"Some people are suffering, and if a doctor feels that he needs to prescribe something to alleviate that suffering, it is immoral for this government to get in the way," Rohrabacher said, his voice rising. "And that's what's happening."

The debate pitted three House Republicans who also are doctors against one another. Rep. Andy Harris (R-Md.) and Rep. John Fleming (R-La.) opposed the amendment, while Rep. Paul Broun (R-Ga.) supported it.

Harris insisted that there were no medical benefits to marijuana and that medical marijuana laws were a step toward legalizing recreational pot.

"It's the camel's nose under the tent," said Harris. He cited piece of anti-marijuana propaganda published by the DEA this month that claimed medical marijuana was just "a means to an end" -- the eventual legalization of marijuana for recreational purposes. The taxpayer-funded report uses scare quotes around the word "medical."

"I don't think we should accept at all that this is history in the making," said Fleming, who lamented earlier this month that it wasn't realistic to make alcohol illegal.

Broun said there were "very valid medical reasons" to use marijuana extracts or products. "It's less dangerous than some narcotics that doctors prescribe all over this country," Broun said. He said medical marijuana was a states' rights issue and Congress needed to "reserve the states' powers under the Constitution."

Rep. Sam Farr (D-Calif.) co-sponsored the amendment with Reps. Rohrabacher, Don Young (R-Alaska), Earl Blumenauer (D-Ore.), Tom McClintock (R-Calif.), Steve Cohen (D-Tenn.), Paul Broun (R-Ga.), Jared Polis (D-Colo.), Steve Stockman (R-Texas), Dina Titus (D-Nev.), Justin Amash (R-Mich.) and Barbara Lee (D-Calif.).

"The conflicting nature of state and federal marijuana laws has created an untenable situation," Blumenauer said prior to the House debate. "It's time we take the federal government out of the equation so medical marijuana business owners operating under state law aren't living in constant fear of having their doors kicked down in the middle of the night."

Under the Obama administration, the DEA and several U.S. attorneys have raided marijuana dispensaries that complied with state laws. The DEA still classifies marijuana as a Schedule I substance with "no currently accepted medical use," and the agency has engaged in an aggressive public relations campaign to diminish medical benefits.

Currently, 22 states and the District of Columbia have legalized marijuana for medical use. Five other states -- Alabama, Kentucky, Mississippi, Utah, and Wisconsin -- have legalized CBD oils, a non-psychoactive ingredient in marijuana that may treat epilepsy.

A number of studies in recent years have shown the medical potential of cannabis. Purified forms may attack some forms of aggressive cancer. Marijuana use also has been tied to better blood sugar control and may help slow the spread of HIV. Legalization of the plant for medical purposes may lead to lower suicide rates, according to one study.

Thursday's vote follows changing public sentiment toward the government's failed war on drugs. A recent Pew survey found that 67 percent of Americans support drug policies that focus on providing treatment, rather than an arrest and prosecution. An overwhelming majority of Americans also support the legalization of marijuana for medical purposes -- a recent CBS News poll found 86 percent think doctors should be able to prescribe marijuana to seriously ill patients.

"Those who suffer under current policies are not faceless," Blumenauer said. "They are not statistics. They are our neighbors and live in our communities. They are the owners of small businesses that are so important to our economy, and patients with conditions -- often desperate and painful -- who have turned to medical marijuana to help them get through each day. They're not the enemy, and it's time we stopped treating them like it."

UPDATE: 12:38 a.m. -- Tom Angell, chairman of Marijuana Majority, issued this statement:

"This historic vote shows just how quickly marijuana reform has become a mainstream issue. The last time a similar amendment came up it didn't come very close to passing but, since then, more states have passed medical marijuana laws and a couple have even legalized marijuana for all adults. More states are on this way later this year and in 2016, and it's clear that more politicians are beginning to realize that the American people want the federal government to stop standing in the way. If any political observers weren't aware that the end of the war on marijuana is nearing, they just found out."

Legal Pot Too Costly

- **Juliette Fairley**
- Sep 10, 2014

NEW YORK (**MainStreet**) — Low-income smokers may still prefer to purchase marijuana on the street even if marijuana were legalized across the country. **That's because of the hefty taxes attached to cannabis that's sold in legal states**.

"Legal marijuana is more expensive and excludes lower-income populations that are disproportionately African-American and Latino, leading them to turn to less safe marijuana available on the illegal market," said Nazgol Ghandnoosh, research analyst at The Sentencing Project.

Although legal when purchased from a licensed dispensary, pot purchased on the street and consumed could be a health hazard.

"It's not just private interest but also the state that has created a formal system to tax," Ghandnoosh told *MainStreet*. "It has implemented testing to make sure legal marijuana doesn't have mold, for example."

If there's a higher amount of illicit marijuana having mold that's weeded out in the formal system, then those drugs may be safer to ingest.

"There's a quality and safety concern," said Ghandnoosh. "The kind of testing that's being done on marijuana that's legal make it safer than what low income smokers may have access to on the illegal market."

In Washington state, an excise tax of 25% is imposed on each licensed retail sale of recreational marijuana or marijuana infused product.

"This tax constitutes part of the total retail price and is in addition to all state and local sales and use taxes," said Carol Kokinis-Graves, an attorney and senior state tax analyst with Wolters Kluwer.

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

Forbes.com July 2011

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

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

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

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

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

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

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

Prescription painkiller deaths fall in medical marijuana states

REUTERS

- Aug 25, 2014

By Kathryn Doyle

NEW YORK (Reuters Health) – Researchers aren't sure why, but in the 23 U.S. states where medical marijuana has been legalized, deaths from opioid overdoses have decreased by almost 25 percent, according to a new analysis.

"Most of the discussion on medical marijuana has been about its effect on individuals in terms of reducing pain or other symptoms," said lead author Dr. Marcus Bachhuber in an email to Reuters Health. "The unique contribution of our study is the finding that medical marijuana laws and policies may have a broader impact on public health."

California, Oregon and Washington first legalized medical marijuana before 1999, with 10 more following suit between then and 2010, the time period of the analysis. Another 10 states and Washington, D.C. adopted similar laws since 2010.

For the study, Bachhuber, of the Philadelphia Veterans Affairs Medical Center and the University of Pennsylvania, and his colleagues used state-level death certificate data for all 50 states between 1999 and 2010.

In states with a medical marijuana law, overdose deaths from opioids like morphine, oxycodone and heroin decreased by an average of 20 percent after one year, 25 percent by two years and up to 33 percent by years five and six compared to what would have been expected, according to results in JAMA Internal Medicine.

Meanwhile, opioid overdose deaths across the country increased dramatically, from 4,030 in 1999 to 16,651 in 2010, according to the Centers for Disease Control and Prevention (CDC). Three of every four of those deaths involved prescription pain medications.

Of those who die from prescription opioid overdoses, 60 percent have a legitimate prescription from a single doctor, the CDC also reports.

Medical marijuana, where legal, is most often approved for treating pain conditions, making it an option in addition to or instead of prescription painkillers, Bachhuber and his coauthors wrote.

In Colorado, where recreational growth, possession and consumption of pot has been legal since 2012 and a buzzing industry for the first half of 2014, use among teens seems not to have increased (see Reuters story of July 29, 2014 here: http://reut.rs/1o040NI).

Medical marijuana laws seem to be linked with higher rates of marijuana use among adults, Bachhuber said, but results are mixed for teens.

But the full scope of risks, and benefits, of medical marijuana is still unknown, he said.

“I think medical providers struggle in figuring out what conditions medical marijuana could be used for, who would benefit from it, how effective it is and who might have side effects; some doctors would even say there is no scientifically proven, valid, medical use of marijuana,” Bachhuber said. “More studies about the risks and benefits of medical marijuana are needed to help guide us in clinical practice.”

Marie J. Hayes of the University of Maine in Orno co-wrote an accompanying commentary in the journal.

“Generally healthcare providers feel very strongly that medical marijuana may not be the way to go,” she told Reuters Health. “There is the risk of smoke, the worry about whether that is carcinogenic but people so far haven’t been able to prove that.”

There may be a risk that legal medical marijuana will make the drug more accessible for kids and smoking may impair driving or carry other risks, she said.

“But we’re already developing Oxycontin and Vicodin and teens are getting their hands on it,” she said.

If legalizing medical marijuana does help tackle the problem of painkiller deaths, that will be very significant, she said.

“Because opioid mortality is such a tremendously significant health crisis now, we have to do something and figure out what’s going on,” Hayes said.

The efforts states currently make to combat these deaths, like prescription monitoring programs, have been relatively ineffectual, she said.

“Everything we’re doing is having no effect, except for in the states that have implemented medical marijuana laws,” Hayes said.

People who overdose on opioids likely became addicted to it and are also battling other psychological problems, she said. Marijuana, which is not itself without risks, is arguably less addictive and almost impossible to overdose on compared to opioids, Hayes said.

Adults consuming marijuana don’t show up in the emergency room with an overdose, she said. “But,” she added, “we don’t put it in Rite Aid because we’re confused by it as a society.”

SOURCE: http://bit.ly/1pYZf8d JAMA Internal Medicine, August 25, 2014

Proposition 215: Text of Proposed Law

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8 of the Constitution.

This initiative measure adds a section to the Health and Safety Code; therefore, new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

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

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

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

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

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

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

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

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

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

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

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

BILL NUMBER: SB 420 CHAPTERED

FILED WITH SECRETARY OF STATE OCTOBER 12, 2003
APPROVED BY GOVERNOR OCTOBER 12, 2003

INTRODUCED BY Senator Vasconcellos
(Principal coauthor: Assembly Member Leno)
(Coauthors: Assembly Members Goldberg, Hancock, and Koretz)

FEBRUARY 20, 2003

An act to add Article 2.5 (commencing with Section 11362.7) to Chapter 6 of Division 10 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 420, Vasconcellos. **Medical marijuana**.

Existing law, the Compassionate Use Act of 1996, prohibits any physician from being punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes. **The act prohibits the provisions of law making unlawful the possession or cultivation of marijuana from applying to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.**

This bill would require the State Department of Health Services to establish and maintain a voluntary program for the issuance of identification cards to qualified patients and would establish procedures under which a qualified patient with an identification card may use marijuana for medical purposes. The bill would specify the department's duties in this regard, including developing related protocols and forms, and establishing application and renewal fees for the program.

The bill would impose various duties upon county health departments relating to the issuance of identification cards, thus creating a state-mandated local program.

The bill would create various crimes related to the identification card program, thus imposing a state-mandated local program.

This bill would authorize the Attorney General to set forth and clarify details concerning possession and cultivation limits, and other regulations, as specified. The bill would also authorize the Attorney General to recommend modifications to the possession or cultivation limits set forth in the bill. The bill would require the Attorney General to develop and adopt guidelines to ensure the security and nondiversion of marijuana grown for medical use, as specified.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that no reimbursement is required by this act for specified reasons.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) On November 6, 1996, the people of the State of California enacted the Compassionate Use Act of 1996 (hereafter the act), codified in Section 11362.5 of the Health and Safety Code, in order to allow seriously ill residents of the state, who have the oral or written approval or recommendation of a physician, **to use marijuana for medical purposes without fear of criminal liability under Sections 11357 and 11358 of the Health and Safety Code.**

(2) However, reports from across the state have revealed problems and uncertainties in the act that have impeded the ability of law enforcement officers to enforce its provisions as the voters intended and, therefore, have prevented qualified patients and designated primary caregivers from obtaining the protections afforded by the act.

(3) Furthermore, the enactment of this law, as well as other recent legislation dealing with pain control, demonstrates that more information is needed to assess the number of individuals across the state who are suffering from serious medical conditions that are not being adequately alleviated through the use of conventional medications.

(4) In addition, the act called upon the state and the federal government to develop a plan for the safe and affordable distribution of marijuana to all patients in medical need thereof.

(b) It is the intent of the Legislature, therefore, to do all of the following:

(1) Clarify the scope of the application of the act and facilitate the prompt identification of qualified patients and their designated primary caregivers in order to avoid unnecessary arrest and prosecution of these individuals and provide needed guidance to law enforcement officers.

(2) Promote uniform and consistent application of the act among the counties within the state.

(3) **Enhance the access of patients and caregivers to medical marijuana through collective, cooperative cultivation projects.**

(c) It is also the intent of the Legislature to address additional issues that were not included within the act, and that must be resolved in order to promote the fair and orderly implementation of the act.

(d) The Legislature further finds and declares both of the following:

(1) A state identification card program will further the goals outlined in this section.

(2) With respect to individuals, the identification system established pursuant to this act must be wholly voluntary, and a patient entitled to the protections of Section 11362.5 of the Health and Safety Code need not possess an identification card in order to claim the protections afforded by that section.

(e) The Legislature further finds and declares that it enacts this act pursuant to the powers reserved to the State of California and its people under the Tenth Amendment to the United States Constitution.

SEC. 2. Article 2.5 (commencing with Section 11362.7) is added to Chapter 6 of Division 10 of the Health and Safety Code, to read:

Article 2.5. Medical Marijuana Program

11362.7. For purposes of this article, the following definitions shall apply:

(a) "Attending physician" means an individual who possesses a license in good standing to practice medicine or osteopathy issued by the Medical Board of California or the Osteopathic Medical Board of California and who has taken responsibility for an aspect of the

medical care, treatment, diagnosis, counseling, or referral of a patient and who has conducted a medical examination of that patient before recording in the patient's medical record the physician's assessment of whether the patient has a serious medical condition and whether the medical use of marijuana is appropriate.

(b) "Department" means the State Department of Health Services.

(c) "Person with an identification card" means an individual who is a qualified patient who has applied for and received a valid identification card pursuant to this article.

(d) "Primary caregiver" means the individual, designated by a qualified patient or by a person with an identification card, who has consistently assumed responsibility for the housing, health, or safety of that patient or person, and may include any of the following:

(1) In any case in which a qualified patient or person with an identification card receives medical care or supportive services, or both, from a clinic licensed pursuant to Chapter 1 (commencing with Section 1200) of Division 2, a health care facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, a residential care facility for persons with chronic life-threatening illness licensed pursuant to Chapter 3.01 (commencing with Section 1568.01) of Division 2, a residential care facility for the elderly licensed pursuant to Chapter 3.2 (commencing with Section 1569) of Division 2, a hospice, or a home health agency licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2, the owner or operator, or no more than three employees who are designated by the owner or operator, of the clinic, facility, hospice, or home health agency, if designated as a primary caregiver by that qualified patient or person with an identification card.

(2) An individual who has been designated as a primary caregiver by more than one qualified patient or person with an identification card, if every qualified patient or person with an identification card who has designated that individual as a primary caregiver resides in the same city or county as the primary caregiver.

(3) An individual who has been designated as a primary caregiver by a qualified patient or person with an identification card who resides in a city or county other than that of the primary caregiver, if the individual has not been designated as a primary caregiver by any other qualified patient or person with an identification card.

(e) A primary caregiver shall be at least 18 years of age, unless the primary caregiver is the parent of a minor child who is a qualified patient or a person with an identification card or the primary caregiver is a person otherwise entitled to make medical decisions under state law pursuant to Sections 6922, 7002, 7050, or 7120 of the Family Code.

(f) "Qualified patient" means a person who is entitled to the protections of Section 11362.5, but who does not have an identification card issued pursuant to this article.

(g) "Identification card" means a document issued by the State Department of Health Services that document identifies a person authorized to engage in the medical use of marijuana and the person's designated primary caregiver, if any.

(h) "Serious medical condition" means all of the following medical conditions:

(1) Acquired immune deficiency syndrome (AIDS).

(2) Anorexia.

(3) Arthritis.

(4) Cachexia.

(5) Cancer.

(6) Chronic pain.

(7) Glaucoma.

(8) Migraine.

(9) Persistent muscle spasms, including, but not limited to,

spasms associated with multiple sclerosis.
(10) Seizures, including, but not limited to, seizures associated with epilepsy.
(11) Severe nausea.
(12) Any other chronic or persistent medical symptom that either:

(A) Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336).
(B) If not alleviated, may cause serious harm to the patient's safety or physical or mental health.
(i) "Written documentation" means accurate reproductions of those portions of a patient's medical records that have been created by the attending physician, that contain the information required by paragraph (2) of subdivision (a) of Section 11362.715, and that the patient may submit to a county health department or the county's designee as part of an application for an identification card.
11362.71. (a) (1) The department shall establish and maintain a voluntary program for the issuance of identification cards to qualified patients who satisfy the requirements of this article and voluntarily apply to the identification card program.
(2) The department shall establish and maintain a 24-hour, toll-free telephone number that will enable state and local law enforcement officers to have immediate access to information necessary to verify the validity of an identification card issued by the department, until a cost-effective Internet Web-based system can be developed for this purpose.
(b) Every county health department, or the county's designee, shall do all of the following:
(1) Provide applications upon request to individuals seeking to join the identification card program.
(2) Receive and process completed applications in accordance with Section 11362.72.
(3) Maintain records of identification card programs.
(4) Utilize protocols developed by the department pursuant to paragraph (1) of subdivision (d).
(5) Issue identification cards developed by the department to approved applicants and designated primary caregivers.
(c) The county board of supervisors may designate another health-related governmental or nongovernmental entity or organization to perform the functions described in subdivision (b), except for an entity or organization that cultivates or distributes marijuana.
(d) The department shall develop all of the following:
(1) Protocols that shall be used by a county health department or the county's designee to implement the responsibilities described in subdivision (b), including, but not limited to, protocols to confirm the accuracy of information contained in an application and to protect the confidentiality of program records.
(2) Application forms that shall be issued to requesting applicants.
(3) An identification card that identifies a person authorized to engage in the medical use of marijuana and an identification card that identifies the person's designated primary caregiver, if any. The two identification cards developed pursuant to this paragraph shall be easily distinguishable from each other.
(e) No person or designated primary caregiver in possession of a valid identification card shall be subject to arrest for possession, transportation, delivery, or cultivation of medical marijuana in an amount established pursuant to this article, unless there is reasonable cause to believe that the information contained in the card is false or falsified, the card has been obtained by means of fraud, or the person is otherwise in violation of the provisions of this article.

(f) It shall not be necessary for a person to obtain an identification card in order to claim the protections of Section 11362.5.

11362.715. (a) A person who seeks an identification card shall pay the fee, as provided in Section 11362.755, and provide all of the following to the county health department or the county's designee on a form developed and provided by the department:

(1) The name of the person, and proof of his or her residency within the county.

(2) Written documentation by the attending physician in the person's medical records stating that the person has been diagnosed with a serious medical condition and that the medical use of marijuana is appropriate.

(3) The name, office address, office telephone number, and California medical license number of the person's attending physician.

(4) The name and the duties of the primary caregiver.

(5) A government-issued photo identification card of the person and of the designated primary caregiver, if any. If the applicant is a person under 18 years of age, a certified copy of a birth certificate shall be deemed sufficient proof of identity.

(b) If the person applying for an identification card lacks the capacity to make medical decisions, the application may be made by the person's legal representative, including, but not limited to, any of the following:

(1) A conservator with authority to make medical decisions.

(2) An attorney-in-fact under a durable power of attorney for health care or surrogate decisionmaker authorized under another advanced health care directive.

(3) Any other individual authorized by statutory or decisional law to make medical decisions for the person.

(c) The legal representative described in subdivision (b) may also designate in the application an individual, including himself or herself, to serve as a primary caregiver for the person, provided that the individual meets the definition of a primary caregiver.

(d) The person or legal representative submitting the written information and documentation described in subdivision (a) shall retain a copy thereof.

11362.72. (a) Within 30 days of receipt of an application for an identification card, a county health department or the county's designee shall do all of the following:

(1) For purposes of processing the application, verify that the information contained in the application is accurate. If the person is less than 18 years of age, the county health department or its designee shall also contact the parent with legal authority to make medical decisions, legal guardian, or other person or entity with legal authority to make medical decisions, to verify the information.

(2) Verify with the Medical Board of California or the Osteopathic Medical Board of California that the attending physician has a license in good standing to practice medicine or osteopathy in the state.

(3) Contact the attending physician by facsimile, telephone, or mail to confirm that the medical records submitted by the patient are a true and correct copy of those contained in the physician's office records. When contacted by a county health department or the county's designee, the attending physician shall confirm or deny that the contents of the medical records are accurate.

(4) Take a photograph or otherwise obtain an electronically transmissible image of the applicant and of the designated primary caregiver, if any.

(5) Approve or deny the application. If an applicant who meets the requirements of Section 11362.715 can establish that an

identification card is needed on an emergency basis, the county or its designee shall issue a temporary identification card that shall be valid for 30 days from the date of issuance. The county, or its designee, may extend the temporary identification card for no more than 30 days at a time, so long as the applicant continues to meet the requirements of this paragraph.

(b) If the county health department or the county's designee approves the application, it shall, within 24 hours, or by the end of the next working day of approving the application, electronically transmit the following information to the department:

(1) A unique user identification number of the applicant.

(2) The date of expiration of the identification card.

(3) The name and telephone number of the county health department or the county's designee that has approved the application.

(c) The county health department or the county's designee shall issue an identification card to the applicant and to his or her designated primary caregiver, if any, within five working days of approving the application.

(d) In any case involving an incomplete application, the applicant shall assume responsibility for rectifying the deficiency. The county shall have 14 days from the receipt of information from the applicant pursuant to this subdivision to approve or deny the application.

11362.735. (a) An identification card issued by the county health department shall be serially numbered and shall contain all of the following:

(1) A unique user identification number of the cardholder.

(2) The date of expiration of the identification card.

(3) The name and telephone number of the county health department or the county's designee that has approved the application.

(4) A 24-hour, toll-free telephone number, to be maintained by the department, that will enable state and local law enforcement officers to have immediate access to information necessary to verify the validity of the card.

(5) Photo identification of the cardholder.

(b) A separate identification card shall be issued to the person's designated primary caregiver, if any, and shall include a photo identification of the caregiver.

11362.74. (a) The county health department or the county's designee may deny an application only for any of the following reasons:

(1) The applicant did not provide the information required by Section 11362.715, and upon notice of the deficiency pursuant to subdivision (d) of Section 11362.72, did not provide the information within 30 days.

(2) The county health department or the county's designee determines that the information provided was false.

(3) The applicant does not meet the criteria set forth in this article.

(b) Any person whose application has been denied pursuant to subdivision (a) may not reapply for six months from the date of denial unless otherwise authorized by the county health department or the county's designee or by a court of competent jurisdiction.

(c) Any person whose application has been denied pursuant to subdivision (a) may appeal that decision to the department. The county health department or the county's designee shall make available a telephone number or address to which the denied applicant can direct an appeal.

11362.745. (a) An identification card shall be valid for a period of one year.

(b) Upon annual renewal of an identification card, the county health department or its designee shall verify all new information and may verify any other information that has not changed.

(c) The county health department or the county's designee shall transmit its determination of approval or denial of a renewal to the department.

11362.755. (a) The department shall establish application and renewal fees for persons seeking to obtain or renew identification cards that are sufficient to cover the expenses incurred by the department, including the startup cost, the cost of reduced fees for Medi-Cal beneficiaries in accordance with subdivision (b), the cost of identifying and developing a cost-effective Internet Web-based system, and the cost of maintaining the 24-hour toll-free telephone number. Each county health department or the county's designee may charge an additional fee for all costs incurred by the county or the county's designee for administering the program pursuant to this article.

(b) Upon satisfactory proof of participation and eligibility in the Medi-Cal program, a Medi-Cal beneficiary shall receive a 50 percent reduction in the fees established pursuant to this section.

11362.76. (a) A person who possesses an identification card shall:

(1) Within seven days, notify the county health department or the county's designee of any change in the person's attending physician or designated primary caregiver, if any.

(2) Annually submit to the county health department or the county's designee the following:

(A) Updated written documentation of the person's serious medical condition.

(B) The name and duties of the person's designated primary caregiver, if any, for the forthcoming year.

(b) If a person who possesses an identification card fails to comply with this section, the card shall be deemed expired. If an identification card expires, the identification card of any designated primary caregiver of the person shall also expire.

(c) If the designated primary caregiver has been changed, the previous primary caregiver shall return his or her identification card to the department or to the county health department or the county's designee.

(d) If the owner or operator or an employee of the owner or operator of a provider has been designated as a primary caregiver pursuant to paragraph (1) of subdivision (d) of Section 11362.7, of the qualified patient or person with an identification card, the owner or operator shall notify the county health department or the county's designee, pursuant to Section 11362.715, if a change in the designated primary caregiver has occurred.

11362.765. (a) Subject to the requirements of this article, the individuals specified in subdivision (b) shall not be subject, on that sole basis, to criminal liability under Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570. However, nothing in this section shall authorize the individual to smoke or otherwise consume marijuana unless otherwise authorized by this article, nor shall anything in this section authorize any individual or group to cultivate or distribute marijuana for profit.

(b) Subdivision (a) shall apply to all of the following:

(1) A qualified patient or a person with an identification card who transports or processes marijuana for his or her own personal medical use.

(2) A designated primary caregiver who transports, processes, administers, delivers, or gives away marijuana for medical purposes, in amounts not exceeding those established in subdivision (a) of Section 11362.77, only to the qualified patient of the primary caregiver, or to the person with an identification card who has designated the individual as a primary caregiver.

(3) Any individual who provides assistance to a qualified patient or a person with an identification card, or his or her designated

primary caregiver, in administering medical marijuana to the qualified patient or person or acquiring the skills necessary to cultivate or administer marijuana for medical purposes to the qualified patient or person.

(c) A primary caregiver who receives compensation for actual expenses, including reasonable compensation incurred for services provided to an eligible qualified patient or person with an identification card to enable that person to use marijuana under this article, or for payment for out-of-pocket expenses incurred in providing those services, or both, shall not, on the sole basis of that fact, be subject to prosecution or punishment under Section 11359 or 11360.

11362.77. (a) A qualified patient or primary caregiver may possess no more than eight ounces of dried marijuana per qualified patient. In addition, a qualified patient or primary caregiver may also maintain no more than six mature or 12 immature marijuana plants per qualified patient.

(b) If a qualified patient or primary caregiver has a doctor's recommendation that this quantity does not meet the qualified patient's medical needs, the qualified patient or primary caregiver may possess an amount of marijuana consistent with the patient's needs.

(c) Counties and cities may retain or enact medical marijuana guidelines allowing qualified patients or primary caregivers to exceed the state limits set forth in subdivision (a).

(d) Only the dried mature processed flowers of female cannabis plant or the plant conversion shall be considered when determining allowable quantities of marijuana under this section.

(e) The Attorney General may recommend modifications to the possession or cultivation limits set forth in this section. These recommendations, if any, shall be made to the Legislature no later than December 1, 2005, and may be made only after public comment and consultation with interested organizations, including, but not limited to, patients, health care professionals, researchers, law enforcement, and local governments. Any recommended modification shall be consistent with the intent of this article and shall be based on currently available scientific research.

(f) A qualified patient or a person holding a valid identification card, or the designated primary caregiver of that qualified patient or person, may possess amounts of marijuana consistent with this article.

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.

11362.78. A state or local law enforcement agency or officer shall not refuse to accept an identification card issued by the department unless the state or local law enforcement agency or officer has reasonable cause to believe that the information contained in the card is false or fraudulent, or the card is being used fraudulently.

11362.785. (a) Nothing in this article shall require any accommodation of any medical use of marijuana on the property or premises of any place of employment or during the hours of employment or on the property or premises of any jail, correctional facility, or other type of penal institution in which prisoners reside or persons under arrest are detained.

(b) Notwithstanding subdivision (a), a person shall not be prohibited or prevented from obtaining and submitting the written information and documentation necessary to apply for an identification card on the basis that the person is incarcerated in a

jail, correctional facility, or other penal institution in which prisoners reside or persons under arrest are detained.

(c) Nothing in this article shall prohibit a jail, correctional facility, or other penal institution in which prisoners reside or persons under arrest are detained, from permitting a prisoner or a person under arrest who has an identification card, to use marijuana for medical purposes under circumstances that will not endanger the health or safety of other prisoners or the security of the facility.

(d) Nothing in this article shall require a governmental, private, or any other health insurance provider or health care service plan to be liable for any claim for reimbursement for the medical use of marijuana.

11362.79. Nothing in this article shall authorize a qualified patient or person with an identification card to engage in the smoking of medical marijuana under any of the following circumstances:

(a) In any place where smoking is prohibited by law.

(b) In or within 1,000 feet of the grounds of a school, recreation center, or youth center, unless the medical use occurs within a residence.

(c) On a schoolbus.

(d) While in a motor vehicle that is being operated.

(e) While operating a boat.

11362.795. (a) (1) Any criminal defendant who is eligible to use marijuana pursuant to Section 11362.5 may request that the court confirm that he or she is allowed to use medical marijuana while he or she is on probation or released on bail.

(2) The court's decision and the reasons for the decision shall be stated on the record and an entry stating those reasons shall be made in the minutes of the court.

(3) During the period of probation or release on bail, if a physician recommends that the probationer or defendant use medical marijuana, the probationer or defendant may request a modification of the conditions of probation or bail to authorize the use of medical marijuana.

(4) The court's consideration of the modification request authorized by this subdivision shall comply with the requirements of this section.

(b) (1) Any person who is to be released on parole from a jail, state prison, school, road camp, or other state or local institution of confinement and who is eligible to use medical marijuana pursuant to Section 11362.5 may request that he or she be allowed to use medical marijuana during the period he or she is released on parole. A parolee's written conditions of parole shall reflect whether or not a request for a modification of the conditions of his or her parole to use medical marijuana was made, and whether the request was granted or denied.

(2) During the period of the parole, where a physician recommends that the parolee use medical marijuana, the parolee may request a modification of the conditions of the parole to authorize the use of medical marijuana.

(3) Any parolee whose request to use medical marijuana while on parole was denied may pursue an administrative appeal of the decision. Any decision on the appeal shall be in writing and shall reflect the reasons for the decision.

(4) The administrative consideration of the modification request authorized by this subdivision shall comply with the requirements of this section.

11362.8. No professional licensing board may impose a civil penalty or take other disciplinary action against a licensee based solely on the fact that the licensee has performed acts that are necessary or appropriate to carry out the licensee's role as a

designated primary caregiver to a person who is a qualified patient or who possesses a lawful identification card issued pursuant to Section 11362.72. However, this section shall not apply to acts performed by a physician relating to the discussion or recommendation of the medical use of marijuana to a patient. These discussions or recommendations, or both, shall be governed by Section 11362.5.

11362.81. (a) A person specified in subdivision (b) shall be subject to the following penalties:

(1) For the first offense, imprisonment in the county jail for no more than six months or a fine not to exceed one thousand dollars ($1,000), or both.

(2) For a second or subsequent offense, imprisonment in the county jail for no more than one year, or a fine not to exceed one thousand dollars ($1,000), or both.

(b) Subdivision (a) applies to any of the following:

(1) A person who fraudulently represents a medical condition or fraudulently provides any material misinformation to a physician, county health department or the county's designee, or state or local law enforcement agency or officer, for the purpose of falsely obtaining an identification card.

(2) A person who steals or fraudulently uses any person's identification card in order to acquire, possess, cultivate, transport, use, produce, or distribute marijuana.

(3) A person who counterfeits, tampers with, or fraudulently produces an identification card.

(4) A person who breaches the confidentiality requirements of this article to information provided to, or contained in the records of, the department or of a county health department or the county's designee pertaining to an identification card program.

(c) In addition to the penalties prescribed in subdivision (a), any person described in subdivision (b) may be precluded from attempting to obtain, or obtaining or using, an identification card for a period of up to six months at the discretion of the court.

(d) In addition to the requirements of this article, the Attorney General shall develop and adopt appropriate guidelines to ensure the security and nondiversion of marijuana grown for medical use by patients qualified under the Compassionate Use Act of 1996.

11362.82. If any section, subdivision, sentence, clause, phrase, or portion of this article is for any reason held invalid or unconstitutional by any court of competent jurisdiction, that portion shall be deemed a separate, distinct, and independent provision, and that holding shall not affect the validity of the remaining portion thereof.

11362.83. Nothing in this article shall prevent a city or other local governing body from adopting and enforcing laws consistent with this article.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because in that regard this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

In addition, no reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for other costs mandated by the state because this act includes additional revenue that is specifically intended to fund the costs of the state mandate in an amount sufficient to fund the cost of the state mandate, within the meaning of Section 17556 of the Government Code.

Top U.S. doctor says medical marijuana may help some conditions

REUTERS

By **Ian Simpson** Feb 4, 2015

By Ian Simpson

WASHINGTON (Reuters) - The United States' top doctor said that medical marijuana can help some patients in comments on Wednesday that may boost pressure on the Justice Department to redesignate the drug under federal law.

In an interview on "CBS This Morning," U.S. Surgeon General Vivek Murthy said the medical effectiveness of marijuana had to be shown scientifically and much more information about it was coming.

"We have some preliminary data showing that for certain medical conditions and symptoms, marijuana can be helpful," said Murthy, who became surgeon general in December.

"I think we have to use that data to drive policymaking, and I'm very interested to see where that data takes us."

The Justice Department designates marijuana as a Schedule I controlled substance, a category for drugs that have no accepted medical value and have a high potential for abuse.

Twenty-three states and the District of Columbia have legalized medical marijuana, according to the Drug Policy Alliance advocacy group.

Florida also allows a narrow use of medical marijuana. Two states, Washington and Colorado, have legalized marijuana for recreational use.

Tom Angell, chairman of Marijuana Majority, another advocacy group, said in a statement that Murthy's remarks mean that President Barack Obama should direct Attorney General Eric Holder to begin changing how the department categorizes marijuana.

"Dr. Murthy's comments add to a growing consensus in the medical community that marijuana can help people suffering from painful conditions," Angell said.

The Justice Department had no immediate response to Murthy's comments.