ZENIA K. GILG, SBN 171922
809 Montgomery Street, 2nd Floor
San Francisco CA 94133
Telephone: 415/394-3800
Facsimile: 415/394-3806
zenia@jacksonsquarelaw.com

Attorney for Defendant
BRIAN JUSTIN PICKARD

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

BRYAN R. SCHWEDER,
BRIAN JUSTIN PICKARD,
JUAN MADRIGAL OLIVERA,
MANUAL MADRIGAL OLIVERA,
FRED W. HOLMES, III,
EFREN RODRIGUEZ,
PAUL BRUCE ROCKWELL,
HOMERO LOPEZ-BARRON
VICTORINO BETANCOURT-MERAZ,
OSEAS CARDENAS-TOLENTINO,
FERNANDO REYES-MOJICA,
JUAN CISNEROS-VARGAS,
LEONARDO TAPIA,
FILBERTO ESPINOZA-TAPIA
OSIEL VALENCIA-ALVAREZ

Defendants.
_______________________________/

2:11-CR-00449-KJM

DEFENDANT BRIAN PICKARD'S NOTICE OF MOTION AND MOTION TO DISMISS INDICTMENT AS VIOLATIVE OF THE UNITED STATES CONSTITUTION (AMENDMENT V, AND ARTICLE VI/AMENDMENT X), AND REQUEST FOR EVIDENTIARY HEARING

[Excludable Time: 18 U.S.C. § 3161(h)(1)(D) through disposition]

Date: January 22, 2014
Time: 9:00 a.m.
Judge: Hon. Kimberly J. Mueller

TO THE CLERK OF THE ABOVE-ENTITLED COURT AND TO THE UNITED STATES ATTORNEY FOR THE EASTERN DISTRICT OF CALIFORNIA:

PLEASE TAKE NOTICE that on the date and at the time indicated above, or as soon thereafter as the matter may be heard, before the Honorable United States District Court Judge

1 Kimberly J. Mueller, Defendant, BRIAN JUSTIN PICKARD, by and through counsel, will and
2 hereby does move this Court to dismiss the Indictment upon a finding that the United States
3 Constitution renders *21 U.S.C. Section 812, Schedule 1(c) (10)* and *(17)* unenforceable, and
4 therefore, may not form the basis for a prosecution under *21 U.S.C. Sections 846, 841(a)(1)*.
5 Specifically, the defense asserts:
6 1. The challenged statute violates defendant's right to Equal Protection as guaranteed by
7 the Constitution's Fifth Amendment.
8 A. The scientific studies on the use of cannabis demands a finding that the
9 scheduling of marijuana is overinclusive when viewed in light of the factors
10 enumerated in *21 U.S.C. § 812*, and further that when compared to other
11 substances which are legally distributed in the open market cannabis is proven to
12 be far less harmful, and thus its continued prohibition serves no Government
13 interest. The inclusion, therefore, of marijuana and THC in Schedule I of the
14 Controlled Substances Act is based on an arbitrary classification in violation of
15 Equal Protection Clause of the Fifth Amendment. United States v. Carolene
16 Prods. Co., 304 U.S. 144 (1938).
17 B. The policy statement presented in the Memorandum to U.S. Attorneys from
18 Deputy Attorney General James Cole, issued on August 29, 2013, by Attorney
19 General Eric Holder has resulted in a discriminatory application of federal law, in
20 that it protects similarly situated individuals from criminal sanctions for actions
21 identical to that alleged to have been conducted by the defendant, and thereby
22 violates the Equal Protection Clause. Oyler v. Boles, 368 U.S. 448 (1962).
23 2. The Government's prosecution policy announced on August 29, 2013, as it relates to
24 marijuana and THC violates the doctrine of Equal Sovereignty by adopting a scheme which
25 allows for the distribution of marijuana in States where it has been decriminalized for medical or
26 recreational use, while exposing those in other states to serious criminal sanctions. A federal
27 law's disparate geographic application requires the current burdens of disparate treatment
28 between the states be justified by current needs, and the imposition on the equal sovereignty is

limited to remedy present-day "local evils." Further, an imposition upon the sovereignty of the States must be applied strictly as an "extraordinary measure" that should only be applied to remedy an "extraordinary problem." The defense contends that the Government will be unable to justify this disparate geographic coverage. Accordingly, the statute which criminalizes the distribution of marijuana and THC must be found to violate Article VI and the Tenth Amendment of the United States Constitution. Shelby County (Alabama) v. Holder, __ U.S.__, 133 S.Ct. 2612, 2623 (2013)

Defendant request this Court hold an evidentiary hearing at which the testimony and evidence proffered in this motion will be presented in support of the constitutional challenges herein articulated.

This motion is based on this notice, the Memorandum of Points and Authorities and Declarations and Exhibits filed herewith, on such supplemental points and authorities as may be hereafter filed with this Court, on the records and files in this action, and on such oral and documentary evidence as may be presented at the hearing on this matter.

Dated: November 20, 2013

/s/ Zenia K. Gilg
ZENIA K. GILG
Attorney for Defendant
BRIAN JUSTIN PICKARD

ZENIA K. GILG, SBN 171922
809 Montgomery Street, 2nd Floor
San Francisco CA 94133
Telephone: 415/394-3800
Facsimile: 415/394-3806
zenia@jacksonsquarelaw.com

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BRIAN JUSTIN PICKARD

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Defendants.

_____________________________________/

2:11-CR-00449-KJM

MEMORANDUM IN SUPPORT OF DEFENDANT BRIAN PICKARD'S NOTICE OF MOTION AND MOTION TO DISMISS INDICTMENT AS VIOLATIVE OF THE UNITED STATES CONSTITUTION (AMENDMENT V, AND ARTICLE VI/AMENDMENT X), AND REQUEST FOR EVIDENTIARY HEARING

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1 I. INTRODUCTION

> One *must* reasonably conclude that there is an accepted safety for use of marijuana under medical supervision. To conclude otherwise, on this record, would be *unreasonable*, *arbitrary*, and *capricious*.

In the Matter of Marijuana Rescheduling Petition, Docket 86-22, (Dept. of Justice, September 6, 1988) Opinion of the Drug Enforcement Agency [DEA] Administrative Judge Francis Young, italics emphasis added.

Decades after this judicial acknowledgment of the irrationality of classifying marijuana as a Schedule I Controlled Substance, the possession and cultivation of this plant remains subject to the harshest criminal penalties authorized under the Controlled Substances Act of 1972 (CSA). Despite the federal prohibition, science has forged ahead to prove Judge Young correct, and in the twenty-first century, cannabis has been proven to be a harmless yet effective medication for treating, and possibly preventing, serious illnesses. In fact, the United States Supreme Court has acknowledged this to be true.

> We acknowledge that evidence proffered by respondents in this case regarding the effective medical uses for marijuana, if found credible after trial, would cast serious doubt on the accuracy of the findings that require marijuana to be listed in Schedule I. See, *e.g.,* Institute of Medicine, Marijuana and Medicine: Assessing the Science Base 179 (J. Joy, S. Watson, & J. Benson eds. 1999) (recognizing that "[s]cientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC [Tetrahydrocannabinol] for pain relief, control of nausea and vomiting, and appetite stimulation"); see also Conant v. Walters, 309 F.3d 629, 640-643 (CA9 2002) (Kozinski, J., concurring) (chronicling medical studies recognizing valid medical uses for marijuana and its derivatives).

Gonzales v. Raich, 545 U.S. 1, 28 (2005)

By this motion, the defense asks this Court to hold an evidentiary hearing at which the evidence proffered in the attached Declarations of Philip A. Denney, M.D.,[1] James J. Nolan, III,

[1] Dr. Philip A. Denney is a physician licensed to practice medicine in the State of California in 1977. He attended medical school at the University of Southern California after serving in the United States Navy. Before his retirement in 2010, he practiced Family, Emergency and Occupational Medicine. He has qualified to testify as an expert witness regarding the medical use of cannabis in at least 21 counties throughout California, and has also testified before the California Medical Board regarding medicinal cannabis. He is the founding member of the Society of Cannabis Clinicians, and has been active in the development of policy regarding cannabis as medicine in El Dorado County, and in this regard he has been asked to

Ph.D.,[2] and Christopher Conrad[3] will be presented establishing that the continued inclusion of marijuana as a Schedule I Controlled Substance violates the Equal Protection Clause of the Fifth Amendment, and the enforcement policies employed by the U.S. Department of Justice violate the Doctrine of Equal Sovereignty and Federalism, born out of the United States Constitution.

II. ISSUES PRESENTED AND SUMMARY OF ARGUMENT

A. Whether *21 U.S.C. § § 812, Schedule I(c)(10)* and *(17)* must Be Stricken as Violative of the Fifth Amendment's Equal Protection Clause.

1. In Light of the Current Scientific and Medical Research, There Is No Rational Basis for Treating Marijuana as a Controlled Substance.

A prosecution based on an arbitrary classification may violate the equal protection clause of the Fifth Amendment. United States v. Carolene Prods. Co., 304 U.S. 144 (1938). The current medical and scientific studies overwhelmingly establish that marijuana is a beneficial and safe medicine and, when compared to many over-the-counter medications, marijuana has been

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consult with Judges, District Attorneys, and law enforcement officers about the medical use of cannabis. He has also testified before the Arkansas State Legislature regarding the implementation of cannabis as medicine laws and policies, and has been consulted by members of the campaign to legalize the medical use of cannabis in the state of Montana. (See Declaration of Philip A. Denney, M.D., and Curriculum Vitae, attached thereto and hereinafter referred to as Denney Declaration.)

[2] James J. Nolan, Ph.D., served as a Police Officer for the City of Wilmington (Delaware) Department of Police for thirteen years, from 1980-1993. During that time he was assigned to the Special Investigations Units for drug, organized crime, and vice investigations. In 1993, he served as the Senior Policy Advisor to the Secretary of Public Safety for the State of Delaware, until 1995, when he joined the Federal Bureau of Investigation (FBI) as Chief of the Crime Analysis, Research and Development Unit in the Criminal Justice Information Services Division. Presently he is an Associate Professor at West Virginia University in the Division of Sociology and Anthropology, specializing in Procedures and Processes, Organizational Behavior in Criminal Justice Agencies, and Hate Crime. (See Declaration of James J. Nolan, III, Ph.D., and Curriculum Vitae, attached thereto and hereinafter referred to as Nolan Declaration.)

[3] Christopher Conrad is a court-qualified expert witness on marijuana related issues such as cultivation, consumption, genetics, cloning, crop yields, medical use, recreational use, commercial sales, and medical distribution. He has testified in this capacity in at least 28 Counties in California, as well as in the states of Colorado, Oklahoma, Oregon, North Dakota, Maryland and the Commonwealth of Virginia. In addition, he has qualified as an expert in all California District Courts, the District Court for the Middle District of Louisiana, and U.S. Courts Martial. His experience includes the cultivation and processing of cannabis in Holland and Switzerland, Countries in which marijuana is not prohibited. In addition, he has been asked to consult with government agencies instituting medical marijuana laws, and has testified before the National Academy of Science, Institute of Medicine, and presented his finding at the *Fifth Conference on Cannabis Therapeutics.* (See Declaration of Christopher Conrad and Curriculum Vitae, attached thereto and hereinafter referred to as Conrad Declaration.)

proven to be more effective and cause less harm. Accordingly, the defense asks this Court to hold a hearing at which evidence will be presented supporting the assertion that the inclusion of marijuana and tetrahydrocannabinol (hereinafter THC) in *21 U.S.C. § 812 (c), Schedule I* violates the Equal Protection Clause.

2. The Government's Decision to Prosecute Defendant Is Based on an Arbitrary Classification, and Therefore, Violates the Equal Protection Clause.

The decision to prosecute may not be based on an unjustified standard such as an arbitrary classification. Oyler v. Boles, 368 U.S. 448, 456 (1962); United States v. Batchelder, 442 U.S. 114, 125 (1979); Wayte v. United States, 470 U.S. 598, 608 (1985). The defense contends that the policy statement presented in the Memorandum to U.S. Attorneys from Deputy Attorney General James Cole, issued on August 29, 2013, by Attorney General Eric Holder (herein after referred to as "Cole Memorandum,"[4]) has resulted in a discriminatory application of federal law, in that it protects similarly situated individuals from criminal sanctions for actions identical to that alleged to have been conducted by the defendant. It is hereby requested that this Court hold an evidentiary hearing at which evidence will be presented establishing the statute under which defendant is being prosecuted has been applied pursuant to an arbitrary classification, and thereby violates the Equal Protection Clause.

B. Whether the Government's Prosecution Policy Violates the Doctrine of Equal Sovereignty of States and Federalism.

Constitutional principles mandate all the States enjoy "equal sovereignty." Shelby County (Alabama) v. Holder, __ U.S.__, 133 S.Ct. 2612, 2623 (2013); United States v. Louisiana, 363 U.S. 1, 16, 80 (1960) (citing Lessee of Pollard v. Hagan, 44 U.S. 212 (1845)); *see also* Texas v. White, 74 U.S. 700 (1869). An Act which differentiates between the States can only be justified if predicated on *local* evils which have subsequently appeared. Shelby County, *supra*, at 2624; Northwest Austin Municipal Utility District v. Holder, 557 U.S. 193, 203 (2009). Moreover, a departure from the fundamental principle of equal sovereignty requires a showing

[4] United States Department of Justice Memorandum dated August 29, 2013, entitled "Guidance Regarding Marijuana Enforcement," is attached hereto as Exhibit A at 1-3, and located online at http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf.

that a statute's disparate geographic coverage is sufficiently related to the problem that it targets. *Id*.

The defense here urges this Court to find the policy adopted by the Attorney General governing the prosecutorial discretion of his officers (i.e., the Cole Memorandum) sets up a scheme which violates the principles of "equal sovereignty" by prosecuting individuals in States where cannabis is still prohibited, but not those involved in the distribution of marijuana under states law where it has been decriminalized for medical or recreational use. Further, as will be established at the hearing on this motion, the Government will be unable to justify this disparate geographic coverage as being related to a targeted problem. Accordingly, the statute which criminalizes the distribution of marijuana and THC must be found to violate Article VI cl.2 and Amendment X of the United States Constitution.

III. PREDICATE FACTS

Defendant, Brian Pickard, is charged along with fifteen others by Indictment with conspiring to violate *21 U.S.C. §§ 846*, *841(a)(1),* which provides:

> Prohibited acts A
>
> (a) Unlawful acts. Except as authorized by this title, it shall be unlawful for any person knowingly or intentionally--
>
> (1) to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, **a controlled substance**.…

A "controlled substance" is a drug or substance included in Schedule I, II, III, IV or V. *21 U.S.C. § 802(6)*. A Schedule I substance is defined in *21 U.S.C. § 812(b)(1)* by the following factors:

> (A) The drug or other substance has a high potential for abuse;
>
> (B) The drug or other substance has no currently accepted medical use in treatment in the United States;
>
> (C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.

Cannabis/marijuana is designated in Schedule I at *21 U.S.C. § 812, Schedule I (c)(10*), as "marihuana," and its principal psychoactive constituent, THC, is designated at *21 U.S.C. § 812, Schedule I (c)(17)*. Unlike Schedule I substances, those listed in Schedule II-V may have a

currently accepted medical use, and thus may legally be dispensed with a valid prescription. *21 U.S.C. § 829*.

In 1970, the United States Congress classified the plant "marihuana," now known as marijuana or cannabis, as a Schedule I controlled substance. *See Notes to 21 U.S.C. § 801;* United States v. Nocar, 497 F.2d 719, 721, fn.1 (7th Cir. 1974). When enacting this statutory scheme, however, Congress also established the Commission on Marihuana and Drug Abuse (the Commission), entrusted to report to the President and Congress the results of a marijuana study which included, *inter alia*: (1) the extent of marijuana use in the United States; (2) a study of the pharmacology of marijuana and its immediate and long-term effects, both physiological and psychological, and (3) the relationship between marijuana and the use of other drugs. *21 U.S.C. § 801*. See, Notes to *21 U.S.C. § 801*, entitled "Commission on Marihuana and Drug Abuse Act," *subsection (d)(1)*).[5] Because Congress "recognized that much of the information regarding marijuana was inaccurate and that bias and ignorance had perpetuated many myths about the consequences and dangers of marijuana," as well as Congress' admitted uncertainty about the harms associated with marijuana, Congress placed marijuana in the strictest of the Schedules as a *temporary* measure while the Commission's report was pending.[6] Gonzales v. Raich, 545 U.S. 1, 14 (2005); Bell, *supra*, 488 F. Supp at 135.

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[5] Additionally, Congress delegated to the Attorney General the authority to schedule drugs, a task that was then delegated to the Administrator of the Drug Enforcement Administration (DEA). *21 U.S.C. § 811; 28 C.F.R. § 0.100*; United States v. Wisniewski, 741 F.2d 138, 142, fn.4 (7th Cir. 1984). The DEA, however, has repeatedly refused to reschedule marijuana, the most current purported reason being that there is no currently accepted medical use in the United States. *See, inter alia*, Americans for Safe Access v. DEA, 706 F.3d 438, 439 (D.C. Cir. 2013), petition for *certiorari* denied October 7, 2013, No.13-84; Alliance for Cannabis Therapeutics v. Drug Enforcement Administration, 15 F.3d 1131 (D.C. Cir. 1994); Alliance for Cannabis Therapeutics v. Drug Enforcement Administration, 930 F.2d 936 (D.C. Cir. 1991); National Organization for the Reform of Marijuana Laws v. Bell, 488 F. Supp. 123 (D.C. Cir. 1980).

[6] See, Exhibit B, Letter from Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, to Hon. Harley O. Staggers, Chairman, House Comm. on Interstate and Foreign Commerce, stating "[s]ince there is still a considerable void in our knowledge of the plant and effects of the active drug contained in it, our recommendation is that marihuana be retained in Schedule I at least until the completion of certain studies now underway to resolve the issue." H.R. Rep. No. 91-1444, P.L. 91-513, U.S. Code Cong. & Admin. News, reprinted in (1970), 4566, 4629-30.

The Commission issued a first report in 1972, entitled "*Report of the National Comission on Marihuana and Drug Abuse: Marihuana, A Signal of Misunderstanding.*[7] As suggested by the title, the federal Commission's first report recommended the decriminalization of marijuana.[8] The federal Commission further reported, "[i]n a word, cannabis does not lead to physical dependence" and "fact and fancy have become irrationally mixed regarding marihuana's physiological and psychological properties."[9]

Despite these early opinions of Congress' own experts, marijuana and THC remain on the list of Schedule I Controlled Substances. (*21 U.S.C. §§ 812, Schedule I(c)(10)* and *(17)*, respectively.) Moreover, despite the overwhelming scientific evidence which has developed over the course of the past 40 years supporting the Commission's original findings, the Government continues to treat cannabis as one of the most harmful narcotics known in this Country.

Yet, even the Federal Government has been forced to accept that the "myths" have been disproved. Since 1996, 21 states and the District of Columbia have decriminalized marijuana for medical use, two of which have also decriminalized its recreational use, and on August 29, 2013, the Department of Justice released a memorandum to all United States Attorneys directing them to decline prosecution of cannabis cases against individuals who are possessing, cultivating and/or distributing marijuana in compliance with their state law. (Exhibit A, at 1-3.) Having taken this position, the Government demonstrates a recognition of the benign nature of the cannabis plant; it is unfathomable to believe that had states legalized the production and sales of

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[7] Report of the National Commission on Marihuana and Drug Abuse: Marijuana, a Signal of Misunderstanding, commissioned by President Richard M. Nixon, issued on March 1972, abstract located online at http://www.sciencemag.org/content/179/4069/167.1.extract?sid=3b2f85ef-782c-4617-b492-0ba91f57a666.

[8] See, Exhibit C, Report of the National Commission on Marihuana and Drug Abuse: Marijuana, a Signal of Misunderstanding, subsection entitled "A Final Comment," wherein the Commission states "the criminalization of possession of marihuana for personal [sic] is socially self-defeating as a means of achieving this objective." (i.e., prevention and treatment of heavy and very heavy users of marijuana).

[9] See, Exhibit D Report of the National Commission on Marihuana and Drug Abuse: Marijuana, a Signal of Misunderstanding, subsection entitled "Social Impact of Marijuana: Addiction Potential.

methamphetamine (incidently a Schedule III controlled substance)[10] that the Attorney General would be declining to prosecute, and allowing local political leaders to engage in conduct consistent with conspiring to manufacture and distribute meth.

Nearly 40 years ago the Honorable District Court Judge Will questioned the scientific basis for the harsh penalties imposed in marijuana offenses.

> [A]s has been the experience with the marijuana laws, hopefully, a more enlightened factual foundation, grounded upon our expanding medical and scientific knowledge, will allow us to deal firmly, but also more fairly, with our drug problems.

United States v. Castro, 401 F. Supp. 120, 127 (7th Cir. 1975).

Yet, despite the more enlightened factual foundation that has developed over the intervening decades, marijuana is still treated as the most dangerous of controlled substances. Where the legislative and executive branches of government refuse to rectify an unconstitutional application of a statute, it is the duty and obligation of the judicial branch to invalidate that statute. By this motion the defense asks this Honorable Court to step in where Congress and the DEA have failed to act and consider the evidence to be presented, as proffered herein, and reach a reasoned conclusion based on an enlightened factual foundation regarding the constitutionality of listing marijuana as a Schedule I Controlled Substance.

MEMORANDUM OF LAW

IV. EQUAL PROTECTION OF THE LAW

The *Fourteenth Amendment* commands that no state "shall deny to any person within its jurisdiction the equal protection of the laws." The Equal Protection Clause prevents the government from making improper classifications. Plessy v. Ferguson, 163 U.S. 537 (1896), dissenting opinion by J. Harlan, "[t]he Constitution neither knows nor tolerates classes among its citizens; *see also* Brown v. Board of Education, 347 U.S. 483, 495 (1954), overruling Plessy's "separate but equal" doctrine. In essence, it guarantees that people who are similarly situation will be treated similarly. *Id.; see also* Romer v. Evans, 517 U.S. 620, 635 (1996). The Equal Protection Clause applies to the federal government via the *Fifth Amendment* Due Process

[10] *21 U.S.C. § 812, Schedule III (a).*

1 Clause. Boiling v. Sharpe, 347 U.S. 497, 500 (1954), "it would be unthinkable that the same
2 Constitution would impose a lesser duty on the Federal Government."

3 Importantly, the courts have the power and *responsibility* to protect the citizenry from
4 congressional actions which violate the constitution. As Alexander Hamilton proclaimed: "the
5 courts of justice are to be considered as the bulwarks of a limited Constitution against legislative
6 encroachments." The Federalist, No. 78.[11]

7 And as the United States Supreme Court recently affirmed:

8 > The power the Constitution grants it also restrains. And though
> Congress has great authority to design laws to fit its own
9 > conception of sound national policy, it cannot deny the liberty
> protected by the *Due Process Clause of the Fifth Amendment*.

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United States v. Windsor, __ U.S. __, 47, 133 S.Ct. 2675, 26965; 186 L.Ed.2d 808 (2013)

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In Windsor the Court struck down the Defense of Marriage Act (DOMA), finding the law

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had no legitimate purpose. *Id*., at 48. Recognizing the historical support for defining marriage as

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between one man and one woman, the Court determined that it was the duty of the judiciary to

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rectify past misperceptions which result in constitutionally unsound legislation.[12]

15

16 > For marriage between a man and a woman no doubt had been
> thought of by most people as essential to the very definition of that
17 > term and to its role and function throughout the history of
> civilization. That belief, for many who long have held it, became
18 > even more urgent, more cherished when challenged. For others,
> however, came the beginnings of a new perspective, a new insight.

19 *Id*. at 2689.

20 Like the long held beliefs regarding the marital relationship, the long held beliefs about
21 the effects of marijuana have evolved. While the former evolution has been the result of societal
22 ideologies, the latter is predicated on scientific evidence, and therefore, can be more readily
23 established through an evidentiary hearing.

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25 [11] The Federalist, No. 78 is located online at
26 http://www.constitution.org/fed/federa78.htm.

27 [12] As the High Court reiterated, "[w]hen an Act of Congress is alleged to conflict with the Constitution, '[i]t is emphatically the province and duty of the judicial department to say what the law is.' Zivotofsky v. Clinton, 566 U.S. __ , __, 132 S,Ct, 1421, 182 L.Ed.2d 423, 430
28 (2012)." Windsor, at 822.

Accordingly, the Defendant asks this Court to afford him the opportunity to challenge the constitutionality of *21 U.S.C. §§ 812, Schedule I (c)(10)* and *(17)* by presenting evidence which will establish: (1) In light of the current scientific and medical research, there is no rational basis for treating marijuana as a Controlled Substance, and (2) the government's decision to prosecute defendant is based on an arbitrary classification, and therefore, violates the Equal Protection Clause.

A. Standard of Review – Level of Scrutiny Applied in and Equal Protection Challenge.

The first step in any Equal Protection analysis is to establish under what standard the law should be scrutinized. The most exacting level, commonly referred to as "strict scrutiny," is applied when a statute is based on a "suspect classification" (e.g. race, national origin, and alienage), or involves a fundamental right, (e.g., the rights to liberty, to vote, and to travel). City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 439-440 (1985), superceded by statute on other grounds. The second level or "mid-level review" is used for "semi-suspect" classifications (e.g., gender and illegitimacy). *Id.*, at 441-442; *see also* United States v. Windsor, *supra*, 133 S.Ct. 2675, 2694, applying an intermediate level of scrutiny. The third level, "rational review," is applied in all other cases. City of Cleburne, *supra*, 473 U.S. at 439-440.

In determining whether an asserted right is fundamental, this Court must query whether the asserted right is so "implicit in the concept of ordered liberty … that neither liberty nor justice would exist if [it] were sacrificed." Washington v. Glucksberg, 521 U.S. at 720-721 (1997), internal quotations omitted. The defense here asserts the right at issue is liberty.[13] A right fundamental to this nation's system of ordered justice so as to be included in the Magna Carta[14] and *thrice* in the U.S. Constitution. *See U.S. Const. pmbl., Amend. V, XIV*. It is without a

[13] *Title 21 U.S.C. § 841* sets forth strict mandatory minimums for the violation of the challenged law, which include a 10 year mandatory incarceration minimum for a violation of the Code involving 1,000 kilograms of cannabis, a 5 year minimum for 100 kilograms of cannabis, and of no more than 5 years for quantities less than 50 kilograms. *21 USC § 841(b)(1)(A), (B), (D)*.

[14] This document demands, "[n]o free man shall be taken or imprisoned or dispossessed, or outlawed, or banished, or in any way destroyed, nor will we go upon him, nor send upon him, except by the legal judgment of his peers or by the law of the land." *Magna Carta, Clause 39,*

doubt that "[t]he Framers viewed freedom from unlawful restraint as a fundamental precept of liberty." Boumediene v. Bush, 553 U.S. 723, 739 (2008); *see also* Glucksberg, *supra*, 521 U.S. at 702, 721, the "liberty" protected by the Constitution includes protection from physical restraint. Indeed, it is this fundamental right to be free from the arbitrary impositions of the King that spurred the inception of this nation's system of government. Boumediene, *supra,* 553 U.S. at 742-743. There can be no more fundamental right than the basic right to freedom and liberty, even more so than the rights to privacy which were developed as legal principle by Constitutional implication. *See, e.g.* Griswold v. Connecticut, 381 U.S. 479 (1965), applying increased level of scrutiny to rights arising under an implied penumbra of privacy. Thus, this Court should find the right to be free from incarceration is one of the greatest of the fundamental rights.[15]

Accordingly, as the Constitution "forbids the government to infringe…fundamental liberty interests at all, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest," this Court should apply strict scrutiny when analyzing the constitutionality of the challenged statute. *See* Glucksberg, *supra*, 521 U.S. at 721.[16]

1215, as noted in Boumediene v. Bush, 553 U.S. 723, 740 (2008); complete text online at http://www.constitution.org/eng/magnacar.htm.

[15] The right to liberty and to be free from arbitrary restrain have been determined to be basic human rights, as indicated in the Universal Declaration of Human Rights, ratified by the United States in 1948, as well as the International Covenant on Civil and Political Rights (ICCPR), ratified by the United States in 1992. *See* Article 9, UN General Assembly, Universal Declaration of Human Rights, 10 December 1948, 217 A (III), available at: http://www.refworld.org/docid/3ae6b3712c.html [accessed 26 September 2013]; *also see* Article 9 of ICCPR, located online at http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx [accessed 26 September 2013].

[16] The Court may also employ a higher level of scrutiny if the law exhibits animus towards a particular group or was enacted with a discriminatory purpose. *See, inter alia,* Village of Arlington Heights v. Metro. Hous. Dev. Corp., 429 U.S. 252 (1977); Department of Agriculture v. Moreno, 413 U.S. 528 (1973). Moreover, Courts may apply a "disparate impact" test to determine whether a law is based on a discriminatory purpose. *See* Village of Arlington Heights v. Metro. Hous. Dev. Corp., 429 U.S. 252 (1977), overruled by statute on unrelated grounds. The party challenging the law must show that an "invidious discriminatory purpose was a motivating factor" and that the law burdens one race more heavily than another. *Id.* The defense asserts the scheduling of marijuana was based on race-based fear and that the law burdens people of color over and above white people. As Dr. James J. Nolan states, "Marijuana was first outlawed in 1937 via The Marijuana Tax Act, an act resulting from what can only be

1 The defense contends, however, that given the present state of the scientific evidence, as
2 well as the policies adopted by the Department of Justice, the law can not survive even the
3 rational basis test. For while rational basis review is less burdensome than strict scrutiny, it is by
4 no means a "toothless" review. Mathews v. Lucas, 427 U.S. 495, 510 (1976). It still requires
5 that the law be reasonable and not arbitrary. Windsor, *supra*, 133 S.Ct. at 2716. The law "must
6 rest upon some ground of difference having a fair and substantial relation to the object of the
7 legislation, so that all persons similarly circumstanced shall be treated alike." *Id.,* quoting F. S.
8 Royter Guano Co. v. Virginia, 253 U. S. 412, 415 (1920); *see also* Romer, *supra*, 517 U.S. at
9 635, "by requiring that the classification bear a rational relationship to an independent and
10 legitimate legislative end, we ensure that classifications are not drawn for the purpose of
11 disadvantaging the group burdened by the law." Thus, in determining whether this rational
12 relationship exists, the court must insist on knowing the challenged classification and the
13 objective of the statute being analyzed. (Romer, *supra*, 517 U.S. at 632 - 635, commenting:
14 "[t]he search for the link between classification and objective gives substance to the Equal
15 Protection Clause; it provides guidance and discipline for the legislature, which is entitled to
16 know what sorts of laws it can pass; and it marks the limits of our own authority." The statute
17 must be set aside if it is shown the reasons for the statute are "totally unrelated to the purpose of
18 [its stated] goal." McDonald v. Board of Election Commissioners, 394 U.S. 802, 809. The
19 Court "owe[s] no deference to a statutorily invalid exercise of discretion." National Organization
20 for the Reform of Marijuana Laws v. Drug Enforcement Administration, 559 F.2d 735, 755
21 (D.C. Cir. 1977).
22
23 characterized as a crusade against marijuana led by Harry J. Anslinger, the Commissioner of the Federal Bureau of Narcotics at that time. Anslinger characterized marijuana users as drug-
24 addicted and violent and, importantly, almost exclusively racial minorities, even incorrectly testifying to Congress that a Latino man murdered his entire family due to the influence of the
25 "killer weed," in hearings that later saw the approval of The Marijuana Tax Act. Anslinger infamously said "[r]eefer makes darkies think they're as good as white men.'" In fact, black
26 people are 3.73 times more likely to be arrested for marijuana related crimes than their white counterparts, despite studies which show that white people use marijuana at a higher rate. *See*
27 Nolan Declaration, p. 3 ¶ 2-3; *see also* American Civil Liberties Union report entitled "The War on Marijuana in Black and White," excerpts attached hereto as Exhibit E at 1-23.) Thus, animus
28 in enacting the classification and disparate impact is shown here and strict scrutiny should be applied.

The defense urges this Court to find that as the fundamental right to liberty is implicated in this case the challenged statute must survive a strict scrutiny analysis. Regardless, however, of which standard is applied the evidence will support a finding of unconstitutionality. For the purpose of consistency, the following discussion will address the lesser standard, as it will be apparent that there is no rational basis for the designation of marijuana as a Schedule I Controlled Substance.

B. In Light of the Current Scientific and Medical Research, There Is No Rational Basis for Treating Marijuana as a Controlled Substance.

A law is subject to Equal Protection challenge as overinclusive where one item is placed within a prohibited class without rational distinction. United States v. Carolene Prods. Co., 304 U.S. 144, 153-154 (1938).

> The constitutionality of a statute, valid on its face, may be assailed by proof of facts tending to show that the statute as applied to a particular article is without support in reason because the article, although within the (particular) class, is so different from others of the class as to be without the reason for the prohibition.

Id.; see also Bell*, supra*, 488 F. Supp. 123, 138.

An accused may challenge the statutory scheme under the Equal Protection Clause by establishing that the facts which initially supported the inclusion of the challenged provision have ceased to exist. United States v. Carolene Products Co., *supra,* 304 U.S. at 153.

As discussed in detail *infra*, the defense proffers evidence establishing that the scientific studies on the use of cannabis demands a finding that the scheduling of marijuana is overinclusive when viewed in light of the factors enumerated in *21 U.S.C. § 812*, and further that when compared to other substances which are legally distributed in the open market cannabis is proven to be far less harmful, and thus its continued illegalization serves no Government interest.

1. Cannabis Does Not Meet the Requirements for Inclusion as a Schedule I Controlled Substance.

As outlined above, a Schedule I Controlled Substance is defined by statute as meeting all three of the following criteria: (A) the drug or other substance has a high potential for abuse; (B) the drug or other substance has no currently accepted medical use in treatment in the United States, *and* (C) there is a lack of accepted safety for use of the drug or other substance under

medical supervision. *21 U.S.C. § 812(b)(1)*. As discussed below, and presented in the declarations of noted experts Philip A. Denney, M.D., James J. Nolan, III, Ph.D., and Christopher Conrad which are supported by citations to recent medical and sociological studies, marijuana fails to meet any one of these three criteria.

a. The drug or other substance has a high potential for abuse.

In assessing a substances potential for abuse, this Court must evaluate the physiological and psychological impact a drug may have on the individual. In this regard, the salient inquiries are: (1) is the drug physically addictive, and (2) does the drug cause damage to the health of the user. The defense proffers evidence which will establish that the scientific research overwhelming concludes that cannabis, unlike the over-the-counter medications described below, is *not* physically addictive, and causes *no* illness, disease, or organ damage.

i. Acetaminophen (Tylenol)

The commonly-used substance called acetaminophen (name brand: Tylenol) is the leading cause of acute liver failure in the United States. In fact, acetaminophen hepatotoxicity results in more calls to poison control centers than the overdose of any other pharmacological substance. (Denney, Declaration, p. 3 ¶ 7.A.) The National Institutes of Health has found that "Acetaminophen overdose is one of the most common poisonings world wide." (*See* National Institutes of Health website printout, entitled "Acetaminophen Overdose," attached hereto as Exhibit F at 1-3.) In fact, the danger is so great that Johnson and Johnson, makers of Tylenol have recently modified their label in order to reduce the number of accidental acetaminophen overdoses that occur each year. (*See* Cable News Network (CNN) article entitled "New Tylenol cap will have warning label," dated August 30, 2013, attached hereto as Exhibit G.) On August 2, 2013, the U.S. Food and Drug Administration (FDA) released a statement warning that overuse of acetaminophen could cause serious rashes and even death. (*See* FDA website printout, entitled "FDA Warns of Rare Acetaminophen Risk," last updated Nov. 10, 2013, attached hereto as Exhibit H at 1-2.) It has long been noted that acetaminophen use can cause upper gastrointestinal complications such as bleeding, kidney damage, and even increased risk of blood cancer. (*Id.*; *see also* Denney Declaration, p. 3 ¶ 7.A.) Despite the significant harm caused by

1 this substance, it is entirely excluded from the scheduling scheme.

2 ii. Dextromethorphan (Cough Medicine)

3 Dextromethorphan (DXM or DM) is distributed and used as a popular cough syrup,
4 although the substance can result in drowsiness and hallucinations even at recommended doses,
5 as well as euphoria and black outs at high doses. (Denney Declaration, p. 4-5 ¶ 7.B.) The DEA
6 has reported that abuse of DXM for its dissociative effects is gaining popularity and is of
7 "particular concern of use by teenagers and young adults." (Drug Enforcement Administration
8 (DEA), Drug & Chemical Evaluation Sheet for Dextromethorphan, attached as Exhibit I.)[17]
9 Abuse of DXM is exceedingly dangerous when used in conjunction with alcohol or other drugs
10 and can even result in death. *(Id.)* Despite the current medical science which establishes that
11 DXM has a greater potential for abuse than marijuana, DXM is explicitly excluded from the list
12 of controlled substances. *See 21 U.S.C. § 811 (g)(2),* "[d]extromethorphan shall not be deemed
13 to be included in any schedule…"

14 iii. Acetylsalicylic acid (Aspirin)

15 Acetylsalicylic acid, or aspirin, is a nonsteroidal anti-inflammatory drug used for
16 temporary pain relief and fever reduction. At recommended doses, aspirin may cause Dyspepsia,
17 mild to life-threatening gastric blood loss, Reye's Syndrome (a childhood disease related to
18 aspirin use), and significant allergic reactions. (Denney Declaration, p 5 ¶ 7.C.) At toxic doses,
19 the danger of life-threatening gastrointestinal bleeding also increases. *Id.* Toxic doses of aspirin
20 can also cause Salicylism, a condition with symptoms including tinnitus, deafness, nausea,
21 abdominal pain, flushing and fever. *Id.*

22 iv. Ibuprofen

23 Like aspirin, Ibuprofen is a nonsteroidal anti-inflammatory pain reliever and fever
24 reducing over-the-counter medication. Also, like aspirin, Ibuprofen use may be extremely
25 harmful even at recommended doses. Studies show chronic use causes hypertension and possibly
26 myocardial infarction, renal impairment, broncho spasm, and esophageal ulceration. It is

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28 [17] Located online at
http://www.deadiversion.usdoj.gov/drug_chem_info/dextro_m/dextro_m.pdf.

1 important to note that ibuprofen use can actually cause death in limited instances. Further, this
2 substance is often combined with sedatives, such as diphenhydramine, the ingredients in Motrin
3 PM, and therefore, causes drowsiness. (Denney Declaration, p. 5 ¶ 7.D.)

4 v. Cannabis

5 Medical science evidences that marijuana has a notably low potential for abuse.
6 First, there have been *zero* documented deaths caused by an overdose of cannabis, and as
7 noted by Dr. Denney, based on the physiological properties of the plant an overdose would be
8 impossible. (Denney Declaration, p. 6 ftnt 1.) The Therapeutic Index (the number denoting the
9 relationship between a toxic and therapeutic dose of a substance) for marijuana is 1,000 to
10 40,000, as compared to Paracetamol which has an index of between 7.5 and 30. *Id*. p. 5-6 ¶ 9.
11 Since, however, there have been no reported deaths nor life threatening harm caused by the
12 overdose of cannabis, the Therapeutic Index for marijuana is theoretical. Also, because it would
13 be impossible to ingest 1,000 to 40,000 times the therapeutic level within the time required to
14 test its impact, practically the Therapeutic Ratio in the case of marijuana ingestion simply does
15 not exist. *Id.*
16 Second, it has long been established that marijuana is not physically addictive, and there
17 are minimal, if any, withdrawal symptoms associated with the cessation of marijuana use.
18 (Exhibit D; *see also* (Denney Declaration, p. 3 ¶4.)
19 Third, unlike the critical damage to the body's internal organs caused by the over-the-
20 counter medications described above, studies have not only proven cannabis does not cause such
21 damage, but also suggest that in some instances cannabis has a curative effect. (Denney
22 Declaration, p. 8 ¶ ¶ 16-17, and Exhibit N.)
23 Compared to the over-the-counter substances listed above, cannabis has the lowest
24 potential for abuse, as it is impossible to die from an overdose; further, no studies have proven
25 that the use of cannabis causes harms similar to those caused by the use of common over-the-
26 counter medications, even at recommended dosages. (Denney Declaration, pp. 3-6.)
27 The distinction between harms caused by the four over-the-counter medications described
28 above and marijuana is demonstrated in the following table which compares the Therapeutic

1 Index of above OTCs with cannabis:

Substance	Therapeutic Index
Cannabis	< 1,000 - 40,000
Dextromethorphan: (cough meds)	< 10
Acetaminophen	< 3
Aspirin	< 5
Ibuprofen	< 20

Further, an evaluation of cannabis is not complete without comparing it to prescription medications, alcohol and tobacco.

As Dr. Denney observes, the Therapeutic Index for many prescription medications such as psychiatric medications, opiates, cardiac medications, etc., are less than 10. The mortality rate for many prescription medications is significant, and known serious side effects numerous. Dr. Denney concludes that he can think of no prescription medication which has fewer potential harmful effects than cannabis. (Denney Declaration at p.6-7 ¶ 10.)

In addition, the Doctor asserts that tobacco and alcohol are clearly more harmful than cannabis, and this is evident by the number of annual deaths resulting from their use and abuse (i.e., 400,000 - 500,000 excess deaths from tobacco and 100,000 - 200,000 excess deaths from alcohol). (Denney Declaration at p.7 ¶ 11.)

In effect, the facts upon which marijuana was scheduled as one of the most dangerous narcotics in 1970 have been disproven. As the classification was imposed as a temporary measure pending the Commission Report in the first instance, today, particularly when compared to the substances described above, the medical and scientific knowledge support a finding that the classification is irrational, arbitrary and capricious.

b. The drug or other substance has no currently accepted medical use in treatment in the United States.

The second requirement for placement in Schedule I is that the substance has no currently accepted medical use in treatment in the United States. *21 U.S.C. § 811*. The DEA's insistence

1 that despite the science, cannabis has no accepted medical use evidences the Agency's refusal to
2 rationally evaluate the wisdom of this classification. Twenty-five years ago this assertion was
3 squarely challenged by Administrative Law Judge Francis Young who observed: "Marijuana, in
4 its natural form, is one of the safest therapeutically active substances known to man."[18] And
5 since this judicial determination, studies have proven this observation to be accurate. While the
6 DEA persists in thwarting all efforts to intelligently assess the medical benefits of this benign
7 substance, under the Agency's own standard of review, their position is not only irrational it is
8 unfathomable.

9 To assess whether marijuana has a medical use, the DEA applies a five-part test: "(1) the
10 drug's chemistry must be known and reproducible; (2) there must be adequate safety studies; (3)
11 there must be adequate and well-controlled studies proving efficacy; (4) the drug must be
12 accepted by qualified experts, and (5) the scientific evidence must be widely available." Alliance
13 for Cannabis Therapeutics v. DEA, *supra*, 15 F.3d at 1135; Americans for Safe Access [ASA] v.
14 DEA, *supra*, 706 F.3d at 450-452."[19]

15 As indicated below, and as will be established through expert testimony at the hearing on
16 the motion, the only rational conclusion based on the scientific studies is that marijuana
17 surpasses the DEA's criteria for establishing an accepted medical use in the United States.

18 i. Marijuana's chemistry is known and reproducible.

19

20 [18] In the Matter of Marijuana Rescheduling Petition, Docket 86-22,, Docket No. 86-22 (1988), on appeal from DEA denial of petition to reschedule marijuana that was filed in 1972, just over a year after the Controlled Substance Act went into effect.

21

22 [19] The DEA recently asserted that the fourth factor, whether "adequate and well controlled studies proving efficacy" is only satisfied by approval by the Food and Drug
23 Administration (FDA) via its New Drug Application (NDA) process, as opposed to the hundreds upon hundreds of "peer reviewed" medical and scientific studies agreeing marijuana is generally
24 accepted by the medical community in the United States as having an accepted medical use to treat and even prevent cancer. Americans for Safe Access [ASA] v. DEA, *supra*, 706 F.3d at
25 452, cert. denied. However, several courts have held just the opposite on the same issue. In the D.C. Circuit, as well as in the 1st and 11th Circuits, the Justices held that the lack of FDA
26 approval does not negate "the possibility that the substance in question has an accepted medical use. *See* Grinspoon v. DEA, 828 F.2d 881, 890-891 (1st Cir. 1987), holding this "accepted
27 medical use" factor is *not* coextensive with approval by the Food and Drug Administration (FDA), cited approvingly to United States v. Franz, 818 F. Supp. 1478 (11th Cir. 1993) and John
28 Doe, Inc. v. DEA, 484 F.3d 561, (D.C. Cir. 2007), "the absence of FDA marketing approval may not be a reasonable proxy for a lack of currently accepted medical use."

1 Scientists have identified over 480 natural components found in the Cannabis sativa
2 plant, and have classified 66 as "cannabinoids" which have further been broken down into six
3 subclasses. (Conrad Declaration, p. 2 ¶ 1.) Like most plants, reproduction can be as simple as
4 planting seeds or taking cuttings from a mother, and placing them in the soil (a process known as
5 cloning). In addition, each cannabinoid can, and has been isolated to allow an examination of
6 each component. In fact, cannabis is possibly the most studied plant in history. *Id*.
7 Delta-9-tetrahyrocannabinol (THC), the only component known to have a psychoactive
8 effect, has already been synthetically reproduced in the prescription drug Marinol. *(Id.; see also*
9 Denney Declaration, p. 9-10 ¶ 23.) Ironically, it has been established that cannabinoids, other
10 than THC, particularly Cannabidiol (CBD) are most effective in treating diseases such as seizure
11 disorders. (*Id*,) Yet, these have not been even synthetically made available. In the highly
12 publicized case of six-year old Charlotte, a Colorado child who suffers from Dravet Syndrome,
13 the physicians found her life-threatening seizure disorder could be treated and managed using a
14 high CBD and low THC strain of the cannabis plant. (*See* CNN article entitled "Marijuana stops
15 child's severe seizures," dated August 7, 2013, attached hereto as Exhibit J at 1-5.) Despite the
16 small market for marijuana with a low THC level, growers in the region in which Charlotte lives
17 have been able to develop a strain which works particularly well for this child and, according to
18 her physicians and parents, have saved Charlotte's life. *Id.*
19 Following the publicity surrounding the successful treatment of Charlotte, families with
20 children suffering from seizure disorders have been relocating to Colorado in order to seek
21 cannabis treatment. (*See* Exhibit K at 1-4, Salt Lake City Tribune article entitled "Families
22 Migrating to Colorado for a Medical Marijuana Miracle," dated Nov. 11, 2013, and Denney
23 Declaration, p. 10 ¶ 25.) Margaret Gedde, M.D., a Colorado Springs physician, has been
24 monitoring 11 children using cannabis to treat their severe seizures. She reports nine of these
25 children have had a 90-100% reduction in their seizures, one has had a 50% reduction, and one
26 has reported no change. (*Id*.) Yet, as one more demonstration of irrationality, an inquiry
27 regarding the federal classification of CBD, a non-psychoactive, medically useful compound,
28 received the following reply on July 29, 2013, from Lisa Kubaska, speaking on behalf of the

Center for Drug Evaluation and Research within the FDA: "CBD meets the definition of Schedule I under the Controlled Substances Act. The DEA is the regulatory agency." (*See* Kubaska Email, dated July 29, 2013, entitled "FW: CBD legal status - CDER Response 7/29/2013," attached as Exhibit L.)

In sum, despite its status as a Schedule I Controlled Substance, the chemistry of the marijuana plant is clearly known and understood by the scientific community, and the reproducibility of the plant is evident.

ii. There are adequate safety studies on marijuana.

In addition to the studies performed by the Commission, discussed above, the federal government has been involved in other known research projects testing the safety of cannabis.

In fact, the government has cultivated and distributed marijuana for over 35 years through the Compassionate Investigational New Drug Program (IND), which authorizes marijuana to be grown at the University of Mississippi and sent to enrolled patients in the form of marijuana cigarettes. (Conrad Declaration, p. 2 ¶ 2.) The IND program was established in 1978, in response to the presentation of a successful medical necessity defense by a man afflicted with glaucoma, Robert Randall. United States v. Randall, 104 Wash. D.L.Rep. 2249 (D.C. Super. Ct. 1976).[20] Due to the growing number of people entering the program resulting from the AIDS epidemic it was closed to new patients in 1992. It is believed that up to 35 participants were accepted at the program's peak, and the government continues to distribute 300 marijuana cigarettes each month to the four remaining patients. (Conrad Declaration, p. 2 ¶ 2.)

Through the life of the program there have been *no* reports of ill effects suffered by the patients caused by the use of cannabis, rather all available information suggests cannabis as medicine is a remarkable success. While "results" of this study have never been publicized, the remaining patients have become stalwart advocates for the medical use of cannabis. For example, George McMahon wrote a book in 2003, and has been on a national tour since 1997

[20] In finding a medical necessity existed, the trial court remarked "[m]edical evidence suggests that the prohibition [against marijuana] is not well founded." United States v. Randall, 104 Wash. D.L.Rep. 2249 (D.C. Super. Ct. 1976); *see* opinion, attached as Exhibit M at 1-4.

speaking about how cannabis has relieved the pain, spasms and nausea caused by a rare genetic disease called Nail Patelia Syndrome. Prior to his cannabis treatment he had 19 major surgeries, been declared clinically dead five times and was taking 17 different pharmaceutical medications, some of which caused severe side effects resulting in his hospitalization. Mr. McMahon reports that since he was accepted into the IND program in 1990, he smokes 10 marijuana cigarettes daily, and has had *no* surgeries, *no* hospitalizations, and has discontinued the use of *all* pharmaceutical medications. (George McMahon and Christopher Largen, 2003, *Prescription Pot: A Leading Advocate's Heroic Battle to Legalize Marijuana*, New Horizon Press,[21] *see also*, Conrad Declaration p. 3 ¶ 4.

Also, the National Institute of Health's National Institute on Drug Abuse (NIDA) funded a project performed at the University of California at Los Angeles by Donald Tashkin, M.D.[22] The purpose of which was to study the potential harm caused by smoking marijuana. It was one of the largest studies sponsored by the government and included a population of 2,240 people. While the belief going into the research project was that smoked cannabis would cause health problems similar to smoked tobacco, the results presented a very different picture. Not only did they find *no* link between smoking marijuana and an increased risk of lung and upper airway cancer, the evidence suggested there was a decrease in the risk of cancer to those who smoked only marijuana. (Exhibit N and Denney Declaration, p. 8 ¶ 16.) Research suggests that this conclusion is supported by observations of marijuana enhancing apoptosis (i.e., THC's ability to enhance the demise of aging cells some of which may turn cancerous.) *Id* ¶ 17. Accordingly, rather than proving marijuana was unsafe, Dr. Tashkin's work proved it to be possibly beneficial in preventing cancer.

In sum, federally sponsored studies are available and conclude that cannabis is a non-toxic, non-lethal and natural substance, the use of which has never been known to cause death,

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[21] *See also* Irvin Rosenfeld (2010). *My Medicine*, Open Archive Press, written by another of the surviving IND program patients.

[22] Abstract of Tashkin study attached hereto as Exhibit N, also located online at http://www.ncbi.nlm.nih.gov/pubmed/16128224.

1 serious health risks, nor chronic disease. Unfortunately, the same cannot be said for the over-the-
2 counter medicines discussed above. (Denney Declaration, p.3-5 ¶ 7.)

3 iii. Adequate and well-controlled studies prove marijuana's efficacy.

4 As outlined in the Declaration of Dr. Denney, an extensive body of scientific research has
5 been conducted over the past 15 years, and the results are consistent and indisputable: not only
6 does marijuana treat symptoms such as pain, but several studies suggest THC may actually
7 inhibit cancer by enhancing apoptosis, where abnormal cells die rather than continue to multiply,
8 and by inhibiting angiogenesis, the formation of new blood vessels. (Denney Declaration, p. 8 ¶
9 17.)[23]

10 A significant number of studies evidencing the medical benefits of cannabis have been
11 published in the United States and around the world. Much of the research has been conducted
12 using a large control group of a thousand or more patients. Over 225 such studies, listed in the
13 the Addendum to the Declaration of Dr. Denney, conclude that cannabis can be used to treat:
14 Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Pain, Diabetes Mellitus,
15 Dystonia, Fibromyalgia, Gastrointestinal Disorders, Gliomas/Cancer, Hepatitis C, HIV,
16 Huntington's Disease, Hypertension, Incontinence, Methicillin-resistant Staphyloccus aureus
17 (MRSA), Multiple Sclerosis, Osteoporosis, Pruritis, Rheumatoid Arthritis, Sleep Apnea, and
18 Tourette's Syndrome.

19 It should also be noted that Marinol, which is a synthetic form of THC, has been
20 approved by the FDA for treatment of wasting syndrome associated with cancer and AIDS, as
21 well as anorexia. Patients report, however, that the use of Marinol is ineffectual because
22 swallowing and keeping down a pill can prove impossible for those using the drug to reduce
23 nausea. (Denney Declaration, p. 9-10 ¶ 23.)

24 A medication proven effective in treating even one of the above described illnesses would
25 be considered sufficient to warrant FDA approval, particularly since none of the studies report

26

27 [23] See also, *Cannabinoids reduce ErbB2-driven breast cancer progression through Akt inhibition*, Molecular Cancer, 2010, http://www.molecular-cancer.com, Study out of the
28 University of Madrid found cannabinoids THC and JWH-133, reduce tumor growth, tumor number and the amount/severity of lung metastases in MMTV-neu mice.

serious adverse side-effects caused by taking cannabis. Yet, despite both the results of the government and non-government sponsored research studies, marijuana and *natural* THC have remained on the list of the most dangerous controlled substances.

iv. Marijuana is accepted by qualified experts.

A recent study conducted by the *New England Journal of Medicine*, found that the majority of clinicians polled favor the use of marijuana for medicinal purposes, with votes in favor of cannabis' use as medicine tallying at 76%.[24] As the benefits and risks of marijuana is largely a medical issue, these clinicians are the relevant qualified experts. Also, as marijuana is a legal medication in 21 of our 50 states, and in those states physicians are recommending its use to hundreds of thousands of patients, it must be inferred that the medical community has not only accepted, but embraced the use of cannabis as medicine. Numerous medical associations have called either for legalization of cannabis as medicine, or at minimum further study in specified areas, such as pain treatment. These include the American Medical Association, the American Cancer Society, American Academy of Family Physicians, American Medical Student Association, American Nurses Association, American Preventive Medical Association, American Public Health Association, American Society of Addiction Medicine and various associations for the following states: Alaska, California, Colorado, Connecticut, Florida, Hawaii, Illinois, Missiippi, New Jersey, New Mexico, New York, North Carolina, Rhode Island, Texas, Vermont, and Wisconsin. (Denney Declaration, p. 7 ¶ 14 and Conrad Declaration, pp 3-4 ¶ 5-6.)

That qualified experts believe cannabis has medicinal benefits is further evidenced by the statement of former Surgeon General Joycelyn Elders, who remarked "the evidence is overwhelming that marijuana can relieve certain types of pain, nausea, vomiting and other symptoms caused by such illnesses as multiple sclerosis, cancer and AIDS – or by the harsh drugs sometimes used to treat them. And it can do so with remarkable safety." (Exhibit P.)

On August 24, 2013, Sanjay Gupta, former contender for Surgeon General, and CNN's

[24] Exhibit O at 1-2, New England Journal of Medicine, May 30, 2013, "Medicinal Use of Marijuana – Polling Results," Jonathan N. Adler, M.D., and James A. Colbert, M.D., located online at http://www.nejm.org/doi/full/10.1056/NEJMclde1305159.

Chief Medical Correspondent, apologetically reversed his opinion regarding the medical use of cannabis in a special news report that aired on CNN entitled, "Weed: Dr. Sanjay Gupta Reports" (hereinafter "the CNN Report").[25] Dr. Gupta, a neurosurgeon and considered an expert on numerous medical issues in the United States, ultimately found:

> [The DEA] didn't have the science to support that claim [that marijuana did not have an accepted medical use or high potential for abuse], and I now know that when it comes to marijuana neither of those things are true. It doesn't have a high potential for abuse, and there are very legitimate medical applications. In fact, sometimes *marijuana is the only thing that works*.

Indeed, the number of qualified experts who believe cannabis has a medical benefit is vast and expanding, as evidenced by the statistics noted above and the positions taken by this nation's leading physicians.

v. The scientific evidence is widely available.

Scientific evidence regarding marijuana is widely available and is often disseminated online through publications by first party sources, such as the New England Journal of Medicine, the National Center for Biotechnology Information (NCBI), and other publications respected and utilized by physicians. In addition to the published research papers, medical journals and newsletters often include reporting on marijuana-related research. For example, a recent edition of the Family Practice News, a leading news publication relied upon by family physicians, covered marijuana's medical benefits for pain as its top story. (Denney Declaration, p. 7-8 ¶ 15.) Interestingly, this publication contained not one, but *two*, articles concerning marijuana's medical efficacy in various contexts, further evidencing that the medical and scientific information about marijuana is widely available. *Id.*

The abundance of information on the medical benefits of cannabis available to the medical community is astounding when considered in light of the DEA's repeated refusal to

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[25] CNN PressRoom report located online at http://cnnpressroom.blogs.cnn.com/2013/08/13/weed-dr-sanjay-gupta-reports.

grant approval for research into the topic.[26] Because it is necessary to use marijuana in these studies, the Agency is in control of and obstructs their progress by withholding immunity for the possession of cannabis. Yet, despite these efforts, the research goes on, and with each finding the DEA's position becomes more unacceptable.

vi. Additional factors for consideration

The irrationality of the scheduling is further evidenced by the opinion of the American people, as polling taken by the PEW Research Center just this year indicates that 77% of Americans believe marijuana has a legitimate medical use, including 60% of those age 65 and over.[27] Also, a Gallup Poll published on October 22, 2013, reported that 58% of Americans support the legalization of marijuana for all purposes, compared to 39% opposed.[28]

Although public opinion is not a factor articulated in *21 U.S.C. § 812(b)*, it is relevant to the analysis when assessing whether the DEA's continued insistence that marijuana is a Schedule I Controlled Substance is arbitrary, particularly since the spirit of separation of powers requires

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[26] Although federal research projects are expressly authorized by the CSA, the completion of very large studies sufficient to satiate the DEA are nearly impossible to conduct in the U.S. This is so because the federal government itself denies approval to researchers seeking to test the efficacy of cannabis as medicine. *See 21 U.S.C. § 823(f);* Raich, *supra*, 545 U.S. at 14; *See also* Craker v. DEA, 714 F.3d 17 (1st Cir. 2013). Without approval, the act of cultivating, possessing and distributing the cannabis needed to perform research on the scale required by the FDA would equate to a violation of federal criminal law. Many leading researchers from various facilities around the nation have repeatedly petitioned the federal government for permission to grow marijuana for research purposes; these requests are repeatedly denied. *See generally* Craker, *supra*, 714 F.3d 17; *also see* Denney Declaration, p. 8 ftnt 2. Although the National Institute on Drug Abuse (NIDA) cultivates marijuana for research at the University of Mississippi, it is currently the "only entity registered by the DEA to manufacture marijuana." Craker, *supra*, 714 F.3d at 20. In Craker, as is common elsewhere regarding marijuana, the DEA Administrator ignored the finding of the DEA Administrative Law Judge, who held that the Agency should permit Dr. Craker to cultivate cannabis for research purposes.

[27] PEW Research Center Report, entitled "*Majority Now Supports Legalizing Marijuana*," published April 5, 2013, attached herto as Exhibit Q at 1-2 and located online at: http://www.people-press.org/2013/04/04/majority-now-supports-legalizing-marijuana.

[28] Gallup Poll article entitled "For First Time, Americans Favor Legalizing Marijuana," attached hereto as Exhibit R at 1-3, and located online at: http://www.gallup.com/poll/165539/first-time-americans-favor-legalizing-marijuana.aspx

this Court to protect the American people against unreasonable government action.[29]

Thus, this Court is asked to hold in accord with the science as well as the American public for whom the judiciary is entrusted to protect from legislative encroachments, and find that marijuana does indeed have a generally accepted medical use.

c. Accepted safety for use of the drug or other substance under medical supervision.

The third factor which qualifies a drug for Schedule I under *21 U.S.C. § 812 (b)(1)* is a finding that there is a lack of accepted safety for its use under medical supervision. As discussed below, the evidence overwhelmingly defeats such a finding.

The use of cannabis has been recommended and supervised by the medical community since marijuana was first decriminalized for medical use in California in 1996 by a proposition known as the Compassionate Use Act.[30] Since 1996, twenty other states and the District of Columbia have followed suit and legalized or decriminalized the medicinal use of cannabis.[31]

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[29] *See Fed. Rule of Evidence No. 201,* a fact "generally known" is appropriate for judicial notice; *see also U.S. Const*., *prmbl*., in enacting the separation of powers in Article I-III, "[w]e the People of the United States, in Order to … secure the Blessings of Liberty to ourselves and our Posterity."

[30] *California Health & Safety Code § 11362.5*, the enactment of the first successful voter initiative, Cal. Proposition 215, authorizing the cultivation and possession of cannabis by persons with physician recommendations.

[31] Alaska, *Alaska Stat. §§ 11.71.090* (Lexis 2013); Arizona, *Ariz. Rev. Stat. Ann. § 13-3412.01* (Lexis 2013); California, *Cal. Health & Safety Code § § 11362.5, 11362.7 et. seq.* (Lexis 2013); Colorado, *Colo. Const., Art. XVIII, § 14; Colo. Rev. Stat. § 18-18-406.3* (Lexis 2013); Connecticut, *Conn. Gen. Statute Ch. 420f, § 21a-408, et. seq*. (Lexis 2013); District of Columbia, *D.C. Code § 7-1671.01, et, seq*. (Lexis 2013); Delaware, *16 Del. C. § 4901A*, *et. seq*. (Lexis 2013); Hawaii, *Haw. Rev. Stat. §§ 329-121, et. seq*. (Lexis 2013); Illinois, *House Bill 1 (2013), Ill. Public Act 98-0122* (in effect Jan. 1, 2014, as noted online at http://www.ilga.gov/legislation/billstatus.asp?DocNum=01&GAID=12&GA=98&DocTypeID=HB&LegID=68357&SessionID=85); Maine, *Me. Rev. Stat. Ann., Tit. 22, § 2421,* et. seq. (Lexis 2013); Maryland, *Md. Code Ann., Crim. Law §5-601(c)(3)(II)* (Lexis 2013); Massachusetts, *105 C.M.R. 725.000, et. seq* (Lexis 2013); Michigan, *Mich. Comp. Law § 333.26424(j)* (Lexis 2013); Montana, *Mont. Code Anno., § 50-46-301, et. seq*. (Lexis 2013); Nevada, *Nev. Const., Art. 4, § 38; Nev. Rev. Stat. § 453A.010, et. seq*. (Lexis 2013); New Hampshire, *House Bill 573-FN* (July 2013), located online at http://www.gencourt.state.nh.us/legislation/2013/HB0573.html; New Jersey, *N.J. Stat. Ann. §24:6I-3* (Lexis 2013); New Mexico, *N.M. Stat. Ann. § 26-2B et. seq*. (Lexis 2013); Oregon, *Ore. Rev. Stat. §§ 475.300, et. seq*. (Lexis 2013); Rhode Island, *R.I. Gen. Laws § 21-28.6-4* (Lexis 2013); Vermont,. *18 V.S.A. § 4472, et. seq*. (Lexis 2013); Washington, *Wash. Rev. Code §§ 69.51A.005, et. seq.* (medical use) (Lexis 2013); Initiative No. 502 legalized marijuana for social use as of December 6, 2013, full text located online at

1 Not a single lethal overdose of marijuana has been reported by the supervising physicians in any
2 of these states, nor throughout history. Nor has there been any reported detrimental side-effect
3 resulting from its use. (*See* Denney Declaration, p. 9 ¶ ¶ 20-22, Nolan Declaration, p. 3 ¶ ¶ 3-4,
4 and Conrad Declaration p. 4 ¶ 8.)[32] Interestingly, the impact of the legalization of the medical
5 use of cannabis has been to decrease the cost, and therefore, create disincentives for cartels and
6 gang affiliates to operate within the state. (*See* Denney Declaration, p. 9 ¶ 22, Nolan
7 Declaration, p. 4 ¶ 7, and Conrad Declaration, p. 4 ¶ 9.)
8 As discussed *supra*, the federal government's own IND program proves marijuana has
9 been safely used by the participants since its inception some 35 years ago. With four patients
10 still being provided 300 marijuana cigarettes per month, the absence of any evidence showing
11 that the use of marijuana by these patients was unsafe (under the supervision of government-
12 funded physicians) supports a finding that marijuana may indeed be safely administered and
13 supervised under physician care. (Conrad Declaration, p. 2 ¶ ¶ 2-4.)
14 Importantly, the Department of Justice has all but proclaimed that cannabis may be safely
15 distributed. For by issuing the Cole Memorandum, the government has effectively
16 acknowledged that a "strong and effective regulatory and enforcement systems" will be
17 sufficient to protect against criminal prosecution for large scale marijuana distribution. (Exhibit
18 A, at 1-3.) The DOJ memorandum explicitly applies to federal enforcement "concerning
19 marijuana in all states" and noted that the strong regulation of marijuana in those states that have
20 legalized marijuana in some form are less likely to invoke federal concern. *Id.* at pp. 1, 3. Thus,
21 by the federal government's own admission, marijuana may be safely distributed regardless of
22 medical supervision.
23 As both Doctors Denney and Nolan observe, the greatest harm caused by marijuana is a
24
25 http://www.liq.wa.gov/publications/Marijuana/I-502/i502.pdf.

26 [32] It could be argued that other than the period of prohibition starting in 1937, marijuana has been used regardless of medical supervision, and without resulting in any known societal or
27 individual harm. In fact, in the 18th and 19th Century, farmers were legally required to grow marijuana as it was determined to be a necessary product for the American people. *See, inter*
28 *alia*, the website for the Hemp Industries Association, located online at http://www.thehia.org/history.html.

1 direct result of the plant's status as a Schedule I Controlled Substance. For this reason many
2 government officials and law enforcement officers have become vocal supporters of the
3 legalization of marijuana. Law Enforcement Against Prohibition (LEAP) is a group of current
4 and former law enforcement agents who have organized for the purpose of advocating against the
5 prohibition of marijuana and other drugs.[33]

6 King County, Washington, Sheriff John Urquhart testified before the Senate Judiciary
7 Committee on Conflicts between State and Federal Marijuana Laws on September 10, 2013, and
8 noted that marijuana's continued illegality under federal laws created potential danger of armed
9 robberies. (*See*, Testimony of Sheriff John Urquhart before the Senate Judiciary Committee on
10 September 10, 2013, attached as Exhibit S at 1-2.) Sheriff Urquhart urged Congress to change
11 federal laws to allow banks to work with cannabis related business to prevent crime. *Id*.

12 The Sheriff's Office for the County of Mendocino, California, enacted a local ordinance
13 to regulate the cultivation of marijuana in the county;[34] this ordinance was shelved only after the
14 federal government threatened to take action against local government officials. Thereafter,
15 County Board Chairman John McCowen noted this federal intimidation which resulted in the
16 elimination of the county cultivation program meant that cultivation and distribution was "going
17 to go back underground. It's going to become more dangerous."[35]

18 As former Vice Officer and FBI Agent Dr. Nolan concludes:

19 > In sum, it is my opinion that the classification of marijuana as a
> Schedule I Controlled Substance is predicated on the racially
20 > offensive attitudes existing in the 1930s. Based on my extensive
> experience as a law enforcement officer, as well as my research
21 > and training, it is also my opinion that the only harm caused by
> marijuana is the direct result of this classification, a classification
22 > which is nonsensical given that the nature and effect of the

23

24 [33] Law Enforcement Against Prohibition (LEAP) website and further information located online at http://www.leap.cc/.

25 [34] Mendocino County Code Ch. 9.31, Medical Marijuana Cultivation Regulation, located online at http://library.municode.com/index.aspx?clientId=16484.

26

27 [35] National Public Radio story published February 13, 2012, entitled "*Mendocino Snuffing Medical Marijuana Experiment*," and located online at
28 http://www.npr.org/2012/02/13/146826169/mendocino-ending-its-medical-marijuana-experimen t.

1 cannabis plant fail to meet the definition of a Schedule I Controlled Substance.

2 Nolan Declaration, at page 5 ¶ 12.

3 Despite the federal prohibition, state and local governments have over the years
4 developed networks for the safe distribution of medical cannabis, and as evidenced by the above
5 comments the only harm arising from these actions is the direct result of the federal
6 government's refusal to acknowledge the mis-classification of marijuana. Simply stated, it can
7 no longer be asserted that the designation of marijuana in Schedule I is based on any enlightened
8 factual foundation, but rather upon blind adherence to irrational political hyperbole.

9 C. There is No Rational Basis for the Selective State-Based Prosecution Policy.

10 The decision to prosecute may not be "based upon an unjustifiable standard such as …
11 arbitrary classification." Oyler v. Boles, 368 U.S. 448, 456 (1962); United States v. Batchelder,
12 442 U.S. 114, 125 (1979); Wayte v. United States, 470 U.S. 598, 608 (1985). Prosecution based
13 on an arbitrary classification constitutes selective prosecution and may violate the equal
14 protection component of the United States Constitution. Oyler, *supra*, 368 U.S. at 452-456
15 (1962); *see also* United States v. Armstrong, 517 U.S. 456, 463-467 (1996). Selective
16 prosecution claims are evaluated according to ordinary equal protection standards, with the
17 caveat that the compared groups need not be similarly situated in a claim of selective
18 prosecution. Armstrong, 517 U.S. at 465; *see also* Wayte, *supra*, 470 U.S. at 608. The accused
19 must show clear evidence the "federal prosecutorial policy had a discriminatory effect and that it
20 was motivated by a discriminatory purpose." Armstrong, *supra,* 517 U.S. at 466, citing Wayte,
21 *supra*, 470 U.S. at 608. A discriminatory purpose is found where the federal prosecution policy
22 is based on an arbitrary classification. Oyler, *surpa*, 368 U.S. at 452-456; Bordenkircher v.
23 Hayes, 434 U.S. 357 (1977), questioned on unrelated grounds; Armstrong, *supra*, 517 U.S. at
24 464.

25 On August 29, 2013, the Attorney General circulated a Memorandum to all United States
26 Attorneys entitled "Guidance Regarding Marijuana Enforcement," advising that the policy of the
27 Department of Justice will be to forego prosecution of those distributing cannabis in states where
28

it has been made legal for medical and/or recreational use, presupposing "states and local governments that have enacted laws authorizing marijuana-related conduct will implement strong and effective regulatory and enforcement systems." (Exhibit A, at 1-3.)

The instant prosecution is based upon the arbitrary classification, in that it protects those who distribute cannabis in states which allow for the legal distribution of marijuana, while subjecting those in states without such laws to mandatory minimum prison sentences. This selective prosecution policy, adopted by the Attorney General by memorandum on August 29, 2013, purposefully discriminates against individuals who engage in identical conduct without state approval.[36]

While it could be argued that there is a rational basis for allowing the distribution of marijuana if authorized by state law, (i.e., in those states it is anticipated a strong regulatory scheme will ensure that the distribution is overseen by state and local government officials), such a rationale can not be reconciled with the DEA's insistence that marijuana is deserving of its status as a Schedule I Controlled Substance. It is absurd to believe the DOJ would decline to prosecute the Mayor of Washington D.C., if he permitted his constituents to open a lab producing

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[36] Although one need not be similarly situated in order to sustain a selective prosecution claim, those who are burdened and those who are protected by Attorney General's selective prosecution policy are similarly situated in that both are conspiring to distribute marijuana. The *United States Code* defines conspiracy as an agreement by two or more persons to commit a violation of Title 21. *21 U.S.C. § 846.* To prove that defendant is guilty of conspiring to distribute cannabis under *21 U.S.C. § 846*, the government must prove: (1) the existence of agreement between the accused and another person to distribute cannabis, and (2) the accused knowingly and intentionally joined that agreement. United States v. Shabani, 513 U.S. 10, 15-16 (1994); United States v. Corson, 579 F.3d 804, 810 (7th Cir. 2009). No overt act to further the purpose of the agreement is necessary under *21 U.S.C. § 846. Id.*

As detailed in footnote 31, *supra*, currently, twenty-one States and the District of Columbia have enacted legislation legalizing marijuana for medical use two of which authorize its recreational use as well. In some of these states, regulatory schemes have been enacted (or are in the process of being enacted) by state and local authorities for the cultivation and distribution of marijuana, as well as the collection of sales taxes. For examples, see Washington State Liquor Control Board information about the impending implementation of Initiative 502 is located online at (full text) http://www.liq.wa.gov/publications/Marijuana/I-502/i502.pdf and (FAQs) http://lcb.wa.gov/marijuana/faqs_i-502., and California has codified the distribution of marijuana in *Cal. Health & Safety Code §§ 11362.5, 11362.7, et. seq.* and is left largely to the Counties. While the process of regulating, issuing the permits, and collecting taxes in the nonexclusive list of states above, as well the District of Columbia, clearly meets the criteria for proving a conspiracy to distribute cannabis under *21 U.S.C. §§ 841, 846,* marijuana distribution with state approval is protected from federal prosecution.

PCP, and distribute it in the Nation's Capitol, and thereafter launder the proceeds from its sale. Yet, this is precisely what has been allowed in the case of marijuana.[37] If marijuana is actually such a dangerous drug, the rational response by the Department of Justice would be to *increase*, not decrease, prosecution in those states which permit its distribution. In effect, the action taken by the Department of Justice is either irrational, or more likely proves the assertions made in Part I (B) of this Memorandum: marijuana does not fit the criteria of a Schedule I Controlled Substance.

V. THE PRESENT PROSECUTION VIOLATES THE PRINCIPLE OF EQUAL SOVEREIGNTY.

Our system of government is founded upon the doctrine of federalism, whereby, under the Tenth Amendment, the States retain all powers not specifically granted to the Federal Government. *U.S. Const. Art. IV, cl. 2; Amend. X*; Shelby County (Alabama) v. Holder, __ U.S.__, 133 S.Ct. 2612, 2623 (2013), and Pollard v. Hagan, 44 U.S. 212 (1845). Federalism preserves the sovereignty, integrity and dignity of each state by "secur[ing] to citizens the liberties that derive from the diffusion of sovereign power." *U.S. Const. Amend. X; see also* Bond v. United States, __ U.S.__, 131 S.Ct. 2355, 2364-2365 (2011). Under the doctrine of federalism, each of the States is considered equal in power and authority; a concept called equal sovereignty. United States v. Louisiana, 363 U.S. 1, 16 (1960).

Equal sovereignty is designed to protect both the States and individuals from arbitrary assertions of federal governmental power, and thereby requires that federal laws be applied evenly among the several States. Bond, *supra*, 131 S.Ct. at 2364 - 2365.

In the recent Supreme Court decision Shelby County v. Holder, *supra*, 133 S.Ct. 2612, the High Court insisted on a strict application of the doctrine of equal sovereignty when striking down a portion of the Voting Rights Act of 1965 (hereinafter "the Act"). The Court found the Act's imposition upon equal sovereignty had previously been Constitutionally permissible only

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[37] In the District of Columbia, the local government legalized marijuana for medical use in 2010. *See D.C.M.R. §§ 22-C, et, seq*., authorizing and regulating medical cannabis dispensaries in the District of Columbia. *See also U.S. Const., Art. I, § 8; see also D.C. Code § 1-201, §§ 601, 602 (c)(1)*, Congress retains exclusive jurisdiction over D.C. in "all Cases whatsoever."

because it "employed extraordinary measures to address an extraordinary problem." Shelby County, *supra,* 133 S.Ct. at 2624. Further, discriminating treatment among the States requires a showing that a law's "disparate geographic coverage must be sufficiently related to the problem that it targets." *Id.*; *see also* South Carolina v. Katzenbach, 383 U.S. 301, 328-329 (1966). Moreover, a law that is neutral on its face may violate the Constitution where the government applies the law in a discriminatory manner. Yick Wo v. Hopkins, 118 U.S. 356 (1886); Gomillion v. Lightfoot, 364 U.S. 339 (1960).

Importantly, to survive a Constitutional challenge, the government must show the *current* burdens of the disparate treatment are justified by *current* needs. Shelby County, *supra*, at 2627, citing Northwest Austin (Municipal Utility District No. One) v. Holder, 557 U.S. 193, 203 (2009). It is mandatory that any imposition upon the equal sovereignty of the States be limited to remedy present-day "*local* evils." Katzenbach, *supra,* 383 U.S. at 328-329.

In effect, the Supreme Court has articulated a standard for evaluating the constitutionality of a federal statute's disparate geographic application which requires the current burdens of the disparate treatment be justified by current needs, and the imposition on the equal sovereignty is limited to remedy present-day "local evils." Further, the Court reviewed the issue of an imposition upon the sovereignty of the States strictly as an "extraordinary measure" that should only be applied to remedy an "extraordinary problem." Shelby County, *supra,* 133 S.Ct. at 2624.

By this motion, the defense asks this Court to find that under the policy expressed in the Cole Memorandum, continued enforcement of *21 U.S.C. §§ 812, Schedule I(c)(10)* and *(17)* violates the doctrine of Equal Sovereignty.

As discussed throughout this brief, when faced with the expanding state laws legalizing marijuana for both medical and recreational use, Attorney General Eric Holder determined that the policy of his office would be to decline prosecution in those states where individuals were distributing cannabis in a manner consistent with their state's regulatory scheme. In effect, this decision imposes upon the equal sovereignty by subjecting the states to disparate application of

the challenged law.[38] As discussed below, the current burden of the disparate treatment is not justified by a current need, nor limited to remedying a present-day "local evil, nor is this federal action designed to address an extraordinary problem.

A. The Current Burdens of the Disparate Treatment Are Not Justified by Current Needs.

In striking *Sections 4* and *5* of the *Voting Rights Act*, the Supreme Court looked to the *current* state of the evidence regarding the evils these sections were designed to address. Concluding that such evils no longer existed, the Court wrote, "[t]here is no denying, however, that the conditions that originally justified these measures no longer characterize" the problem the law originally sought to cure." *Id.* at 2618. Indeed, the Court placed much reliance on the fact that the *Sections 4* and *5* of the *Voting Rights Act* were enacted as *temporary* provisions. Shelby County, *supra*, 133 S.Ct. at 2620, emphasis added; *see also* Northwest Austin, *supra*, 557 U. S. at 199. Yet, held the Court, when renewing the provisions in 2006, Congress did not look to the present day conditions but "instead reenacted a formula based on 40-year-old facts having no logical relation to the present day." Shelby County, *supra*, 133 S.Ct. at 2629. Originally "stringent" and "potent" when enacted in 1965, the challenged legislation was no longer supported by a showing that the "disparate geographic coverage [was] sufficiently related to the problem that it target[ed]"; therefore, the Court struck *Sections 4* and *5* as being violative of our federalist system of governance. *Id*. at 2512.

The similarities between the issues addressed in Shelby County and those in the instant matter are remarkable. Here too, the scheduling of marijuana in *21 U.S.C. § 812* was intended to be a temporary measure. Also, and as in Shelby County, "the conditions that justified these measures no longer characterize" the current state of the medical and scientific evidence

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[38] A law may violate Constitutional principles as applied to a particular group. *See* Yick Wo v. Hopkins, 118 U.S. 356 (1886), "[t]hough the law itself be fair on its face and impartial in appearance, yet, if it is applied and administered by public authority with an evil eye and an unequal hand, so as practically to make unjust and illegal discriminations between persons in similar circumstances, material to their rights, the denial of equal justice is still within the prohibition of the Constitution;" *see also* Gomillion v. Lightfoot, 364 U.S. 339, 347-348 (1960), "[a]cts generally lawful may become unlawful when done to accomplish an unlawful end … and a constitutional power cannot be used by way of condition to attain an unconstitutional result."

regarding the dangers of cannabis.[39]

As articulated in Parts I(B) and (C) of this brief, the Declarations of Philip A. Denney, M.D., James J. Nolan III, Ph.D., and Christopher Conrad, and as will further be established at the hearing on this motion, the "40-year-old facts" as to the danger of marijuana use have "no logical relation" to the state of the evidence today. Accordingly, the current needs sought to be abated by the scheduling of marijuana, (i.e., the claimed dangers of marijuana use), are simply unjustified by the prosecution policy articulated in the Cole Memorandum, which imposes upon the Equal Sovereignty of the States.

B. The Disparate Geographic Coverage of the DOJ's State-Based Policy Is Not Limited to Remedying an Extraordinary Problem.

The disparate geographic application of *21 U.S.C. § 812* relating to marijuana fails to address any problem caused by marijuana's status as a dangerous substance, much less an "extraordinary problem." Again the Shelby County case is instructive; the Supreme Court remarked that the discriminatory application of the Voting Rights Act was an "exceptional measure" that had previously been determined to be Constitutionally permissible because it was designed to address "an extraordinary problem," and here this Court should apply the same strict standard of review. Shelby County, *supra,* 133 S.Ct. at 2624.

The harm caused by marijuana related crime can hardly be characterized as extraordinary, when as the Cole Memorandum demonstrates, the Department of Justice has concluded that large scale marijuana distribution will be permitted. Indeed, if cannabis is truly a dangerous substance that should be abated via the CSA, then no rationale can exist justifying the disparate treatment among the States. In fact, rationality would mandate that the Department of Justice *increase* prosecutions in those states where this "harmful" narcotic is being distributed with the assistance of government officials. It simply makes no sense to assert that the disparate treatment is justified to remedy a local evil (presumably marijuana) when the harshest treatment is reserved for those localities where its distribution is *not* sanctioned. In effect, the Cole Memorandum, is

[39] It should be noted that even in 1972 Congress' own Commission concluded that the classification of marijuana as a Schedule I Controlled Substance was not factually sound, and it can, therefore, be argued that the scientific research has never supported this designation.

an admission that the classification of cannabis as a Schedule I Controlled Substance is arbitrary and capricious, and therefore must be stricken from *Title 21 U.S.C. § 812.*

C. The Imposition on the Equal Sovereignty Is Not Limited to Remedy Present-day "Local Evils."

Where the government encroaches on the doctrine of Equal Sovereignty it must do so as a remedy for "an insidious and pervasive evil which had been perpetuated in" the locality burdened by the disparate treatment. South Carolina v. Katzenbach, 383 U. S. 301, 309; Northwest Austin, *supra,* 557 U. S. at 203; Shelby County, *supra*, 133 S.Ct. at 2628.

As demonstrated throughout this brief, as marijuana is the "evil" the challenged statute is intending to protect against, the imposition on equal sovereignty does not prevent its distribution, but rather promotes it. Thus, there is no justification.

Further, the Government can not defend the formula for applying the challenged statute by reverse-engineering the justification, i.e. by coming up with the justification for the disparate treatment post hoc. As the Court in Katzenbach, *supra*, warned if they government were allowed to "identif[y] the jurisdictions to be covered and then [come] up with criteria to describe them …, there need not be any logical relationship between the criteria in the formula and the reason for coverage." *See* Katzenbach, *supra*, 383 U. S., at 329, 330; *see also* Shelby County, *supra*, 133 S.Ct. at 2628. The analysis may not look backwards and must consider "current political conditions." Northwest Austin, *supra*, at 203.

* * *

The government's admittedly disparate treatment cannot be justified by any evil that is both *current* and *local*, lest the government admit that the factors for scheduling controlled substances is arbitrarily and irrationally applied in the case of marijuana, as both cannot be true. Accordingly, like *Sections 4* and *5* of the Voting Rights Act, *21 U.S.C. §§ 812 Schedule I(c)(10)* and *(17)* must be stricken as violative of the Constitution.

VI. CONCLUSION

In furtherance of the rights afforded under the Constitution of the United States, and consistent with the Judicial responsibility to protect the populace from arbitrary and capricious

government action, defendant asks this Court to hold an evidentiary hearing after which it will be apparent that the Indictment against him can not stand.

Dated: November 20, 2013

Respectfully submitted,

/s/ Zenia K. Gilg
ZENIA K. GILG
Attorney for Defendant
BRIAN JUSTIN PICKARD

By: ZENIA K. GILG
HEATHER L. BURKE

ZENIA GILG, SBN 171922
809 Montgomery Street, 2nd Floor
San Francisco CA 94133
Tel 415/394-3800
Fax 415/394-3806
Email: zenia@jacksonsquarelaw.com

Attorney for Defendant
BRIAN PICKARD

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

BRIAN PICKARD, et al.

Defendants.
_______________________________/

No. 2:11-cr-00449-KJM-16

DECLARATION OF PHILIP A. DENNEY, M.D.

I, PHILIP A. DENNEY, M.D. declare as follows:

I am a physician licensed to practice medicine in the State of California since 1977. I attended medical school at the University of Southern California after serving in the United States Navy. Since graduation I have practiced Family, Emergency and Occupational Medicine. I have never been disciplined by the Medical Board, nor have my hospital privileges been revoked, suspended or restricted. I have been involved in the emerging field of cannabis medicine since 1999, and have practiced in Loomis, Redding, Lake Forrest, Oakland and Sacramento, California. I retired from active practice in 2010, but have continued to study the developments in medical cannabis scientific/medical research.

I have qualified to testify as an expert witness regarding the medical use of cannabis in at least 21 counties throughout California, and have also testified before the California Medical Board regarding medicinal cannabis. I am a founding member of the Society of Cannabis

Clinicians. I have been active in the development of policy regarding cannabis as medicine in El Dorado County, and in this regard have been asked to consult with Judges, District Attorneys, and law enforcement officers about the medical use of cannabis. I also testified before the Arkansas State Legislature regarding the implementation of cannabis as medicine laws and policies, and have been consulted by members of the campaign to legalize the medical use of cannabis in the state of Montana.

While cannabis is considered a Schedule I Controlled Substance under the federal law, the overwhelming majority of current medical research contradicts such a classification. A Schedule I "Controlled Substance" is defined in *21 U.S.C. section 812(b)(1)* as follows:

(A) The drug or other substance has a high potential for abuse

(B) The drug or other substance has no currently accepted medical use in treatment in the United States

(C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.

For the reasons provided in this declaration, and those which may be presented at hearing, it is my professional medical opinion that cannabis has a low potential for abuse, is currently accepted and used medically to treat multiple serious medical conditions, and has been safely used under medical supervision for nearly sixteen years in the State of California and elsewhere. Moreover, the safety and medical efficacy of cannabis far exceeds that of many other prescribed and over-the-counter (OTC) medications, in that it is less toxic, and not physically addictive.

Based on my training, experience, and the current medical/scientific research, I have formed the opinion that cannabis fails to meet the criteria for inclusion in Schedule I of the Controlled Substances Act, and if called to testify would provide the following in support of this opinion:

Cannabis and Potential for Abuse

1. In determining whether a substance has a high potential for abuse, a physician assesses both the physical and psychological effect of the drug. It is my opinion that cannabis has minimal potential for physical abuse, and low potential for psychological abuse.

1 2. Cannabis is a non-toxic, non-lethal substance. There have been *no* reported deaths
2 resulting from an overdose of marijuana, and in fact, based on the physiological properties of the
3 plant an overdose would be nearly impossible. Further, cannabis use does not cause harm to any
4 major organs, and recent studies suggest that even chronic marijuana smoking does not cause
5 cancer of the lungs or upper airway.

6 3. Many over-the-counter medications pose inherent health risks, and some are toxic even
7 when used as recommended. As detailed, *infra*, adverse effects and/or overdoses can result in
8 permanent major organ failure and death.

9 4. Unlike many drugs, including some over-the-counter medications, use of cannabis is
10 not physically addictive, and cessation causes minimal physiological symptoms of withdrawal.

11 5. There are no credible studies to support the belief that marijuana causes psychosis. In
12 fact, it has been successfully used to treat psychological disorders such as anxiety, depression, and
13 PTSD.

14 6. The psychological effects of cannabis are similar to those of many OTCs. For instance,
15 relaxation, euphoria, and sedation are frequently reported with use of THC (the psychoactive
16 cannabinoid in marijuana). These same symptoms are common with cough medicines,
17 antihistamines, nausea medication, and many others.

18 7. Credible peer reviewed studies support my opinion that cannabis is not only an
19 effective medicine, but one with fewer and less serious side effects than many medications in
20 common use. Examples discussed in detail herein include:

21 A. Acetaminophen (OTC analgesics Tylenol)

22 B. Dextromethorphan: (OTC cough medications)

23 C. Acetylsalicylic Acid (aspirin)

24 D. Ibuprofen (Advil)

25 A. Acetaminophen: Common Brand Name Tylenol

26 Acetaminophen, is a widely used temporary pain reliever and fever reducer. The
27 substance carries a warning of the potential for severe liver damage even at relatively low doses.
28 For instance, the Physician's Desk Reference (PDR) for Nonprescription Drugs warns that sever

1 liver damage may occur if a patient takes more than 6 650 mg caplets in a 24 hour period, yet the
2 recommended dose for adults is 2 650 mg caplets every 8 hours. Accordingly even small amounts
3 over the recommended dose could cause serious harm.

4 Other side effects of this substance include upper gastrointestinal complications such as
5 stomach bleeding, and kidney damage. There is also some evidence that chronic users of
6 acetaminophen may have a higher risk of developing blood cancer. For even modest users of
7 alcohol, these effects are more pronounced.

8 The FDA issued a warning on August 2, 2013, that this substance could cause a serious
9 skin reaction which could be fatal. Also, a 2010 study suggests that infertility of adults whose
10 mother used acetaminophen while pregnant could be the result of such use.

11 Significantly, acetaminophen hepatotoxicity is the most common cause of acute liver
12 failure in the United States, and results in more calls to poison control centers than the overdose
13 of *any* other pharmacological substance. Even if treated, an overdose can lead to liver failure
14 within days. While the most important toxic effect of acetaminophen is hepatic necrosis leading
15 to liver failure after an overdose, there are also reported cases of renal failure after overdose.

16 B. Dextromethorphan Common brand names: Benylin, Nyquil and Robitussin

17 Dextromethorphan, also referred to as DXM or DM, is used to temporarily relieve cough
18 due to minor throat and bronchial irritation. DM is widely abused as it acts as a dissociative
19 hallucinogen. Even at recommended doses it can cause nausea, drowsiness, dizziness, difficulty
20 breathing, skin rashes, and hallucinations. At higher doses DM can result in hallucinations,
21 dissociation, vomiting, hypotenstion, hypertension, tachycardia, diarrhea, muscle spasms, sedation,
22 euphoria, black outs, and loss of sight.

23 The National Highway Traffic Safety Administration reported scientific findings regarding
24 the effect of various drugs on ones ability to drive in a publication entitled "Drugs and Human
25 Performance Fact Sheet." In this report it is asserted that in large dose, DM can result in a coma,
26 and cause seizures.

27 In addition, DXM can have serious heath consequences when taken at the same time or
28 shortly after taking certain prescription medication used to treat depression, psychiatric conditions,

1 and Parkinson's Disease.

2 Because this product simulates the effects of alcohol, it may be subject to abuse and
3 addiction in the same way, and has resulted in overdose.

4 C. Acetylsalicylic Acid

5 Acetylsalicylic Acid, or aspirin, is a nonsteroidal anti-inflammatory drug used to
6 temporarily relieve minor aches and pains, and to reduce fever. Even recommended doses have
7 been known to cause Dyspepsia and mild to life-threatening gastrointestinal blood loss, and allergic
8 reactions such as hives, shock, facial swelling and asthma. Reye's syndrome, which is a rare but
9 commonly fatal childhood illness, is a known reaction to the use of aspirin. Further, toxic doses
10 of this substance can cause tinnitus, deafness, nausea, abdominal pain, flushing and fever.

11 D. Ibuprofen: Common brand names include Advil and Motrin.

12 Ibuprofen is a nonsteroidal anti-inflammatory used for temporary pain relief and fever
13 reduction. It is common for those taking therapeutic doses to suffer nausea, dyspepsia,
14 gastrointestinal ulcerations and bleeding, raised liver enzymes, diarrhea, constipation, epistaxis,
15 headache, dizziness, rash, salt and fluid retention, and hypertension.

16 Ibuprofen may cause a severe allergic reaction, causing hives, facial swelling, asthma,
17 shock, skin reddening, rash and blisters. Some studies indicate that chronic use of Ibuprofen may
18 cause hypertension and possibly myocardial infarction, renal impairment, broncho spasm, and
19 esophageal ulceration. Significantly, it can also be fatal to some asthmatics.

20 Also, when combined with diphenhydramine, the ingredients in Motrin PM, a patient is
21 warned not to operate a motor vehicle, as it will cause drowsiness.

22 * * *

23 8. Cannabis has not been linked to any of the side-effects associated with the above
24 described OTC medications. Further, no *credible* peer reviewed study has linked cannabis to any
25 organ damage or disease.

26 9. A widely used measure of a drug's harmful effect is the Therapeutic Index, or Ratio.
27 This refers to the relationship between toxic and therapeutic dose, and is calculated by determining
28 the ratio of the dose that produces toxicity (TD50) and dividing it by that which produces a

1 clinically desired or effective response (ED50), in 50% of the population. A low therapeutic index
2 heightens the drug's potential to be lethal. Some over-the-counter medications have a low
3 Therapeutic Index, meaning the difference between the therapeutic and toxic dose is very small.
4 For example, the estimated Therapeutic Index for acetaminophen is less than 3 and may be lower
5 with alcohol use. The Therapeutic Index for apirin is less than 5 and bleeding can occur even with
6 recommended dose. In contrast, the Therapeutic Index for cannabis is estimated to be between
7 1,000 and 40,000.[1]

8 The following table compares the Therapeutic Index of above OTCs with cannabis:

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Substance	**Therapeutic Index**
Cannabis	< 1000 - 40,000
Dextromethorphan: (cough meds)	< 10
Acetaminophen	< 3
Aspirin	< 5
Ibuprofen	< 20

16 10. I have chosen to make the comparison between cannabis and over-the-counter
17 medications to demonstrate the benign nature of the former; however, the obvious should be noted:
18 the potential for abuse associated with prescription medications is far greater than that posed by
19 OTCs, let alone cannabis. A comparison between cannabis and prescription medications
20 demonstrates compelling evidence that the former is safer and can be more effective in treating
21 illnesses. For example the Therapeutic Index for many prescription medications such as psychiatric
22 medications, opiates, cardiac medications, etc., are less than 10. The mortality rate for each of
23 many prescription medications is significant. Furthermore, known side effects of prescription
24 medications are far to numerous to here articulate. I can think of no prescription medication which
25

26 [1] It should be noted that, since there are no reported deaths nor life threatening harm caused by the overdose of marijuana, the Therapeutic Index for cannabis is theoretical. Also,
27 because it would be impossible to ingest 1,000 to 40,000 times the therapeutic dose within the time required to test its impact, practically the Therapeutic Index in the case of marijuana
28 ingestion does not exist.

1 has fewer potential harmful side effects than cannabis.

2 11. Finally, an evaluation of cannabis is not complete without comparing it to alcohol and
3 tobacco. Tobacco being the more toxic substance, and alcohol a close second. The mortality rate
4 associated with use and abuse of these substances is staggering, with 400,000 - 500,000 excess
5 deaths from tobacco and 100,000 - 200,000 excess deaths from alcohol.

6 **Cannabis is Accepted in the Medical Community as a Safe and Effective Medication**

7 12. Since the passage of the medical cannabis laws in states such as California, scientific
8 and anecdotal studies have confirmed that cannabis is a safe and effective medicine for treating
9 many medical conditions.

10 13. Medical practitioners overwhelmingly support the use of cannabis as medicine. A
11 recent study conducted by the *New England Journal of Medicine*, found that the majority of
12 clinicians polled in favor the use of marijuana for medicinal purposes, with votes in favor of
13 cannabis' use as medicine tallying at 76%.

14 14. Numerous associations of physicians have called either for the medical use of
15 cannabis or at minimum for further study in specified areas. These include the American Medical
16 Association, the American Cancer Society, American Academy of Family Physicians, American
17 Medical Student Association, American Nurses Association, American Preventive Medical
18 Association, American Public Health Association, American Society of Addiction Medicine and
19 various associations for the following states: Alaska, California, Colorado, Connecticut, Florida,
20 Hawaii, Illinois, Missiippi, New Jersey, New Mexico, New York, North Carolina, Rhode Island,
21 Texas, Vermont, and Wisconsin.

22 15. Cannabis has also been increasingly recognized as an effective and safe medicine in
23 medical journals. For example, on July 22, 2013 the Journal *Family Practice News* a respected
24 monthly publication utilized by family medicine practitioners throughout the world, featured an
25 article entitled "Evidence-based medical marijuana for MS Symptoms." The article described the
26 findings of Allen C. Bowling, M.D., in which he concluded that randomized trials using marijuana
27 to treat multiple sclerosis patients supported a positive clinical effect in relieving symptoms of this
28 disease, particularly pain, spasticity and sleep disturbances. *Family Practice News*, July 22, 2013.

1 16. Some studies have found that cannabis may even protect against the development of
2 cancer. The National Institutes of Health's National Institute on Drug Abuse [NIDA] funded a
3 project performed at the University of California at Los Angeles by Donald Tashkin, M.D. The
4 purpose of this project was to determine if smoking cannabis increased the risk of cancer similar
5 to smoking tobacco. The researchers concluded, however, that there was *no* link between smoking
6 marijuana and an increased risk of cancer, and in fact the evidence suggested there was a decrease
7 in the risk of cancer to those who smoked both marijuana and tobacco. Also, in 2010, a study led
8 by Dr. Manual Guzman at the University of Madrid found the combined cannabinoids THC, JWH-
9 133 and CB2 reduced tumor growth, tumor number and the amount/severity of lung metastases in
10 MMTV-neu mice.

11 17. Although difficult to prove given the restrictions on performing clinical trials, these
12 results are supported by scientific hypotheses. The evidence suggests that cannabis enhances
13 Apoptosis which is the process by which an abnormal cell self destructs. Because cancer cells are
14 abnormal, but do not self-destruct this enhancing Apoptosis phenomenon could explain the results
15 of the studies conducted by Doctors Tashkin and Guzman which suggest cannabis may protect
16 against the progression of lung disease related to smoking, and perhaps other cancers.

17 18. Even the National Highway Traffic Safety Administration, a Federal agency, has
18 published reports recognizing the medicinal use of cannabis in its Drugs and Human Performance
19 Fact Sheet, which states:

20 > Medical and Recreational Uses: Medicinal: Indicated for the treatment of anorexia
21 > associated with weight loss in patients with AIDS and to treat mild to moderate nausea and vomiting associated with cancer chemotherapy.

22 19. Despite the difficulty researchers have had in obtaining cannabis in order to conduct
23 medical studies, positive results are being reported both in the United States and abroad.[2] I have
24

25 [2] It should be noted that Dr. Tashkin had some difficulty getting his research paper published after his results demonstrated cannabis was not a carcinogenic, and in fact could
26 prevent cancer, despite the fact that it was sponsored by the National Institutes of Health. Also, Donald Abrams, M.D., had difficulty acquiring research grade cannabis for his landmark study
27 dealing with cannabis and AIDS. Additionally, Dr Lyle Craker's attempts to acquire a license to produce research grade cannabis, like the one issued in Mississippi for the NIDA program,
28 have been unsuccessful.

1 listed over 225 such studies in an addendum to this declaration which I hereby incorporate by
2 reference. These studies show remarkable promise in using cannabis to treat the following illnesses,
3 diseases and symptoms: Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Pain,
4 Diabetes Mellitus, Dystonia, Fibromyalgia, Gastrointestinal Disorders, Gliomas/Cancer, Hepatitis
5 C, HIV, Huntington's Disease, Hypertension, Incontinence, Methicillin-resistant Staphyloccus
6 aureus (MRSA), Multiple Sclerosis, Osteoporosis, Pruritis, Rheumatoid Arthritis, Sleep Apnea, and
7 Tourette's Syndrome.

8 **Cannabis can be safely used particularly under medical supervision**

9 20. The federal government has conducted its own medical cannabis program through the
10 National Institutes of Drug Abuse which has been supervising the distribution of marijuana for forty
11 years.

12 21. As a physician practicing in California following the passage of the Compassionate
13 Use Act, I was easily able to monitor my patients use of cannabis as medicine. In fact, because
14 marijuana has minimal toxicity and has limited side effects, patients using cannabis are much easier
15 to care for than those taking routine prescribed medications.

16 22. Furthermore, as a founding member of The Society of Cannabis Clinicians as well
17 as through my involvement in other professional organizations, I have had many opportunities to
18 discuss the experiences of my colleagues who agree supervision of cannabis patients pose few
19 medical concerns. In fact, the greatest concern for our medical cannabis patients arises out of the
20 fact that marijuana remains illegal for all purposes under federal law, thereby increasing the price
21 of obtaining their medicine and the risk of cultivating the plant.

22 23. The argument is sometimes made that the risks described above can be avoided since
23 the medicinal benefits of marijuana are available through prescription Marinol - a synthetic form
24 of THC approved by the FDA for the treatment of wasting syndrom associated with cancer and
25 AIDS. Patients, however, report that the use of Marinol is ineffectual because swallowing a pill
26 can prove impossible for those using the drug to reduce nausea. Moreover, Marinol incorporates
27 only the one cannabanoid, ironically the one which produces the most psychoactive effect, yet
28 studies have established that cannabidiol (CBD), a non-psychoactive cannabinoid, is effective in

1 treating many serious illnesses including controlling seizures.

2 24. As is obvious from the studies referenced in my addendum, the therapeutic qualities
3 of the cannabis plant reach far beyond the treatment of anorexia and nausea, and in fact some of the
4 most striking benefits are produced from strains which contain low levels of TCH. As is
5 demonstrated by the recent, and highly publicized case of Charlotte, a six year old child suffering
6 from Dravet Syndrom, whose life-threatening seizure disorder is being successfully treated and
7 managed using a high CBD/low THC strain of the cannabis plant.

8 25. Since the publicity surrounding the successful treatment of Charlotte, families with
9 children suffering from seizure disorders have been relocating to Colorado in order to seek cannabis
10 treatment. Margaret Gedde, M.D., a Colorado Springs physician, has been monitoring 11 children
11 using cannabis to treat their severe seizures. She reports nine of these children have had a 90 to 100
12 percent reduction in their seizures, one has had a 50% reduction, and one has reported no change.

13 26. It is apparent that medical supervision is not only possible, but is occurring in places
14 like Colorado Springs where the community has come together to successfully supervise the
15 administration of cannabis to the most vulnerable of our society: severely compromised young
16 children such as Charlotte. Furthermore, they have done so despite the federal government's
17 treatment of cannabis as a Schedule I Controlled Substance.

18 27. In sum, it is my considered opinion that including marijuana and THC in Schedule
19 I of the Controlled Substances Act is inappropriate for the following reasons:

20 A. Medicinal cannabis is effective for many medical conditions;

21 B. Medicinal cannabis can be used safely, particularly under medical supervision;

22 C. Medicinal cannabis is safer than the use of many other commonly used medications;

23 D. The major harm of cannabis use is its continued illegality.

24 I declare under penalty of perjury that the foregoing is true and correct, except for those
25 matters stated on information and belief, and as to those matters I believe them to be true. This
26 declaration signed on the 19th day of November, 2013, in Pahoa, Hawaii.

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28 */s/ Philip A. Denney, M.D.*
PHILIP A. DENNEY

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DECLARATION OF PHILIP A DENNEY, M.D.
ADDENDUM

I, Philip A. Denney, M.D., provide that the following is an non-exhaustive list of medical and scientific studies regarding the use of cannabis as medicine:

Alzheimer's Disease

1. Ramirez et al. 2005. Prevention of Alzheimer's disease pathology by cannabinoids. The Journal of Neuroscience 25: 1904-1913.

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4. Marchalant et al. 2007. Anti-inflammatory property of the cannabinoid agonist WIN-55212-2 in a rodent model of chronic brain inflammation. Neuroscience 144: 1516-1522.

5. Hampson et al. 1998. Cannabidiol and delta-9-tetrahydrocannabinol are neuroprotective antioxidants. Proceedings of the National Academy of Sciences 95: 8268-8273.

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10. Volicer et al. 1997. Effects of dronabinol on anorexia and disturbed behavior in patients with Alzheimer's disease. International Journal of Geriatric Psychiatry 12: 913-919.

Amyotrophic Lateral Sclerosis (ALS)

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2. Raman et al. 2004. Amyotrophic lateral sclerosis: delayed disease progression in mice by treatment with a cannabinoid. Amyotrophic Lateral Sclerosis & Other Motor Neuron Disorders 5: 33-39.

3. Weydt et al. 2005. Cannabinol delays symptom onset in SOD1 transgenic mice without affecting survival. Amyotrophic Lateral Sclerosis & Other Motor Neuron Disorders 6: 182-184.

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8. Lynch and Campbell. 2011. Cannabinoids for treatment of chronic non-cancer pain; a systematic review of randomized trials. British Journal of Clinical Pharmacology 72: 735-744.

9. Sunil Aggerwal. 2012. Cannabinergic pain medicine: a concise clinical primer and survey of randomized-controlled trial results. The Clinical Journal of Pain [E-pub ahead of print].

10. Comelli et al. 2008. Antihyperalgesic effect of a Cannabis sativa extract in a rat model of neuropathic pain. Phytotherapy Research 22: 1017-1024.

11. Johnson et al. 2009. Multicenter, double-blind, randomized, placebo-controlled, parallel-group study of the efficacy, safety and tolerability of THC: CBD extract in patients with intractable cancer-related pain. Journal of Symptom Management 39: 167-179.

12. Abrams et al. 2011. Cannabiniod-opioid interaction in chronic pain. Clinical Pharmacology & Therapeutics 90: 844-851.

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for the treatment of inflammatory diseases. Journal of Neuroimmunology 166: 3-18.

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Huntington's Disease

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Hypertension

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Incontinence

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Osteoporosis

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3. Blake et al. 2006. Preliminary assessment of the efficacy, tolerability and safety of a cannabis medicine (Sativex) in the treatment of pain caused by rheumatoid arthritis. Rheumatology 45: 50-52.

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6. Sumariwalla et al. 2004. A novel synthetic, nonpsychoactive cannabinoid acid (HU-320) with anti-inflammatory properties in murine collagen-induced arthritis. Arthritis & Rheumatism 50: 985-998.

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Sleep Apnea

1. Carley et al. 2002. Functional role for cannabinoids in respiratory stability during sleep. Sleep 25: 399-400.

2. Murillo-Rodriguez et al. 2003. Anandamide enhances extracellular levels of adenosine and induces sleep: an in vivo microdialysis study. Sleep 26: 943-947.

3. Nicholson et al. 2004. Effect of delta-9-tetrahydrocannabinol and cannabidiol on nocturnal sleep and early-morning behavior in young adults. Journal of Clinical Pharmacology 24: 305-313.

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Tourette's Syndrome

1. Muller-Vahl et al. 1999. Treatment of Tourette's syndrome with delta-9-tetrahydrocannabinol. American Journal of Psychiatry 156: 495.

2. Muller-Vahl et al. 2002. Treatment of Tourette's syndrome with Delta-9-tetrahydrocannabinol (THC): a randomized crossover trial. Pharmacopsychiatry 35: 57-61.

3. Muller-Vahl et al. 2001. Influence of treatment of Tourette syndrome with delta9-tetrahydrocannabinol (delta9-THC) on neuropsychological performance. Pharmacopsychiatry 34: 19-24.

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5. Muller-Vahl et al. 2003. Delta 9-tetrahydrocannabinol (THC) is effective in the treatment of tics in Tourette syndrome: a 6-week randomized trial. Journal of Clinical Psychiatry 64: 459-65.

6. Muller-Vahl et al. 2003. Treatment of Tourette syndrome with delta-9-tetrahydrocannabinol (delta 9-THC): no influence on neuropsychological performance. Neuropsychopharmacology 28: 384-8.

7. Kirsten Muller-Vahl. 2003. Cannabinoids reduce symptoms of Tourette's syndrome. Expert Opinions in Pharmacotherapy 4: 1717-25.

Philip A. Denney, M. D.
5500 Hollow Lane
Greenwood, CA 95635

Phone- 530-333-2162
Facsimile- 530-333-2165
Email- padmd@foothill.net

CURRICULUM VITAE

PERSONAL:

Age 55; Married to Latitia; Three children: Sarah, age 29, Elizabeth, age 27, Camille 19; Height 5'10"; Weight 180 lbs.

BACKGROUND:

Born in Washington, D.C.; raised in Hyattsville, MD. Father – Architect; Mother – Registered Nurse. Eldest of three brothers and four sisters. Roman Catholic primary and high school education with participation in baseball, football and boxing with Hyattsville Boys Club.

MILITARY:

U. S. Navy (1966-1972); Active Duty (1966-1970). Aircraft Emergency Equipmentman Second Class (E5). Antisubmarine Flight Crewman, Atlantic Patrol, 1,000 hours flight time. Sport parachute team member.

EDUCATION:

- Pennsylvania State University (1968)
- Bucks County Community College (1968-1971)
- Ohio University (1970-1972); Honors College (1971)
  - Board of Directors of United Campus Ministry (1971)
  - Psychiatric Technician, Athens State Hospital (1970-1972)
  - Clavine Alkaloid Research (1972)
- University of Southern California School of Medicine (1972-1976)
  - Doctor of Medicine (June 3, 1976)
  - Foothill Free Clinic (1974-1976)
  - CMA Alternate Delegate (1973-1974); CMA Delegate (1974-1975)
  - Consultant Reference Committee "B" CMA (1975)

PROFESSIONAL ACTIVITIES:

- L.A. County – USC Medical Center – Flex "A" rotating internship (1976-1977)
- Auburn Medical Clinic, Auburn, CA – Group general and family medical practice (1977-1978)
- Greenwood Medical Clinic, Greenwood, CA – Solo general and family medical practice (1978-1984)
- Sacramento Emergency Medical Group, Cordova Health Center, Rancho Cordova, CA – Urgent Care/Family practice (1984-1987)
- Med Center Medical Group, Citrus Heights, CA – Facility Medical Director, Urgent Care/Family practice (1987-1989)
- Sierra Pacific Emergency Medical Group, Mercy San Juan Hospital Satellite Facility, Carmichael, CA – Assistant Medical Director/Emergency Services (1989-1994)
- Medical Clinic of Sacramento, Sacramento, CA – Urgent Care (1994-1996)
- Meridian Occupational Medicine Group, Sacramento, CA – Facility Medical Director (1996-1997)
- HealthSouth Medical Clinic, Rocklin, CA – Facility Medical Director (1997-1999)
- Marshall Hospital – Medical Director, Marshall Center for Occupational Health (1999-2000)
- Philip A. Denney, M D – Medical Cannabis Evaluation (2000- Present)
- Medicinal Cannabis Testimony – Alameda, Alpine, Butte, El Dorado, Humboldt, Napa, Nevada, Placer, Riverside, Sacramento, San Bernardino, San Francisco, San Joaquin, Santa Clara, Shasta, Sonoma, Stanislaus, Tehama, Trinity and Tulare Counties
- Guest lecturer- USC School of Medicine- Clinical Uses of Cannabis (2005)
- Testimony Medicinal Cannabis Policy- Arkansas State Legislature (2005)

HOSPITAL PRIVILEGES:

- Auburn Faith Community Hospital – Attending staff in family medicine, pediatrics and obstetrics (1977-1985)
- Sutter General Hospital – Attending staff, family practice (1985-1987)
- Mercy San Juan Hospital – Senior staff, emergency medicine (1989-1994)
- Marshall Hospital-Courtesy staff (1999 to 2000)
- California License G34393; BNDD Number AD 7581045

PROFESSIONAL SOCIETIES:

- Society of Cannabis Clinicians- President (2006 to present)

ZENIA K. GILG, SBN 171922
809 Montgomery Street, 2nd Floor
San Francisco CA 94133
Telephone: 415/394-3800
Facsimile: 415/394-3806

Attorney for Defendant
BRIAN PICKARD

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. BRIAN PICKARD, Defendant. _______________/	No. 2:11-cr-00449-KJM-16 DECLARATION OF JAMES J. NOLAN, III, Ph.D.

I, JAMES J. NOLAN, III, declare as follows:

I am currently employed as Associate Professor at West Virginia University in the Department of Sociology and Anthropology, where I have been a Professor since 2000. My areas of specialization include but are not limited to Policing Procedures and Processes, Organizational Behavior in Criminal Justice Agencies, and Hate Crime. I presently teach or have taught the following courses: Sociological Theory, Criminology, Criminal Justice, Deviant Behavior, Hate Crime, Statistical Methods and Data Analysis (graduate course), Inside Out: Exploring Issues of Crime and Justice Behind West Virginia Prison Walls, Justice Roundtable, and Neighborhood Dynamics and Situational Policing.

I worked for the Federal Bureau of Investigation [FBI] from 1995 until 2000 as Chief of the Crime Analysis, Research and Development Unit in the Criminal Justice Information Services

1 Division. My duties included crime analysis using the National Incident-Based Reporting System
2 [NIBRS], and management of the Nation's criminal justice data for the Uniform Crime Reporting
3 Program [UCR].

4 Prior to my employment with the FBI, I was honored to serve as the Senior Policy Advisor
5 to the Secretary of Public Safety for the State of Delaware, from 1993 through 1995.

6 I served as a Police Officer for the City of Wilmington (Delaware) Department of Police
7 for thirteen years, starting in 1980. In addition to being promoted to Police Sergeant and then to
8 Lieutenant, I was assigned to the Special Investigations Units for drug, organized crime, and vice
9 investigations. I was also assigned to the development and oversight of policing programs,
10 including working as the Program Director for the Department's community policing programs.
11 While working in Drug Investigation and Vice units, I personally participated in the execution of
12 over 400 search warrants and often worked in an undercover capacity investigating narcotics
13 conspiracies and distribution of narcotics, including marijuana.

14 I earned my Ph.D. in Psychoeducational Processes from Temple University in
15 Philadelphia, Pennsylvania. I also earned a Master of Education (M.Ed.) degree from Temple
16 University. I hold both a Masters and Bachelor of Science degree from Wilmington College in
17 Wilmington, Delaware. I have published a book, several book chapters, numerous articles, papers,
18 encyclopedia entries, technical reports and peer-reviewed conference papers on my areas of interest,
19 and have presented papers at many professional meetings. Additionally, I have been involved with
20 more than ten research projects funded by private and government grants as a Principal or Co-
21 Investigator and/or Project Administrator, including a study involving a $3.2 million dollar grant
22 from the National Science Foundation, another $470,000 dollar grant from the U.S. Department of
23 Justice, and many others. A copy of my Curriculum Vitae is attached hereto for further reference.

24 Based on my training and experience as a former Police Officer and Unit Chief in the FBI,
25 as well as my significant sociological and other scientific research, I am attesting to the following
26 facts regarding the criminalization of cannabis under *21 U.S.C. §§ 811 and 812*. If called to testify,
27 I would provide the following information:

28

History of Marijuana Laws

1. I am familiar with the history of drug control policy in the United States, including the inception of the laws criminalizing marijuana. Marijuana was first outlawed in 1937 via The Marijuana Tax Act, an act resulting from what can only be characterized as a crusade against marijuana led by Harry J. Anslinger, the Commissioner of the Federal Bureau of Narcotics at that time. Anslinger characterized marijuana users as drug-addicted and violent and, importantly, almost exclusively racial minorities, even incorrectly testifying to Congress that a Latino man murdered his entire family due to the influence of the "killer weed," in hearings that later saw the approval of The Marijuana Tax Act. Anslinger infamously said "[r]eefer makes darkies think they're as good as white men."

2. African Americans are 3.73 times more likely to be arrested for marijuana related crimes, due to an unofficial and perhaps subconscious law enforcement practice of increased surveillance and investigation of persons of color when compared to their white counterparts. Interestingly, studies show that persons of color and white people use marijuana proportionately.

Harm of Marijuana Laws

3. As a patrol officer, and later an investigating officer in the drug investigation and vice units, I was often required to investigate, interrogate, or otherwise interact with drug abusers and addicts. During that time, I did not observe a single death caused by marijuana, nor am I aware of any deaths caused by marijuana.

4. Additionally, unlike the many times I observed alcohol induced violent behavior, in my role as a law enforcement officer I never encountered a subject become violent due to the consumption of marijuana.

5. I believe marijuana can be safely used and distributed. It is my opinion that this has been done in states where it has been decriminalized if recommended by a physician. Based on my training, experience and research, I have concluded marijuana should be treated no different than numerous other plant based medicines that may be used as part of health care plan, as are other common plant based medicines.

6. The greatest harm posed by marijuana is not from use or the pharmacological composition of the plant, but from its status as an illegal substance, as the prohibition for possessing cannabis far exceeds any purported harm to one's body or the community caused by its use.

7. Marijuana's status as an illegal substance results in its distribution on the black market, rather than through regulated commerce; a situation which can attract drug cartels, gangs, and other violent organizations looking to benefit from the premium paid for the risk of engaging in illegal conduct. In addition, because of this illegality, the transfer of marijuana involves large amounts of cash, which in turn invites and increases the risk of robberies and home invasions. Both these harms would be abated by rescheduling marijuana, not only because people will be able to purchase it with a check or credit card, but also because the price would drop significantly as there would no longer be the price of risk built into the cost.

8. The drug enforcement and policing policies and strategies related to marijuana and drug investigations cause unreasonable harm by destroying the support system for persons arrested with a personal use quantity of cannabis. For example, a person arrested with a small quantity of marijuana may face numerous felonies for their relatively minor conduct, such as felony possession, or conspiracy if they purchased the cannabis with another person, or for "maintaining a place for the sale of illegal drugs" if they were located in a vehicle with the cannabis. Under these circumstances, the criminal consequences of even minor marijuana possession can be severe and devastate the person's life, livelihood, and other concomitant repercussions of a criminal prosecution.

9. In addition, due to the serious consequences of even a minor marijuana conviction, a common police tactic is to encourage an arrestee to become an informant in return for leniency in their case, such as a misdemeanor plea. Faced with the threat of jail time and/or the seizure of their personal property, such as their home and cars, people often inform on others in their own networks, including family members, long-term friends, and others in the local community, forever fracturing many of these relationships. It is sociologically true that healthy relationships, involvement in conventional activities with friends, family, and community, helps people thrive, and therefore, I convinced that this policing strategy, resulting from marijuana's status as an illegal substance, does

1 more harm than good to our communities and to these relationships.

2 10. By criminalizing a substance which is viewed by the majority of Americans as less
3 harmful than tobacco and alcohol, the government undermines the relationship between police
4 officers and those they are charged with protecting. I have witnessed a widespread negative social
5 impact on law-abiding citizens which can be attributed to the use of undercover officers tasked with
6 establishing relationships and befriending persons to whom they later must arrest or otherwise
7 "come clean." This community mistrust of the police is heightened when the undercover work
8 involves the benign, and generally accepted, substance marijuana, resulting in the breakdown of
9 important social ties, and destroying law enforcement's relationship with the very communities they
10 are charged with protecting. Although in some situations, such as when investigating inherently
11 dangerous activity such as terrorism, the benefits of the breakdown in the relationship between
12 community and police may outweigh the burdens created by the danger of the illicit conduct; just
13 the opposite is true with regards to marijuana.

14 11. Marijuana's status as illegal also causes vigilante behavior because disputes regarding
15 marijuana cannot be enforced in courts via contract law or other avenues of justice-seeking
16 available to those distributing lawful substances, such as alcohol. The "drug deal gone bad" is a
17 common theme for narcotics related violence. I have, however, never heard of an "alcohol deal
18 gone bad," as disputes among those who distribute alcohol may be resolved in the courts. As
19 marijuana distributors cannot seek judicial intervention, the likelihood of self-help methods of
20 settling disagreements including violence increases.

21 12. In sum, it is my opinion that the original classification of marijuana as a Schedule
22 I Controlled Substance was predicated on the racially offensive attitudes existing in the 1930s. The
23 Schedule I Controlled Substance classification itself now serves to reproduce societal beliefs about
24 the dangers of marijuana which then affects the dispositions of those in power to change it. Based
25 on my extensive experience as a law enforcement officer, as well as my research and training, it is
26 also my opinion that the only harm caused by marijuana is the direct result of this classification and
the law enforcement practices that rise from it.

27

28

1 I declare under penalty of perjury that the foregoing is true and correct, except for those
2 matters stated on information and belief, and as to those matters I believe them to be true. This
3 declaration signed on the 18th day of November, 2013, in Morgantown, West Virginia.
4 *<u>/s/ James J. Nolan III</u>*
5 JAMES J. NOLAN, III
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James J. Nolan, III

Division of Sociology & Anthropology
West Virginia University
307 Knapp Hall
Morgantown, WV 26506-6326
(304) 293-8582
jim.nolan@mail.wvu.edu

EDUCATION

1997	Ph.D., Temple University, Philadelphia, PA
1991	M.Ed., Temple University, Philadelphia, PA
1989	M.S., Wilmington College, Wilmington, DE
1986	B.S., Wilmington College, Wilmington, DE (Magna Cum Laude)

AREAS OF INTEREST/ SPECIALIZATION

Police Procedures & Processes
Crime Measurement
Organizational Behavior in Criminal Justice Agencies
Social Psychology/ Group Processes
Hate Crime

EMPLOYMENT

2006 - Present
West Virginia University,
Division of Sociology and Anthropology
Associate Professor

2000 - 2006
West Virginia University,
Division of Sociology and Anthropology
Assistant Professor

1995 - 2000
Federal Bureau of Investigation
Criminal Justice Information Services Division
Chief; Crime Analysis, Research & Development Unit

1993 - 1995
State of Delaware
Senior Policy Advisor to Secretary of Public Safety
Public Safety representative to Governor's Family Services Cabinet Council

1980 - 1993
City of Wilmington (Delaware) Department of Police
Patrol Operations - As patrol officer, sergeant, and lieutenant.
Special Investigations - Drug, organized crime, and vice investigations.
Planning and Research - development, oversight, and evaluation of policing programs, such as mobile mini stations, bike patrols, victim services, and several community policing projects.
Administration of Community Policing - Project director for department's Weed & Seed Program and oversight of department's community services division.

PROFESSIONAL EXPERIENCE

1997 - 2000 **West Virginia University**, Morgantown, WV
Department of Sociology and Anthropology
Adjunct Assistant Professor
Courses: Criminology, Juvenile Delinquency

1995 - 2002 **Federal Bureau of Investigation**, Behavioral Sciences Unit, Quantico, VA
Lecturer
Course: Violence in America
Topic: Hate Crime

1996 - 1999 **Temple University**, Philadelphia, PA
College of Education
Lecturer
Course: Intimacy and Control

1991 - 1993 **University of Delaware**, Newark, Delaware
Department of Continuing Education
Instructor, Community Policing Seminar

ACADEMIC AWARDS AND NOMINATIONS

2010 Robert C. Byrd Research Professorship (nominated)

2010 Professor of the Year (nominated & awarded), Carnegie Foundation for the Advancement of Teaching and the Council for Advancement and Support of Education (CASE)

2009 Eberly College of Arts and Sciences Outstanding Teacher (nominated and awarded)

2009 West Virginia University Foundation Outstanding Teacher (nominated and awarded)

BOOKS AND BOOK CHAPTERS

Conti, N., **Nolan, J.** & Molnar, Z. (2011). Global Law Enforcement and the Cosmopolitan Police Response: The Role of Situational Policing in Transnational Crime Prevention—an example from Hungary, in Albrecht, J.F. & Dilip Das (Eds.) *Effective Crime Reduction Strategies: International Perspectives.*New York: CRC Press.

Nolan, J., Conti, N., & Colyer, C. (2011). A Public Safety Process: Sustained Dialogue for Situational Policing, in Van til, J. Lohmann, R. and Ford, D. (eds.) *Sustained Dialogue and Public Deliberation.* Columbia University Press.

Nolan, J., Kirby, J., Althouse, R. (2011). Facilitating Neighborhood Growth: A Common Sense Public Safety Response from the Relational Paradigm. In Van Til, J., Lohmann, R. & Ford, D. (eds.). *Sustained Dialogue and Public Deliberation.* Columbia University Press.

Nolan, J. & Bennett, S. (2011). *Essential Hate Crime Reader*. Cognella: San Diego, CA.

Levin, J. & **Nolan, J**. (2010). *The Violence of Hate: Confronting Racism, Anti Semitism, and Other Forms of Bigotry* (3rd edition). Boston: Person Allyn and Bacon.

McDevitt, J., Levin, J., **Nolan, J**. & Bennett, S. (2010) Hate Crime Offenders: what motivates offenders to commit these acts of violence? In Chakraborti, N. (ed.) (2010) *Hate Crime: Concepts, Policy, Future Directions*, Cullompton: Willan.

Bennett, S., **Nolan, J.**, Conti, N. (2009). Defining and Measuring Hate Crime: A Potpourri of Issues, in Perry, B. and Levin, B. (eds.) *Hate Crime: Understanding and Defining Hate Crime (Volume 1).* Westport, CT: Praeger.

Nolan, J., Bennett, S. & Goldenberg, P. (2009). Hate Crime Investigations, in Perry, B. & Lawrence, F. M. Lawrence (eds.*) Hate Crime: Responding to Hate Crimes (Volume 5).* Westport, CT: Praeger.

Nichols, L.T. and **Nolan, J.**, Colyer, C. (2004). The Lessons of Lincoln: Regulation as Narrative in the S&L Crisis, in S. Trimbath (ed.). *The Savings and Loan Crisis: Lessons from a Regulatory Failure*. New York: Kluwer Academic Publishers.

Nolan, J.. and Akiyama, Y. (2003) .Assessing the Factors that Affect Law Enforcement Participation, in Hate Crime Reporting in Gerstenfeld, P.B. & Diana Grant (Eds.) *Crimes of Hate: Selected Readings* (reprint). Sage Publications.

JOURNAL ARTICLES

Gilliard-Matthews, S., **Nolan, J.**, and Haas, S. (forthcoming 2013). Assessing the Risk of Nonsexual and Sexual Victimization Using Incident-Based Police Reports. *Victims and Offenders*.

Nolan, J., Haas, S., & Napier, J. (2011). Estimating the Impact of Classification Error on the "Statistical Accuracy" of Uniform Crime Reports. *Journal of Quantitative Criminology*.

Nichols, L. T., **Nolan, J.,** & Colyer, C. J. (2008). Scorekeeping versus Storytelling: Representational Practices in the Construction of Hate Crime. *Studies in Symbolic Interaction, (20)*, 361-379.

Cronin, S., McDevitt, J., Farell, A., & **Nolan, J**. (2007). Bias Crime Reporting: Organizational Responses to Ambiguity, Uncertainty, and Infrequency in Eight Police Departments. *American Behavioral Scientist*.

Barnett, C. and **Nolan, J.,** (2005). The Impact of State UCR Policy and Procedures on Hate Crime Reporting. *Criminal Justice Studies*.

Nolan, J., Conti, N., & McDevitt, J. (2005). Situational Policing. *Law Enforcement Bulletin.*

Conti, N. and **Nolan, J.**, (2005). Policing the Platonic Cave: Ethics and Efficacy in Police Training. *Policing & Society*.

Nolan, J. (2004). Establishing the Statistical Relationship Between Population Size and UCR Crime Rate: It's Impact and Implications. *Journal of Criminal Justice*.

Nolan, J., McDevitt, J., Cronin, S., and Farrell, A. (2004). Learning to *See* Hate Crimes: A Framework for Understanding and Clarifying Ambiguities in Bias Crime Classification, *Criminal Justice Studies, 17* (1).

Nolan, J., Conti, N., & McDevitt, J. (2004). Situational Policing: Neighborhood Development and Crime Control. *Policing & Society.*

Nolan, J., and Conti, N. (2005). Police: Vice and Special Units. *Encyclopedia of Criminology*. New York: Routledge.

Mencken, F. C. and **Nolan, J.** (2004). Juveniles, Illicit Drug Activity, and Homicide Against Law Enforcement Officers. *Homicide Studies*.

Nolan, J., Akiyama, Y. and Berhanu, S. (2002). The Hate Crime Statistics Act of 1990: Developing a Method for Measuring the Occurrence of Hate Violence in *American Behavioral Scientist, 46*(1).

Nolan, J. (2002). From Vice Cop to Sociology Prof: A Long Journey to a Familiar Place in *The American Sociologist, 33(2).*

Nolan, J. and Akiyama, Y. (2002). Assessing the Climate for Hate Crime Reporting in Law Enforcement: A Force Field Analysis in *The Justice Professional, 15(2).*

Nolan, J., Akiyama, Y. and Woods, J. (2001). Improving Measures of Crime: Sample Adjustments to Police Crime Data in *Proceedings of Statistics Canada Symposium 2001, Achieving Data Quality in a Statistical Agency: A Methodological Perspective*.

Nolan, J. and Akiyama, Y. (1999) .Assessing the Factors that Affect Law Enforcement Participation in Hate Crime Reporting in the *Journal of Contemporary Criminal Justice (15) 1.*

Akiyama, Y. and **Nolan, J.** (1999). Methods for Understanding and Analyzing NIBRS Data in the *Journal of Quantitative Criminology (15) 2.*

Nolan, J. and Nuttall, J.J. (1993). "The SPARC Task Force: Solving Problems and Restarting Communities." *Law Enforcement Bulletin*, September 1993.

OTHER PUBLICATIONS

Encyclopedia Entries

Nolan, J. (2005). Uniform Crime Reports. *Criminal Justice*. Salem Publishers

Nolan, J. (2005). Police Athletic League. *Criminal Justice*. Salem Publishers

Technical Reports AND Peer-Reviewed Conference Papers

Haas, S., LaValle, C., Turley, E., **Nolan, J.** (2012). Improving State Capacity for Crime Reporting: An Exploratory Analysis of Data Quality and Imputation Methods Using NIBRS Data.

Nolan, J., Jackson, J. K., Latimer, M., Tower, L., and Borres, A. (2012). New Ideas from the ADVANCE Community: using a Dialogical Change Process and Strategic Planning to Diversify Academic Departments. WEPAN Conference (Women in Engineering).

Haas, S. **Nolan, J.** , Turley, E., and Stump, J. (2011). *Assessing the Validity of Hate Crime Reporting*. Charleston, WV: Criminal Justice Statistical Analysis Center.

Nolan, J. (2010). *Threat Assessment at Wilmington University: A Campus Dynamics Approach*. For Wilmington University Public Safety.

Nolan, J. (2006). *A Training Manual for FBI Officials Assigned to the Uniform Crime Reporting Program*. Funded by the U.S. Department of Justice, Federal Bureau of Investigation.

Nolan, J. *Improving Measures of Crime: Statistical Adjustments to Police Crime Data*. Funded by the American Statistical Association and the Bureau of Justice Statistics.

Nolan, J., Mencken, F.C., and McDevitt, J. (2004). NIBRS Hate Crimes 1995-2000: Juvenile Victims and Offenders. Online publication by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) at http://ojjdp.ncjrs.org/ or www.as.wvu.edu/~jnolan/nibrshatecrime.html.

McDevitt, J., Cronin, S., Balboni, J., Farrell, A., **Nolan, J.**, Weiss, J. (2003). Bridging the Information Disconnect in Bias Crime Reporting. Funded by the Bureau of Justice Statistics, U.S. Department of Justice.

Nolan, J. (2003). The Risk of Violent Crime Victimization by Age, Race, and Sex: A Lifetime Perspective. Funded by the National Center for Juvenile Justice.

Nolan, J., Mencken, F. C., and Berhanu, S. (2002). Law Enforcement Officers Killed in the United States Between 1980-1999: An Examination of Cases Involving Juvenile Offenders. Funded by the National Center for Juvenile Justice.

Op/Ed Article

Woods, J. & **Nolan, J.** (April 5, 2012) To protect freedom, U.S. jurists must pardon terror suspects caught by entrapment. *Christian Science Monitor*.

Nolan, J. & Brunswick, M. (December 2010). Combating Crime with Restorative Justice. *News Journal*. Wilmington, DE.

Nolan, J. (2001). Hate Crime Laws Protects All. *The Dominion Post*, Morgantown, WV (Guest

Commentary, March 31, 2001). This same article appeared under different titles in the *Charleston Daily Mail*, Charleston, WV and the *Daily Athenaeum*, Morgantown, WV.

Book Reviews

Nolan, J. (2003). Review of Jack Levin's "The Violence of Hate: Confronting Racism, Anti-Semitism, and Other Forms of Bigotry." In *Criminal Justice Review, 28*(1).

Nolan, J. (1995). Review of James William Gibson's "Warrior Dreams: Violence and Manhood in Post-Vietnam America" in the *Law Enforcement Bulletin*, November.

FUNDED RESEARCH GRANTS AND PROJECT ADMINISTRATION

2010 – 2015 Co investigator – NSF ADVANCE Grant – ($3.2 million)

2010 Co-Investigator – WV Division of Criminal Justice Services – Hate Crime Reporting Study ($5,400.00)

2010 Co- Investigator- ARTS Grant – Interdisciplinary seed grant. Eberly College of Arts & Sciences ($40, 000.00)

2007 – present Principal Investigator, "Neighborhood Dynamics and Situational Policing" research funded by the U.S. Department of Justice, Office of Community Oriented Policing Services (COPS) ($470,000.00)

2004 - 2005 Principal Investigator - "Improving Measures of Crime: Statistical Adjustments to Police Data" research funded by the American Statistical Association and the Bureau of Justice Statistics ($22,000.00)

2003 - 2006 Co-Principal Investigator - "Forensic Science Initiative at West Virginia University" funded by the National Institute of Justice, U.S. Department of Justice ($3,250,125.00)

2002 - 2003 Principal Investigator - "The Number of Times an Average Person is Victimized by Violent Crimes: A Lifetime Perspective" funded by the National Center for Juvenile Justice ($29,000.00).

2001- 2003 Principal Investigator, "A Study of Hate Crimes Involving Juveniles as Victims or Offenders," a research project funded by the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention ($74,000.00).

2001-2003 Consultant - "Bridging the Information Disconnect in Bias Crime Reporting," research funded by the Bureau of Justice Statistics, U.S. Department of Justice (with Jack McDevitt and Jennifer Balboni, Northeastern University, and Joan Weiss, Justice Research and Statistics) ($150,000.00).

2000- 2001 Principal Investigator, "A Study of Juveniles who Murder Law Enforcement Officers," research funded by the National Center for Juvenile Justice ($29,000.00).

1997-2000 Project Manager, FBI Uniform Crime Reporting (UCR) Automation Project

PAPERS PRESENTED AT PROFESSIONAL MEETINGS

2012 New Ideas from the ADVANCE Community: Using a Dialogical Change Process and Strategic Planning to Diversify Academic Departments (with Melissa Latimer, Kasi Jackson, Awilda Borres)

2012 Understanding Hate as a Motivation for Violent Crime. Annual meeting of the American Society of Criminology (with Karen Weiss).

2011 "Situational Policing." Panel presentation at the annual meeting of the Office of Community Oriented Policing, U.S. Department of Justice.

2010 "A Multi-Site Analysis of Systematic Social Observations: Impact of Neighborhood Disorder on Victimization." A paper presented at the annual conference of the American Society of Criminology, San Francisco (with Rachel Stein and Susie Bennett).

2010 "Situational Policing: Findings from a Mutli-Site Study Assessing Police and Neighborhood Psychoemotional Dynamics." A paper presented at the annual conference of the American Society of Criminology, San Francisco (with Susie Bennett and Rachel Stein)

2010 "Impact of Inside Out Class on Efficacy Beliefs of Students." A paper presented at the annual conference of the American Society of Criminology, San Francisco (with Tom Wytiaz)

2009 "Situational Policing: Seeing & Seizing on Neighborhood Dynamics to Reduce Crime and Build Collective Efficacy." A paper presented at the annual conference of the American Society of Criminology (with Susie Bennett and Ellen Rodrigues), Philadelphia.

2009 "Hate Crimes in the United States Pre and Post September 11, 2001." A paper presented at the annual conference of the American Society of Criminology (with Susie Bennett and Ellen Rodrigues), Philadelphia.

2008 "The Nature of Religious Hate Crimes in the United States Pre and Post 9/11" invited paper 13th International Metropolis Conference Mobility, Integration and Development in a Globalised World 27-31 October 2008 Bonn, Germany (with Susie Bennett and Ellen Rodrigues)

2007 "Measures of Neighborhood-Level Psycho Emotional Development: Why Community Policing Efforts Have Failed or Succeed." A paper presented at the annual conference of the American Society of Criminology, Atlanta (with Anthony Delligatti).

2007 "Uses of Narrative in Law Enforcement: Socialization, Legitimation, and Organizational Memory, " A paper presented at the annual conference of the American Society of Criminology, Atlanta (with Larry Nichols)

2007 "Using NIBRS to Estimate the Probability of Violent Crime Victimization Over a Lifetime." A paper presented at the annual conference of the American Society of Criminology, Atlanta.

2006 ""Commitment, Conflict, and Collective Efficacy: Dynamics of a Capstone Sociology Course Inside a West Virginia Prison," a paper presented at the annual conference of the American Society of Criminology, Los Angeles.

2006 "The Progression and Escalation of Hate: A Confirmatory Analysis Using NIBRS Data," a paper presented at the annual conference of the American Society of Criminology, Los Angeles (with Cynthia Barnett-Ryan).

2006 "Expressing Hate Crimes: From Narrative to NIBRS," a paper presented at the annual conference of the American Society of Criminology, Los Angeles (with Corey Colyer and Larry Nichols).

2006 "Situational Policing: Bridging the Gap Between Police and Neighborhood Residents," a paper presented at the annual conference of the American Society of Criminology, Los Angeles (with Jeri Kirby and Norman Conti).

2006 "Community Representation: Who is Speaking for the Community," a paper presented at the annual conference of the American Society of Criminology, Los Angeles (with Ronald Althouse and Jeri Kirby).

2006 "The Algebra of 'Hiding' and 'Creating' Crimes," a paper presented at the annual meeting of the Academy of Criminal Justice Sciences, Baltimore, Maryland (with Yoshio Akiyama)

2006 "Improving Measures of Crime: Statistical Adjustments to Police Crime Data in West Virginia," a paper presented at the annual meeting of the Academy of Criminal Justice Sciences, Baltimore, Maryland

2005 "Understanding the Psychosocial Development of 'Defended' and 'Corporate' Neighborhoods: Implications for Situational Policing" (with Jeri Kirby and Ronald Althouse), a paper presented at the annual meeting of the American Society of Criminology, Toronto.

2005 "The Progression and Escalation of Hate: A Geographic Analysis Using UCR Data" (with Cynthia Barnett-Ryan), a paper presented at the annual meeting of the American Society of Criminology, Toronto.

2005 "Global Security and Defended Localities: The Role of Situational Policing in Transnational Crime" a paper presented at the International Police Symposium (IPES), Prague, Czech Republic (with Norman Conti and Zsolt Molnar)

2004 "Neighborhood Development and Crime: Implications for Situational Policing" a paper presented at the annual meeting of the American Sociological Association (ASA), San Francisco, CA (with Norman Conti)

2004 "Mediated Hate: Constructions of Bias Crime in Official Statistics and Newspaper Narratives" " a paper presented at the annual meeting of the Society for the Study of Social Problems (SSSP), San Francisco, CA (with Lawrence Nichols)

2004 "Framing Hate Crime: Competing Definitions in Official Databases and Mass Media Accounts" " a paper presented at the annual meeting of the American Society of Criminology, Nashville, TN (with Lawrence Nichols)

2004 "A Splinter in Your Mind: Ethics and Efficacy in Police Training" " a paper presented at the annual meeting of the American Society of Criminology, Nashville, TN (with Norman Conti)

2005 "The Risk of Violent Crime Victimization in the State of West Virginia by Race and Sex: A

Lifetime Perspective" " a paper presented at the annual meeting of the American Society of Criminology, Nashville, TN (with Stephen Haas)

2004 "NIBRS Hate Crimes 1995-2000: Juvenile Victims and Offenders" a paper presented at the annual meeting of the American Society of Criminology, Nashville, TN (with Carson Mencken and Jack McDevitt)

2003 "Situational Policing: Neighborhood Development and Crime Control," a paper presented at the annual meeting of the American Society of Criminology, Denver, CO. (with Norman Conti and Jack McDevitt)

2003 "Understanding and Clarifying Ambiguities in Bias Crime Reporting," a paper presented at the annual meeting of the Academy of Criminal Justice Sciences, Boston, MA.

2003 "Neighborhood Development and Crime Control" a paper presented at the annual meeting of the North Central Sociological Association. Cincinnati, OH.

2002 "Improving Measures of Crime: Statistical Adjustments to Police Crime Data" presentation at the National Institute of Justice Annual Conference on Research and Evaluation, Washington, DC.

2002 "Law Enforcement Officers Killed in the Line of Duty: A Comparison of Juvenile and Adult Offenders, a paper presented at the annual conference of the American Society of Criminology, Chicago, IL (with Carson Mencken)

2002 "The Probability of Violent Crime Victimization for *The Average Person*: A Lifetime Perspective" a paper presented at the annual conference of the American Society of Criminology, Chicago, IL (with Yoshio Akiyama)

2002 "Bridging the Information Disconnect in Bias Crime Reporting" Presidential Panel Session at the annual conference of the American Society of Criminology, Chicago, IL (with Jack McDevitt, Jennifer Balboni, and Shea Cronin)

2002 "Understanding Bias Crime Classification: A Quantitative Analysis" a a paper presented at the

annual conference of the American Society of Criminology, Chicago, IL

2001 "Hate Crime in the Media: An Analysis of News Articles Before and After Passage of the Hate Crime Statistics Act," presented at the annual meeting of the North Central Sociological Association (with Norman Conti and Jennifer Hatcher).

2001 "Improving Measures of Crime: Sample Adjustments to Police Crime Data" paper presented at the International Symposium on Methodological Issues-Statistics Canada (with Yoshio Akiyama and James Woods).

2001 "Juvenile Cop Killers" a paper presented at the annual conference of the American Society of Criminology, Atlanta, GA.

2001 "Hate Crime in the News" a paper presented at the annual conference of the American Society of Criminology, Atlanta, GA.

2000 "Measuring Consensus: An Index of Disagreement via Conditional Probability," presented at the annual conference of the American Psychological Association (with Yoshio Akiyama).

2000 "Expanding the Mode of Tobit Analysis," presented at the annual conference of the American Psychological Association, August 2000 (with Yoshio Akiyama and Samuel Berhanu).

1999 "Methodological Issues in the National Hate Crime Data Collection Program," presented at a conference on hate crime measurement sponsored by the School of Criminal Justice, State University of New York (SUNY) at Albany.

1999 "Do Large Jurisdictions Have Higher Crime Rates Than Small Jurisdictions? Developing an Indicator of Covariance Between Crime Rate and Population," presented at the annual conference of the American Society of Criminology (with Yoshio Akiyama).

1999 "The Hate Crime Statistics Act of 1990: Developing a Method for Measuring and Predicting the Occurrence of Hate Violence" presented at a national conference on hate crime co-sponsored by the Society for the Psychological Study of Social Issues and the University of California at Los Angeles (UCLA).

1998 "Unit of Count and Cross Tabulations in the National Incident-Based Reporting System," presented at the annual conference of the American Society of Criminology (with Yoshio Akiyama), Washington, D.C.

1998 "The Status of the National Hate Crime Data Collection Program," presented at the annual conference of the Academy of Criminal Justice Sciences.

1997 "The Utility of NIBRS Data in Assessing White Collar Crime" presented at the Inaugural National Economic Crime Conference, Providence, RI (with Cynthia Barnett).

1997 "Creation of Hate Crime Policies in Law Enforcement Agencies: A Few Considerations" presented at the annual conference of the Association of State Uniform Crime Reporting Programs, Cincinnati, Ohio.

1997 "Law Enforcement Participation in Hate Crime Reporting" panel chair and presentation at the annual conference of the American Society of Criminology, San Diego, CA.

1997 "Crime Rate: Interaction Between Criminality and Prevention," presented at the annual conference of the American Society of Criminology (with Yoshio Akiyama), San Diego, California.

COURSES TAUGHT

<u>West Virginia University</u>

2011 – present	Sociological Theory SOCA 522
1997 - 2002	Criminology, SOCA 232
2000 - present	Criminal Justice, SOCA 234
2001 - present	Deviant Behavior, SOCA 302
1997 - 2002	Juvenile Delinquency, SOCA 233
2000 - present	Writing Course in Sociology and Anthropology, SOCA 389
2002 - present	Hate Crime SOCA 318
2004 - present	Statistical Methods and Data Analysis (graduate course) SOCA 517, 518
2006 – present	Inside Out: Exploring Issues of Crime and Justice Behind WV Prison Walls
2007 – present	Justice Roundtable (an independent study course at a WV prison)
2008 – present	Neighborhood Dynamics and Situational Policing

OTHER TEACHING ACTIVITY

2002 - present "Sampling Theory and Practice" – annual invited lecture to sociology graduate students at West Virginia University

2001-present Leadership Seminar, West Virginia Mountaineer Boys' State

SERVICE TO UNIVERSITY

2003 - 2005	Eberly College of Arts and Sciences Outstanding Teacher Committee
2002 - 2007	Faculty advisor to Sigma Chi Fraternity
2001 - present	Safe Zone Program
2000 - present	Undergraduate Committee, Division of Sociology and Anthropology
2000 - present	Graduate Committee, Division of Sociology and Anthropology
2000 - 2003	Curriculum and Academic Quality Committee, Eberly College of Arts and Sciences

SERVICE TO PROFESSION

2005- 2007 Consultation to the Organization for Security and Cooperation in Europe (OSCE) and the Office for Democratic Institutions and Human Rights (ODIHR) in regard

	to the development of a hate crime curriculum (including data collection) throughout Europe.
2003 - 2004	Member of Ad Hoc committee on the Crime Index, co-sponsored by the Bureau of Justice Statistics and the Federal Bureau of Investigation
2003 - 2004	Consultant to the Federal Bureau of Investigation regarding crime measurement.
2002 - 2004	Member, UCR Subcommittee of the American Statistical Association's Committee on Law and Justice
2001 - present	Ad hoc reviewer for the following journals: *Justice Research and Policy, American Behavioral Scientist, Criminology, Criminology & Public Policy,* and *Social Forces, Journal of Quantitative Criminology, Sociological Inquiry, Prison Journal.*
1998	Member, U.S. Attorney General's Task Force on Hate Crime Training
1998	Member, U.S. Attorney General's Task Force on Hate Crime Data Collection
1998	Participated in White House Conference on Hate Crime

PROFESSIONAL ASSOCIATIONS

American Psychological Association (APA)
Group Psychology and Group Psychotherapy, Division 49 of APA
American Sociological Association (ASA)
American Society of Criminology (ASC)
Academy of Criminal Justice Sciences (ACJS)
North Central Sociological Association (NCSA)
Society for the Study of Social Issues (SSSP)

ZENIA GILG, SBN 171922
809 Montgomery Street, 2nd Floor
San Francisco CA 94133
Tel 415/394-3800
Fax 415/394-3806
Email: zenia@jacksonsquarelaw.com

Attorney for Defendant
BRIAN PICKARD

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

BRIAN PICKARD, et al.

Defendants.
_______________________________/

No. 2:11-cr-00449-KJM-16

DECLARATION OF CHRISTOPHER CONRAD

I, CHRISTOPHER CONRAD, declare as follows:

I have qualified as an expert witness on marijuana related issues such as cultivation, consumption, genetics, cloning, crop yields, medical use, recreational use, commercial sales, and medical distribution in at least 28 Counties in California, as well as in the states of Colorado, Oklahoma, Oregon, North Dakota, Maryland and the Commonwealth of Virginia. In addition, I have qualified as an expert in all the California District Courts, the District Court for the Middle District of Louisiana, and in Germany at a U.S. Courts Martial.

My experience includes the legal cultivation and processing of cannabis in Holland and Switzerland, in accordance with national laws. In addition, I have been asked to consult with government agencies instituting medical marijuana laws, and have testified before the National Academy of Science, Institute of Medicine, and presented my findings at the *Fifth Conference on Cannabis Therapeutics*, and the Biannual California Association of Toxicologists

1 Conference.

2 For a more comprehensive description of my training and experience, please see the
3 attached Curriculum Vitae which I attest to be accurate and true.

4 Based on my training and experience, as well as my research, I am attesting to the
5 following facts regarding the criminalization of cannabis under *21 U.S.C. §811 and 812* . If
6 called to testify, I would provide the following information:

7 1. The chemistry of a marijuana plant is known and reproducible. Scientists have
8 identified over 480 natural components found in the Cannabis sativa plant, and have classified
9 66 as "cannabinoids" which have further been broken down into six subclasses. Delta-9-
10 tetrahyrocannabinol (THC), the only component known to have a psychoactive effect, has
11 already been synthetically reproduced in the prescription drug Marinol. Like most plants,
12 reproduction can be as simple as planting seeds or taking cuttings from a mother and rooting
13 them in the soil (a process known as cloning). In addition, every known cannabinoid can be,
14 and has been, isolated to allow an examination of each component. In fact, the federal
15 government's National Institute on Drug Abuse (NIDA) has developed and provided three
16 standardized research-grade potencies of marijuana.

17 2. In 1978, the federal government initiated the Compassionate Investigational New
18 Drug Program (IND), which authorizes cultivation and distribution of medical cannabis to a
19 select group of patients. The marijuana, which is grown at the University of Mississippi, is
20 processed and sent to enrolled patients to be smoked in the form of marijuana cigarettes. This
21 program was established in response to a successful medical necessity defense presented by
22 Robert Randall, who suffered from glaucoma. I am informed and believe that up to 35 patients
23 were approved and 15 enrolled in the program at one time; however, due to the growing
24 number of applicants from patients suffering with AIDS, the program was closed to new
25 patients in 1992. Presently, it is my understanding that there are four remaining patients who
26 each receive 300 or more marijuana cigarettes each month.

27 3. I have personally interviewed many of the IND patients, all of whom report no ill
28 effects from their use of cannabis. In fact the opposite is true, and all those I have spoken with

have attested to their improved health and qualify of life resulting from their use of cannabis as medicine. While requests to obtain data from the government documenting its success or failure with the IND program have been denied the available information indicates that through the life of the program there have been *no* reports of ill effects suffered by the enrolled patients, rather all available information suggests cannabis as medicine is a remarkable success.

4. For example, I am informed and believe that George McMahon wrote a book in 2003, and has been on a national tour since 1997 speaking about how cannabis has relieved the pain, spasms and nausea caused by a rare genetic disease called Nail Patelia Syndrome. Prior to his cannabis treatment he had 19 major surgeries, been declared clinically dead five times and was taking 17 different pharmaceutical medications, some of which caused severe side effects resulting in his hospitalization. Mr. McMahon reports that since he was accepted into the IND program in 1990, he smokes 10 marijuana cigarettes daily, and has had *no* surgeries, *no* hospitalizations, and has discontinued the use of *all* pharmaceutical medications. (George McMahon and Christopher Largen, 2003, *Prescription Pot: A Leading Advocate's Heroic Battle to Legalize Marijuana*, New Horizon Press.) Similarly, Irvin Rosenfeld, a successful stock broker and one of the surviving IND patients wrote a book called *My Medicine*, in which he describes how the use of medical cannabis helped his multiple congenital cartiloginous exostoses. Seventy-four year old Glaucoma patient Elvy Musikka, gives speaking tours and writes music to promote the merits of medical cannabis. She was born with congenital cataracts and developed glaucoma when in her 30s. During one of several surgeries she lost sight in one, and according to Ms. Musikka the sight in her other eye has been saved through the use of cannabis. All three of above discussed patients have spoken at scientific conferences on the efficacy and safety of using cannabis to treat their serious medical conditions.

5. I am informed and believe, that numerous medical associations have called either for legalization of cannabis as medicine, or at minimum further study in specified areas, such as pain treatment, including, but not limited to: the American Medical Association, the American Cancer Society, American Academy of Family Physicians, American Medical Student

Association, American Nurses Association, American Preventive Medical Association, American Public Health Association, American Society of Addiction Medicine and various associations in the following states: Alaska, California, Colorado, Connecticut, Florida, Hawaii, Illinois, Mississippi, New Jersey, New Mexico, New York, North Carolina, Rhode Island, Texas, Vermont, and Wisconsin.

6. The Iowa Board of Pharmacy accepted the medical utility of cannabis and moved it out of that state's Schedule I on November 1, 2010.

7. In the 18th and 19th Centuries, farmers were legally required to grow marijuana as it was determined to be a necessary product for commerce and the national security of the American people. As recently as 2012, President Obama signed Executive NS2012 authorizing the Secretary of Agriculture to oversee the Nation's supply of hemp for national security purposes. (National Defense Resources Preparedness, section 201(a)(1).) Also, in 2013, both houses of Congress passed legislation within the National Farm Act to authorize hemp cultivation for research.

8. The use of cannabis has been recommended and supervised by the medical community since marijuana was first decriminalized for medical use in California in 1996 by a proposition known as the Compassionate Use Act. Since that time physicians have increasingly been willing to recommend cannabis for their patients. It is believed that at least a million Californians use marijuana with a physician's approval or recommendation, and still there have been no reports of a lethal overdose of marijuana, nor detrimental side-effect resulting from its use. In addition, it is apparent that in the 21 states and the District of Columbia where marijuana has be made available for medical use, the physicians have been able to safely administer and supervise their patients' progress.

9. Since the passage of the Compassionate Use Act the cost of cannabis has dropped significantly; thereby, reducing the incentive for violent gang and cartel members to involve themselves in the distribution of marijuana. In addition, the quality of the medicine has improved in that quality and labeling controls have been put in place to ensure the product is

1
2 not tainted with potentially harmful chemicals such as pesticides.
3 10. California has codified the distribution of marijuana in *Cal. Health & Safety Code*
4 *section 11362.7, et. seq.* The scope and regulation of this distribution has largely been left to the
5 Counties, although there are some legislative restrictions to the location of dispensaries close to
6 schools and other areas where children predominate. (*Cal Health & Safety Code section*
7 *11362.768.*)
8 I declare under penalty of perjury that the foregoing is true and correct, except for
9 those matters stated on information and belief, and as to those matters I believe them to be true.
10 This declaration signed on the 20th day of November, 2013, in El Sobrante, California.
11
12 */s/ Christopher Conrad*
CHRISTOPHER CONRAD
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CHRISTOPHER CONRAD
— *Court-qualified cannabis expert* —
PO Box 21106, El Sobrante CA 94820
Phone: 510-275-9311 • Fax: 510-275-9245 • Email chris@chrisconrad.com

Curriculum vitae, January 1, 2013

Summary and highlights of experience

Chris Conrad has studied cannabis (marijuana) since 1988. Author of *Cannabis Yields and Dosage*, he also wrote two scholarly books on cannabis, including *Hemp for Health*, and contributed to several others. Presented findings at the *Fifth Clinical Conference on Cannabis Therapeutics* (2008) and California Assn. of Toxicologists (2012). Familiar with many books and scientific studies, including National Institute on Drug Abuse and Drug Enforcement Administration (DEA) data. Consults with government agencies. Reported on dispensaries for California state legislators. Testified before National Academy of Science, Institute of Medicine. Regularly consults with patients, providers and physicians, including some of the world's foremost authorities on cannabis.

Court-qualified as a cannabis expert witness more than 275 times in preparation, consumption, sex, cultivation, odor, genetics, cloning, crop yields, medical use, personal use, dosage, commercial intent, sales, collective associations' activities, etc. Testimony discussed by the California Supreme Court in *People v Kelly* and *People v Mower*. Qualified in at least 38 California counties: Alameda, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Inyo, Kern, Lake, Los Angeles, Madera, Marin, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Stanislaus, Tulare, Tuolumne, Ventura and Yolo. Testimony mentioned by CA Court of Appeals and Supreme Court. Qualified in the federal Ninth Circuit Court in Northern, Southern, and Eastern, Dist. of California, Fifth Circuit Middle Dist. of Louisiana. Qualified in US Courts Martial and in the States of Colorado, Oklahoma, Oregon, North Dakota, Maryland and the Commonwealth of Virginia.

Has since 1991 traveled to Europe numerous times to research cannabis. Has hands-on experience in the breeding, cultivation and processing of cannabis in Holland and Switzerland. Examined personal cannabis gardens in Spain, Argentina, and industrial hemp in Germany and Holland. Observed indoor, outdoor and greenhouse gardens, participated in harvests and processing.

Investigated more than 1750 criminal cases. Reviewed hundreds of police reports and narratives, search warrants, case documents, photos, court transcripts, evidence reports, videos, diagrams, etc. Heard police officers testify at least 150 times. Interviewed scores of defendants and witnesses. Examined, evaluated, weighed, and/or measured forensic material at least 475 times, including microscopic exam, photos, root count, site visit and plant manicure.

Taught accredited CLE courses on marijuana investigations for NORML Criminal Defense Lawyers Committee, Orange County (CA) Office of the Public Defender, and Santa Cruz Criminal Defense Attorneys. Lectured or taught classes on cannabis at institutions including UC Berkeley, Learning Annex, Five Branches Institute, Omega Institute, Mills College, USC, etc. Curator, Hash-Marijuana-Hemp Museum of Amsterdam, designed displays, operating cannabis indoor garden.

Earned Bachelor's degree *magna cum laude* from California State University. Has accredited training by California Medical Association, Institute of Health Professionals, International Association for Cannabis as Medicine, American University, and Nova Institut (Germany). Personally acquainted with patients in the federal Investigational New Drug (IND) medical marijuana program.

Detailed legal qualifications, field research, scientific analysis, literature reviews

2012: Attended CME accredited *Seventh International Clinical Conference on Cannabis Therapeutics* in Arizona. Presented research on Cannabis Yields and Dosage at NIDA co-sponsored *California Association of Toxicologists Biennial Conference.* Qualified as a cannabis expert in California Courts in the counties of Butte, Colusa, Contra Costa, El Dorado, Fresno, Humboldt, Los Angeles, Marin, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara, Shasta, Siskiyou, Solano, Sonoma, Tehama, Tuolumne and Yolo. Qualified as a cannabis expert in the State of Maryland. Qualified as a cannabis expert in federal US court, California northern district. Topics include cultivation, yields, consumption, medical use, personal consumption, sales, commercial intent, odor, collective associations' activities, etc. Examined police files, medical records, financial records, transcripts, photos, videos, audiotapes, weighed, photographed, and examined forensic evidence, interviewed defendants, investigated garden sites, heard police testimony and reviewed police training materials. Visited numerous cannabis gardens and dispensaries, met with patient collectives throughout California. Spoke with many cannabis consumers, growers, experts and providers. Curator of the Oaksterdam Cannabis Museum. Faculty member of Oaksterdam University.

2011: Qualified as a cannabis expert in Fresno, Kern, Lake, Los Angeles, Napa, Nevada, Sacramento, San Diego, San Francisco, San Luis Obispo, San Mateo, Solano and Yolo Counties. Qualified as a cannabis expert in State of Colorado. Topics include cultivation, yields, consumption, medical use, personal consumption, sales, commercial intent, odor, collectives, etc. Examined police files, medical records, financial records, transcripts, photos, videos, audiotapes, weighed, photographed, and examined forensic evidence, interviewed defendants, investigated garden sites, heard police testimony and reviewed police training materials. Visited numerous cannabis gardens and dispensaries, met with patient collectives throughout California. Spoke with other experts as well as numerous cannabis consumers, growers and providers. Curator of Oaksterdam Cannabis Museum. Faculty member of Oaksterdam University. Consulted with other experts nationally and internationally.

2010: Testimony discussed by California Supreme Court in *People v Kelly.* Qualified in numerous counties as an expert on cannabis cultivation, yields, dosage, usage, processing, patient collective organizations, cultivation and operations, lawful and illicit distribution, and related issues in previous years and various counties as detailed below. Qualified as expert on cultivation, medical use, dosage and intent to sell in the Commonwealth of Virginia in Chesterfield County. Taught Mandatory Continuing Legal Education (MCLE) classes in California. Taught accredited CLE for Federal Defenders Of Eastern Washington & Idaho. Examined police files, medical records, financial records, transcripts, photos, videos, audiotapes, weighed, photographed, and examined forensic evidence, interviewed defendants, investigated garden sites, heard police testimony and reviewed police training materials. Consulted with other experts. Faculty of Oaksterdam University. Published revised seventh edition of *Cannabis Yields and Dosage.*

2009: Qualified in numerous California counties as an expert on cannabis cultivation, yields, dosage, usage, processing, patient collective organizations, cultivation and operations, lawful and illicit distribution, and related issues in various counties previously listed. Taught accredited CLE in Oregon. Attended session of the UN High Commission on Narcotic Drugs in Vienna, Austria. Examined and discussed cannabis plants under cultivation in Amsterdam, The Netherlands. Examined personal indoor and outdoor cannabis gardens in Argentina. Participant in the Medical Cannabis Safety Commission. Faculty of Oaksterdam University. Examined police files, medical records, financial records, transcripts, photos, videos, audiotapes, weighed and examined forensic evidence visually and by microscope, interviewed defendants, investigated garden sites, and heard police testimony as to their training, experience, observations and opinions, thereby familiarizing myself with law enforcement investigative techniques. Viewed numerous indoor and outdoor cannabis gardens. Visited numerous cannabis dispensaries, met with patient collectives throughout California. Consulted with other experts nationally and internationally.

2008: Qualified as a cannabis expert in Kern, San Diego, numerous other California counties previously listed, and the State of North Dakota. Qualified as an expert on cannabis cultivation, yields, dosage, usage, processing, patient collective organizations and operations, lawful and illicit distribution, and related issues in various counties previously listed. Presented findings on *Cannabis Yields and Dosage* at the CME-accredited *Fifth Clinical Conference on Cannabis Therapeutics*. Participant in the Medical Cannabis Safety Commission. Attended UN International Drug Control Treaty Assessment and Review meeting in Vienna as representative of NGO. Examined personal indoor and outdoor cannabis gardens in Argentina. Examined police files, medical records, financial records, transcripts, photos, videos, audiotapes, weighed and examined forensic evidence visually and by microscope, interviewed defendants, investigated garden sites, heard police testimony and reviewed police training materials. Consulted with other experts. Viewed numerous cannabis gardens. Visited numerous cannabis dispensaries, met with patient collectives throughout the state.

2007: Qualified as an expert on cannabis cultivation, yields, dosage, usage, in various counties previously listed. Examined police files, medical records, financial records, transcripts, photos, videos, audiotapes, weighed and examined forensic evidence visually and by microscope, interviewed defendants, investigated garden sites, heard police testimony and reviewed police training materials, familiarizing myself with law enforcement investigative techniques. Consulted with other experts. Viewed numerous cannabis gardens. Visited numerous dispensaries, met with patient collectives, individual patients and caregivers throughout the state. Served on San Francisco DA's cannabis policy taskforce. Faculty member at Oaksterdam University. Gave presentation on medical marijuana regulation to Hawaii State legislators.

2006: Qualified as an expert on cannabis odor and detection in federal Northern California district, and in US Courts Martial in Wurzburg, Germany on cultivation, yields, consumption and indicia of intent. Qualified as cannabis expert in California Superior courts of Amador, Fresno, Lake, Humboldt, Los Angeles, Mendocino, Merced, San Bernardino, San Francisco, San Mateo, Santa Clara, Santa Cruz, Siskiyou, Sonoma, and other counties. Research cited to Washington State DOH when it considered the question as to what would constitute a presumptive 60-day medical supply amount. Qualified as an expert on cannabis packaging, consumption, storage and toxicity in Oregon court. Attended CME-accredited *Fourth National Clinical Conference on Cannabis Therapeutics,* UC Santa Barbara. Examined police files, medical records, financial records, transcripts, photos, videos, audiotapes, weighed and examined forensic evidence visually and by microscope, interviewed defendants, investigated garden sites, heard police testimony and reviewed police training materials, familiarizing myself with law enforcement investigative techniques. Consulted with other experts. Viewed numerous gardens. Visited numerous dispensaries, met patient and collectives throughout the state. Served on San Francisco DA's cannabis policy taskforce.

2005: Qualified as cannabis expert in California Superior courts of Los Angeles, Calaveras, Lake, Santa Clara, Santa Cruz, Sacramento, Siskiyou, Solano and Orange counties. Participated in San Francisco DA's medical marijuana advisory group. Received two days instruction at Leiden University, The Netherlands, from the International Association for Cannabis as Medicine conference. Toured the Dutch national medical marijuana garden operated by Bedrocan, B.V. Examined numerous indoor and outdoor cannabis gardens in and around Amsterdam and medical marijuana gardens in California and Oregon. Examined police files, medical records, financial records, transcripts, photos, videos, weighed and examined forensic evidence visually and by microscope, interviewed defendants, investigated garden sites, heard police testimony and reviewed police training materials, familiarizing myself with law enforcement investigative techniques. Consulted with other experts. Viewed gardens, interviewed growers, sellers and consumers of cannabis throughout the state. Taught a CLE on expert issues involving cannabis at the NORML Legal Seminar in Florida. Testimony received favorable mention in California Court of Appeals ruling *People v Urziceau* (2005) 132 Cal.App.4th.

2004: Authored and published *Cannabis Yields and Dosage*. Qualified as cannabis expert in the California Superior courts of Humboldt, Alameda, Lake, Yolo, San Francisco, Santa Cruz, Santa Clara, Los Angeles and San Mateo, on issues of cultivation, medical use, consumption, processing, and personal versus commercial intent. Qualified as cannabis expert in State of Oklahoma. Testimony received favorable mention in California Court of Appeals ruling *People v Arbacauskas* (2004) Cal.App.3rd. Examined police files, medical records, financial records, transcripts, photos, videos, weighed and examined forensic evidence visually and under microscope, interviewed defendants, investigated garden sites, heard police testimony and reviewed police training materials, familiarizing myself with police investigative techniques. Consulted with other experts. Viewed gardens, interviewed growers, sellers and consumers of cannabis throughout the state.

2003: Qualified as cannabis expert in the California Superior courts of Butte, El Dorado, Fresno, Inyo, Los Angeles, Monterey, Nevada, Sacramento, San Mateo, Santa Cruz, Ventura and Yolo Counties Qualified as cannabis expert in the Southern District of the Ninth Circuit Federal Court. Examined police files, medical records, financial records, transcripts, photos, videos, weighed and examined forensic evidence visually and under microscope, interviewed defendants, investigated garden sites, heard police testimony and reviewed police training materials, familiarizing myself with police investigative techniques. Taught Continuing Legal Education (CLE) for Defense Attorneys of Santa Cruz County. Viewed gardens, interviewed growers, sellers and consumers of cannabis throughout the state. Consulted on SB 420. Discussed medical marijuana policy with DA Terrence Hallinan of San Francisco and DA Paul Gallegos in Humboldt. Consulted with Senator John Vasconcellos office regarding SB 420. Member of citizen advisory panel that drafted Senate Bill 420, the California Medical Marijuana Program Act.

2002: Testimony discussed by California Supreme Court in *People v Mower*. Qualified as cannabis expert in the California Superior courts of Los Angeles, El Dorado, Riverside, Sacramento, San Joaquin, Santa Cruz, Tulare and Yolo Counties on issues of cultivation, medical use, consumption, processing, and personal versus commercial intent. Examined police files, medical records, financial records, transcripts, photos, videos, weighed and examined forensic evidence visually and under microscope, interviewed defendants, investigated garden sites, heard police testimony and reviewed police training materials, familiarizing myself with police investigative techniques. Took 12 hours of accredited training in medical marijuana from Institute for Health Professionals, Portland Oregon. Spent three weeks in Holland where I observed at least 12 cannabis gardens and one week in Italy. In both countries I engaged cannabis cultivators in discussion of their gardens, and yields.

2001: Testified as a cannabis expert in California Superior courts of Alameda, Del Norte, Orange, San Joaquin, Sonoma and Ventura Counties on issues of cultivation, medical use, consumption, preparation, and indicia of personal versus commercial intent. Heard court testimony by police officers and other experts. Reviewed numerous court transcripts, search warrants, police reports, evidence lists and case files. Examined medical records, forensic evidence visually and under microscope, analyzed photos and videos, interviewed defendants, reviewed police training materials, and investigated garden sites. Testified as cannabis expert in the Sacramento CA federal district court, on issues of cultivation, consumption, and yields. Gave presentation on yields and consumption to Berkeley, CA, Health and Safety Commission. Taught an accredited CLE for Orange County Public Defenders office.

2000: Testified as cannabis expert in California Superior courts of Butte, Calaveras, Contra Costa, El Dorado, Humboldt, Napa, Placer, Plumas, San Mateo, Shasta, Siskiyou, Santa Cruz, Sonoma and Stanislaus Counties. Qualified on issues of indoor and outdoor cultivation, crop yields, plant sex, olfactory identification (smell), means and rates of consumption, genetic characteristics, indicia of commercial intent, personal and/or medicinal use of cannabis and cannabis preparations, both smoking and otherwise. Investigated cases and provided expert legal services in numerous other counties. Heard court testimony by police officers and other experts. Received seven hours of

California Medical Association-accredited training on medical cannabis. Reviewed court transcripts, search warrants, police reports, evidence lists and case files, familiarizing myself with police investigative techniques. Examined forensic evidence and medical records, analyzed photos and videos, interviewed defendants, provided declarations. Researched all aspects of cannabis cultivation and use. Discussed use patterns with at least 30 medical cannabis patients and numerous doctors. Spent four weeks in Amsterdam, where I designed informational exhibits on cannabis and observed indoor cannabis cultivation, curing and processing. Returned in the fall for 10 days observing and discussing cultivation, processing, marketing and consumption with hundreds of American, Dutch and international growers and consumers.

1999: Testified as cannabis expert in California Superior courts of Butte, Calaveras, El Dorado, Humboldt, Lake, Los Angeles, Marin, Placer, Santa Clara, Shasta, Solano and Sonoma Counties on issues of cultivation, yields, commercial intent, joint size, rate of consumption, personal and/or medicinal use of cannabis and cannabis preparations, both smoking and otherwise. Investigated cases and provided expert legal services in Alameda, Stanislaus, Napa, Plumas, Sacramento, San Francisco, San Mateo, Santa Barbara and Santa Cruz Counties. Reviewed numerous court transcripts, search warrants, investigator's reports and case files, familiarizing myself with police investigative techniques. Heard court testimony by police officers and other experts. Examined forensic evidence, analyzed photos and videos, inspected garden sites, interviewed witnesses and defendants, provided declarations and reports. Examined numerous California patients' legal cannabis gardens. Discussed use patterns with at least 150 medical cannabis patients and numerous doctors. Read numerous studies and reports by the DEA, NIDA, and other federal government agencies regarding the cultivation, miscellaneous effects, and personal consumption of cannabis. Attended numerous conference presentations on medical marijuana and industrial hemp. Went to the Netherlands to research and monitor legal cannabis cultivation, breeding, distribution and consumption. Examined numerous cannabis gardens in Holland, Germany and Spain. Traveled to Germany to study legal industrial hemp fields and processing facilities, the Hanf (hemp) Museum, and CannaBusiness, an international hemp and cannabis business expo.

1998: Testified as qualified expert in the California Superior courts of Butte, Humboldt and Tuolomne Counties regarding cannabis cultivation, yields, plant sex, maturity, preparation, quality, usability, commercial intent versus personal and/or medicinal use, consumption rates, genetics and cannabis preparations, both smoking and otherwise. Reviewed case documents, physical evidence and photos. Investigated cases and/or filed declarations in Alameda, Marin, Merced, Nevada, Placer, San Diego, San Mateo, Santa Cruz, and Sonoma Counties. Examined and evaluated numerous California patients' legal cannabis gardens. Attended numerous conference presentations on medical marijuana and industrial hemp. Read and analyzed *Cannabis Yields*, a cultivation and yield report by the federal DEA and numerous studies by NIDA, and other government agencies regarding the, miscellaneous effects, and personal consumption of cannabis. Discussed use patterns with at least 250 medical cannabis patients and numerous doctors.

1997: Testified as qualified expert in the California Superior court of Marin County regarding crop yields, medical marijuana and personal consumption. Reviewed case documents, physical evidence and photos. Authored *Hemp for Health*. Researched medical literature, visited and surveyed patient gardens. Visited and surveyed patient buyers clubs and discussed medical use of cannabis with at least 300 patients and 20 doctors. Read at least 100 abstracts, studies and peer reviewed medical literature regarding the therapeutic utility of cannabis. Chapters cover cannabis history, botany, pharmacology, clinical research, homeopathy, Ayurvedic medicine, herbalism, therapeutic potential, cannabinoids, side effects, safety tips, recipes for smoked and eaten preparations, and specific symptomatic relief, including diagrams and reference tables, topical applications, nutrition and holistic health care. Attended CannaBusiness Expo, in Germany. Visited patient gardens and buyers clubs throughout California, following passage of Prop 215. Conducted the first survey of state dispensaries at the

request of Assemblyman Senator John Vasconcellos office. Consulted and participated in a legal outdoor cannabis harvest in Switzerland of at least six hectares of plants grown by subcontractors for CannaBioLand, a legal commercial enterprise. Selected and harvested cannabis based on sex, ripeness and mold infestation. Participated in sexing, selecting, cutting, curing, manicuring, and otherwise preparing herb for consumption. Investigated legal cannabis outlets throughout Switzerland. Addressed a hearing of the National Academy of Science on medical marijuana.

1996: Attended numerous scientific presentations and surveys of scientific studies regarding specific medical and personal use of cannabis including pharmacology and symptomatic relief. Discussed use patterns with at least 400 medical marijuana patients and numerous doctors. Monitored legal cannabis indoor cultivation projects at Sensi Seed Bank, the Hash-Marijuana-Hemp Museum, and at Positronics, b.v., in Amsterdam. Observed and interviewed patients, doctors, caregivers and cannabis culture in the US, Canada and Europe.

1995: Monitored legal cannabis indoor cultivation projects at Sensi Seed Bank, the Hash-Marijuana-Hemp Museum, and at Positronics, b.v., in Amsterdam. Discussed medical cannabis and use patterns with at least 300 patients and numerous doctors.

1994: Qualified as expert witness in the California Superior court of Madera County on industrial hemp and hempseed. Studied and consulted on Hemp Agrotech's research crop of industrial hemp grown in the Imperial Valley (California) in conjunction with the US Department of Agriculture research station. Met and had informal consultations with owners of Hempline, the first Canadian group to grow a research crop of industrial hemp in North America. Toured hemp stores and museums throughout the US and Canada. Monitored legal cannabis indoor cultivation projects at Sensi Seed Bank, the Hash-Marijuana-Hemp Museum, Positronics, b.v., and at numerous other cannabis gardens located in Amsterdam. Discussed medical use and patterns with at least 100 patients and numerous doctors.

1993: Authored *Hemp: Lifeline to the Future*, a comprehensive study of the cannabis plant, including a chapter on cannabis botany. Read at least 100 abstracts, studies and peer reviewed medical literature regarding the therapeutic and industrial utility of cannabis. Spent six months in The Netherlands where I designed and arranged informational exhibits and curated the Hash-Marijuana-Hemp Museum in Amsterdam; collected items, prepared and labeled informational displays and explanatory materials, produced handouts for visitors, maintained a library about cannabis, supervised a legal indoor cannabis "grow room" exhibit featuring hydroponic systems, soil, plants from seed and clones, sexing to maturity, harvest, cure and manicure. Utilized various lighting systems and cycles; evaluated growing techniques and yields, planting densities, and pruning patterns; advised in the design of and adjustments to the system and its operation. Field research included investigation and discussion of social use, customs, commercial sales, consumption patterns, medical case histories, regional cultures, kif and hash making, evaluating quality and use of herbal cannabis. Experimented with raw stalk, fibers, hempseed foods and cannabis medicinal preparations including derivatives, tinctures and poultices. Traveled through France, Holland and Hungary researching legal commercial hemp farms and processing. Made a national tour of Dutch cannabis outlets and interviewed the proprietors, staff and clientele. Monitored legal cannabis indoor cultivation projects at Sensi Seed Bank, the Hash-Marijuana-Hemp Museum, and at Positronics, b.v., in Amsterdam. Discussed use patterns with at least 200 medical marijuana patients.

1992: Spent six weeks in The Netherlands working at "Cannabis Castle," a primary facility of Sensi Seed Bank, a legal Dutch cannabis research and breeding company. Participated and monitored all aspects of cultivation from starting seedlings and rooting clones to sexing plants, genetic selection and pollination, hybridization, seed selection and processing for indoor, outdoor and greenhouse varieties. Monitored flower development, resin enhancement, yields, curing, processing and manicure. Researched various genetic materials for characteristics. Met with researchers at Wageningen University (Netherlands) research facility on industrial and horticultural aspects of cannabis hemp.

Made a national tour of regional Dutch cannabis outlets and interviewed the proprietors, staff and clientele.

1989-Present: National and international conferences. Ongoing cannabis research, reviewing scientific, law enforcement and media reports. Personally discussing the production, processing and consumption of cannabis products with thousands American, Dutch, Argentine, Canadian and other international consumers, patients, growers and providers.

Formal Education

2012: Attended CME and university accredited *Seventh International Clinical Conference on Cannabis Therapeutics* in Arizona.

2008: Attended and presented findings on *Cannabis Yields and Dosage* at the CME-accredited *Fifth Biennial Clinical Conference on Cannabis Therapeutics*, Asilomar California.

2006: Attended CME-accredited *Fourth Biennial Clinical Conference on Cannabis Therapeutics*, Santa Barbara California.

2005 Received two days instruction at Leiden University, The Netherlands, at the International Association for Cannabis as Medicine conference.

2002: CME-accredited *Second Biennial Clinical Conference on Cannabis Therapeutics*, 12 hours accredited training in medical marijuana, Institute for Health Professionals, Portland Oregon

2000: Attended 7 hours California Medical Association CME-accredited training at the "Cannabis Therapy: Science, Medicine and the Law" symposium at Cal State University San Francisco.

1995: Attended 20 hours Euroean university-accredited training in cannabis botany, agriculture, horticulture, pharmo-chemistry, industrial technologies and medical use at Biofach international symposium, Nova Institute, Frankfurt Germany.

1993: Attended 18 hours accredited training in cannabis botany, agriculture, horticulture, pharmo-chemistry, industrial technologies, medical use and policy at Journee du Cannabis, Paris, France.

1980: Bachelor's degree. Fine Arts / Communication, California State University Dominguez Hills, Los Angeles California. Graduated *Magna cum laude*. Biology course included botany.

1973: Associate's degree in Humanities / Fine Arts, Frederick Community College, Frederick Maryland. Graduated *Cum laude*. Biology course included botany.

1967-69: Attended Maryknoll Catholic Seminary, Chesterfield, Missouri.

Books authored or assisted

2004 – Present: *Cannabis Yields and Dosage*, as revised and expanded. Seventh edition published, 2010.

2001: Second edition of *Human Rights and the US Drug War* (Creative Xpressions). Hemp for Health translated into Portuguese as *Hemp: O uso medicinal de maconha.*

2000: Revised printing of *Shattered Lives: Portraits from America's Drug War* (Creative Xpressions).

1999: Contributed to revised *The Very Best of Sinsemilla Tips* (New Moon). Co-authored *Human Rights and the US Drug War* (Creative Xpressions).

1998: *Hemp for Health* translated *Heilpflanze Haschisch* (German, Knaur), and *Cannabis para la Salud* (Spanish, M. Roca). Co-authored *Shattered Lives: Portraits from America's Drug War* (Creative Xpressions).

1996: Authored *Hemp for Health* (Inner Traditions), reviewing scientific data on medical, physiological and psychological effects of cannabis. It discusses medical cannabis in allopathy, homeopathy, herbalism and Ayurveda; THC and other cannabinoids, hempseed nutrition, uses of seed oil, holistic and ecological value of hemp as a restorative resource. Bibliography, footnotes and appendices. *Hemp,*

Lifeline to the Future Australian edition published; *Cannabis, 1 mille usi di una pianta miracolosa.* (Italian, Carravecchi)

1995: Contributed portions on the development of the modern hemp industry and fuel potential of industrial hemp to *The Great Book of Hemp*, by Rowan Robinson (Inner Traditions).

1994: Contributed a chapter on market potentials to *Hemp Today* compilation (Quick American).

1993: Authored *Hemp, Lifeline to the Future* (Creative Xpressions), a comprehensive review of the industrial, medicinal and social / spiritual applications of cannabis with technical data on how to grow and process cannabis, its history, commerce, technologies, botany, ecology, cultivation and medical uses. Contributed chapter to *Le Premier Journee Internationale du Cannabis* (French: Lezard).

1990: Designed and edited *The Emperor Wears No Clothes*, by Jack Herer (Hemp Publishing).

Supreme Court cites, legislative and advisory consultation, teaching, conferences, lectures, symposia

2012: Presented research on Cannabis Yields and Dosage at NIDA co-sponsored *California Association of Toxicologists Biennial Conference.*

2011: Curator, Oaksterdam Cannabis Museum. Qualified as court expert on cultivation in state of Colorado.

2010: Testimony discussed by California Supreme Court in *People v Kelly*. Taught accredited CLE for Federal Defenders Of Eastern Washington & Idaho.

2008 – 2009: Participant in the Medical Cannabis Safety Commission, based in Berkeley CA. Attended UN International Drug Control Treaty Assessment and Review in Vienna as representative of NGO.

2008: Presented findings on *Cannabis Yields and Dosage* at the CME-accredited *Fifth Clinical Conference on Cannabis Therapeutics.*

2007: Gave presentation on medical marijuana regulation to Hawaii State legislators.

2005 - 2010: Member of San Francisco District Attorney Kamala Harris's Cannabis Advisory Panel.

2004: Testified before the Oakland City Council and Humboldt County Board of Supervisors.

2003: Testified before the County Board of Supervisors for the counties of Kern and San Francisco, Oakland Public Safety Committee. Taught CLE seminar for Santa Cruz Criminal Defense Attorneys.

2002: Testimony discussed by California State Supreme Court in *People v Mower*.

2001: Presented expert testimony and prepared displays on issues of cannabis cultivation and consumption and presented a report to Berkeley Public Health and Safety Commission; guest lectured in political science at University of California, Berkeley. Consulted with Sonoma Alliance for Medical Marijuana in developing guidelines adopted by County District Attorney.

2000: Keynote speaker on medical marijuana at Alameda Medical Group staff dinner. Guest lectured at Mills College. Presented expert testimony for the City of Martinez (CA) on the federal IND medical marijuana program, garden yields and consumption. Presented data on medical marijuana use and cultivation at the Drug Policy Foundation conference, Washington DC. Gave presentations at Santa Cruz Industrial Hemp Expo (CA). Gave two presentations at Cannabis College (Amsterdam).

1999: Guest lectured at Mills College; gave presentations at University of California Davis Forum, UC Berkeley Global Crisis Solutions Conference, CannaBusiness (Germany), Cannabis College (Netherlands), Natural Products Expo, and Santa Cruz Industrial Hemp Expo.

1998: Taught cannabis at the Omega Institute (NY). Testified at National Academy of Science / Institute of Medicine hearings on medical marijuana (Irvine). Presented report on medical cannabis to SSSP sociologists convention. Gave presentations at the Hemp Industries Association convention, Santa Cruz Industrial Hemp Expo, VisionQuest, State of the World Forum and National Organization to Reform Marijuana Laws (NORML). Debated former DEA head Peter Bensinger at Cal State University, Northridge.

1997: Participated in legislative advisory panel for California medical marijuana research bill SB 535. Supported legislative efforts on industrial hemp bills in 12 state legislatures. Taught classes on medical cannabis at Learning Annex, Five Branches Institute, and California legal patient groups. Lectured on hemp at Eco Expo, Natural Products Expo, and on cannabis research at the Drug Policy Foundation (DPF) conference plenary session.

1996: Consulted on hemp legislation with State Representatives Fred Maslack of Vermont and David Tarnas of Hawai'i. Authored the industrial hemp plan for the Jamaican government). Coordinated petitioners for California medical marijuana initiative, Prop. 215 (passed). Testified at Oakland City Council and Contra Costa County Supervisors on medical cannabis, regulations and options. Lectured at Stanford University. Lectured at Eco Expo and Whole Life Expo (CA). Participant in State of the World Forum (CA). Panelist in DPF conference (Washington DC) plenary session on medical cannabis.

1995: Met with European Cities on Drug Policy staff to discuss the Frankfurt Resolution on cannabis policy. Testified at Colorado State Senate Agriculture Committee hearing on economic and agricultural value of low-THC industrial hemp as a farm crop, European hemp regulations and subsidies, infrastructure and other commercial aspects, and genetic and environmental influences that maintain the non-drug characteristic of industrial hemp. Panelist in DPF conference plenary session on hemp. Spoke at Land, Air and Water legal conference (Oregon), Chapman University (CA), Whole Earth Expo (CA), Winnipeg University (Canada), European Cannabis Consumers Organization organizing conference (Netherlands). Attended four day *Biorohstoff Hanf* symposium (Nova Institut, Frankfurt, Germany).

1994: Had discussions with Eric Fromberg, head of The Netherlands National Institute on Alcohol and Drugs, and other Dutch officials regarding their policy of tolerance, regulation and control of cannabis distribution. Panelist in ACLU drug policy forum (Los Angeles CA). Chapman University (CA). Presented hemp seminars throughout Holland and the US.

1993 Presenter at *Le Premier Journee Internationale du Cannabis* (Paris, France). Had discussions with Eric Fromberg, head of the Dutch National Institute on Alcohol and Drugs, and other officials regarding their policy of regulation and control of cannabis distribution.

1992: Testified on hemp development and regulatory options at the US Congressional Hearings on Improving the Operations and Activities of the United Nations (Los Angeles, CA).

1991: Consulted with Senator Joseph Galiber (NY) to develop separate industrial hemp and cannabis bills. Guest lectured at University of Southern California (USC) program for substance abuse counselors.

Some Honors and Awards

2010: Lifetime Achievement Award, Oaksterdam University.

2008: Freedom Fighter of the Year, Los Angeles NORML.

2004: Achievement in Citizen Activism, from NORML.

2002: Strathmore's Who's Who.

2001: Strathmore's Who's Who. Lindesmith Center "Robert Randall Award."

2000: San Francisco *Bay Guardian* Local Hero Award. Hemp Awareness Group Award.

1999: Top 10 Activist of the Century, High Times magazine.

1998: Hemp Industries Association President's Award.

1991: Long Beach Area Citizens Involved Achievement Award.

1980: Who's Who in American Colleges and Universities;

1972: Who's Who in American Junior Colleges.

Born: March 10, 1953.

ZENIA K. GILG, SBN 171922
809 Montgomery Street, 2nd Floor
San Francisco CA 94133
Telephone: 415/394-3800
Facsimile: 415/394-3806
zenia@jacksonsquarelaw.com

Attorney for Defendant
BRIAN JUSTIN PICKARD

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

BRYAN R. SCHWEDER,
BRIAN JUSTIN PICKARD,
JUAN MADRIGAL OLIVERA,
MANUAL MADRIGAL OLIVERA,
FRED W. HOLMES, III,
EFREN RODRIGUEZ,
PAUL BRUCE ROCKWELL,
HOMERO LOPEZ-BARRON
VICTORINO BETANCOURT-MERAZ,
OSEAS CARDENAS-TOLENTINO,
FERNANDO REYES-MOJICA,
JUAN CISNEROS-VARGAS,
LEONARDO TAPIA,
FILBERTO ESPINOZA-TAPIA
OSIEL VALENCIA-ALVAREZ

Defendants.
_________________________________/

2:11-CR-00449-KJM

EXHIBITS IN SUPPORT OF DEFENDANT BRIAN PICKARD'S NOTICE OF MOTION AND MOTION TO DISMISS INDICTMENT AS VIOLATIVE OF THE UNITED STATES CONSTITUTION (AMENDMENT V, AND ARTICLE VI/AMENDMENT X), AND REQUEST FOR EVIDENTIARY HEARING

[Excludable Time: 18 U.S.C. § 3161(h)(1)(D) through disposition]

Date: January 22, 2014
Time: 9:00 a.m.
Judge: Hon. Kimberly J. Mueller

Exhibit A

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Thursday, August 29, 2013

Justice Department Announces Update to Marijuana Enforcement Policy

Today, the U.S. Department of Justice announced an update to its federal marijuana enforcement policy in light of recent state ballot initiatives that legalize, under state law, the possession of small amounts of marijuana and provide for the regulation of marijuana production, processing, and sale.

In a new memorandum outlining the policy, the Department makes clear that marijuana remains an illegal drug under the Controlled Substances Act and that federal prosecutors will continue to aggressively enforce this statute. To this end, the Department identifies eight (8) enforcement areas that federal prosecutors should prioritize. These are the same enforcement priorities that have traditionally driven the Department's efforts in this area.

Outside of these enforcement priorities, however, the federal government has traditionally relied on state and local authorizes to address marijuana activity through enforcement of their own narcotics laws. This guidance continues that policy.

For states such as Colorado and Washington that have enacted laws to authorize the production, distribution and possession of marijuana, the Department expects these states to establish strict regulatory schemes that protect the eight federal interests identified in the Department's guidance. These schemes must be tough in practice, not just on paper, and include strong, state-based enforcement efforts, backed by adequate funding. Based on assurances that those states will impose an appropriately strict regulatory system, the Department has informed the governors of both states that it is deferring its right to challenge their legalization laws at this time. But if any of the stated harms do materialize—either despite a strict regulatory scheme or because of the lack of one—federal prosecutors will act aggressively to bring individual prosecutions focused on federal enforcement priorities and the Department may challenge the regulatory scheme themselves in these states.

A copy of the memorandum, sent to all United States Attorneys by Deputy Attorney General James M. Cole, is available below.

Related Material:

- DAG Memo 8-29-13

13-974 Office of Public Affairs

Exhibit B

H.R. 18583, WAS INTRODUCED AS A CLEAN BILL ON JULY 22, 1970, AFTER THE CONCLUSIONS OF HEARINGS AND EXECUTIVE SESSIONS BEFORE THE SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE. NO AGENCY REPORTS HAVE BEEN RECEIVED ON THIS BILL; HOWEVER, REPORTS RECEIVED ON H.R. 13743 AND OTHER BILLS ON WHICH HEARINGS WERE HELD BEFORE THE SUBCOMMITTEE ARE RELEVANT, AND ARE INCLUDED BELOW.

IN ADDITION, A LETTER FROM THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE WITH RESPECT TO THE SCHEDULING OF MARIHUANA, AND A LETTER FROM THE DEPARTMENT OF JUSTICE CONCERNING CERTAIN RECORDKEEPING REQUIREMENTS IN THE BILL, ARE ALSO SET FORTH BELOW.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
AUGUST 14, 1970.

HON. HARLEY O. STAGGERS,

CHAIRMAN, COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,

HOUSE OF REPRESENTATIVES, WASHINGTON, D.C.

DEAR MR. CHAIRMAN: IN A PRIOR COMMUNICATION, COMMENTS REQUESTED BY YOUR COMMITTEE ON THE SCIENTIFIC ASPECTS OF THE DRUG CLASSIFICATION SCHEME INCORPORATED IN H.R. 18583 WERE PROVIDED. THIS COMMUNICATION IS CONCERNED WITH THE PROPOSED CLASSIFICATION OF MARIHUANA.

IT IS PRESENTLY CLASSED IN SCHEDULE IC) ALONG WITH ITS ACTIVE CONSTITUENTS, THE TETRAHYDROCANNABINOLS AND OTHER PSYCHOTROPIC DRUGS.

SOME QUESTION HAS BEEN RAISED WHETHER THE USE OF THE PLANT ITSELF PRODUCES 'SEVERE PSYCHOLOGICAL OR PHYSICAL DEPENDENCE' AS REQUIRED BY A SCHEDULE I OR EVEN SCHEDULE II CRITERION. SINCE THERE IS STILL A CONSIDERABLE VOID IN OUR KNOWLEDGE OF THE PLANT AND EFFECTS OF THE ACTIVE DRUG CONTAINED IN IT, OUR RECOMMENDATION IS THAT MARIHUANA BE RETAINED WITHIN SCHEDULE I AT LEAST UNTIL THE COMPLETION OF CERTAIN STUDIES NOW UNDERWAY TO RESOLVE THIS ISSUE. IF THOSE STUDIES MAKE IT APPROPRIATE FOR THE ATTORNEY GENERAL TO CHANGE THE PLACEMENT OF MARIHUANA TO A DIFFERENT SCHEDULE, HE MAY DO SO IN ACCORDANCE WITH THE AUTHORITY PROVIDED UNDER SECTION 201 OF THE BILL.

***4630** WE ARE ADVISED BY THE OFFICE OF MANAGEMENT AND BUDGET THAT THERE IS NO OBJECTION TO THE PRESENTATION OF THIS REPORT FROM THE STANDPOINT OF THE ADMINISTRATION'S PROGRAM.

SINCERELY YOURS,

ROGER O. EGEBERG, M.D.
ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS.

OFFICE OF THE DEPUTY ATTORNEY GENERAL,
WASHINGTON, D.C., AUGUST 28, 1970.

HON. HARLEY O. STAGGERS,

CHAIRMAN, COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,

Exhibit C

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Marihuana, A Signal of Misunderstanding

The Report of the National Commission on Marihuana and Drug Abuse

Chapter V

marihuana and social policy

A Final Comment

In this Chapter, we have carefully considered the spectrum of social and legal policy alternatives. On the basis of our findings, discussed in previous Chapters, we have concluded that society should seek to discourage use, while concentrating its attention on the prevention and treatment of heavy and very heavy use. The Commission feels that the criminalization of possession of marihuana for personal is socially self-defeating as a means of achieving this objective. We have attempted to balance individual freedom on one hand and the obligation of the state to consider the wider social good on the other. We believe our recommended scheme will permit society to exercise its control and influence in ways most useful and efficient, meanwhile reserving to the individual American his sense of privacy, his sense of individuality, and, within the context of ail interacting and interdependent society, his options to select his own life style, values, goals and opportunities.

The Commission sincerely hopes that the tone of cautious restraint sounded in this Report will be perpetuated in the debate which will follow it. For those who feel we have not proceeded far enough, we are reminded of Thomas Jefferson's advice to George Washington that "Delay is preferable to error." For those who argue we have gone too far, we note Roscoe Pound's statement, "The law must be stable, but it must not stand still."

We have carefully analyzed the interrelationship between marihuana the drug, marihuana use as a behavior, and marihuana as a social problem. Recognizing the extensive degree of misinformation about marihuana as a drug, we have tried to demythologize it. Viewing the use of marihuana in its wider social context, we have tried to desymbolize it.

Considering the range of social concerns in contemporary America, marihuana does not, in our considered judgment, rank very high. We would deemphasize marihuana as a problem.

The existing social and legal policy is out of proportion to the individual and social harm engendered by the use of the drug. To replace it, we have attempted to design a suitable social policy, which we believe is fair, cautious and attuned to the social realities of our time.

Exhibit D

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National Commission on Marihuana and Drug Abuse

Marihuana: A Signal of Misunderstanding

Chapter III

Social Impact of marihuana use

Addiction Potential

Unfortunately, fact and fancy have become irrationally mixed regarding marihuana's physiological and psychological properties. Marihuana clearly is not in the same chemical category as heroin insofar as its physiologic and psychological effects are concerned. In a word, cannabis does not lead to physical dependence. No torturous withdrawal syndrome follows the sudden cessation of chronic, heavy use of marihuana. Although evidence indicates that heavy, long-term cannabis users may develop psychological dependence, even then the level of psychological dependence is no different from the syndrome of anxiety and restlessness seen when an American stops smoking tobacco cigarettes.

Library Highlights

Drug Information Articles

Drug Rehab

Exhibit E

THE WAR ON MARIJUANA IN BLACK AND WHITE

BILLIONS OF DOLLARS WASTED ON RACIALLY BIASED ARRESTS

June 2013

The War on Marijuana in Black and White

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American Civil Liberties Union
125 Broad Street
New York, NY 10004
www.aclu.org

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EXECUTIVE SUMMARY

This report is the first to examine marijuana possession arrest rates by race for all 50 states (and the District of Columbia) and their respective counties from 2001 to 2010. The report relies on the Federal Bureau of Investigation's Uniform Crime Reporting Program and the United States Census' annual county population estimates to document arrest rates by race per 100,000 for marijuana possession.

The report finds that between 2001 and 2010, there were over 8 million marijuana arrests in the United States, 88% of which were for possession. Marijuana arrests have increased between 2001 and 2010 and now account for over half (52%) of all drug arrests in the United States, and marijuana possession arrests account for nearly half (46%) of all drug arrests. In 2010, there was one marijuana arrest every 37 seconds, and states spent combined over $3.6 billion enforcing marijuana possession laws.

Marijuana arrests have increased between 2001 and 2010 and now account for over half (52%) of all drug arrests in the United States

The report also finds that, on average, a Black person is 3.73 times more likely to be arrested for marijuana possession than a white person, even though Blacks and whites use marijuana at similar rates. Such racial disparities in marijuana possession arrests exist in all regions of the country, in counties large and small, urban and rural, wealthy and poor, and with large and small Black populations. Indeed, in over 96% of counties with more than 30,000 people in which at least 2% of the residents are Black, Blacks are arrested at higher rates than whites for marijuana possession.

The report concludes that the War on Marijuana, like the larger War on Drugs of which it is a part, is a failure. It has needlessly ensnared hundreds of thousands of people in the criminal justice system, had a staggeringly disproportionate impact on African-Americans, and comes at a tremendous human and financial cost. The price paid by those arrested and convicted of marijuana possession can be significant and linger for years, if not a lifetime. Arrests and convictions for possessing marijuana can negatively impact public housing and student financial aid eligibility, employment opportunities, child custody determinations, and immigration status. Further, the War on Marijuana

has been a fiscal fiasco. The taxpayers' dollars that law enforcement agencies waste enforcing marijuana possession laws could be better spent on addressing and solving serious crimes and working collaboratively with communities to build trust and increase public health and safety. Despite the fact that aggressive enforcement of marijuana laws has been an increasing priority of police departments across the country, and that states have spent billions of dollars on such enforcement, it has failed to diminish marijuana's use or availability.

To repair this country's wrecked War on Marijuana, the ACLU recommends that marijuana be legalized for persons 21 or older through a system of taxation, licensing, and regulation. Legalization is the smartest and surest way to end targeted enforcement of marijuana laws in communities of color, and, moreover, would eliminate the costs of such enforcement while generating revenue for cash-strapped states. States could then reinvest the money saved and generated into public schools and public health programs, including substance abuse treatment. If legalization is not possible, the ACLU recommends depenalizing marijuana use and possession for persons 21 or older by removing all attendant civil and criminal penalties, or, if depenalization is unobtainable, decriminalizing marijuana use and possession for adults and youth by classifying such activities as civil, not criminal, offenses.

The ACLU also recommends that until legalization or depenalization is achieved, law enforcement agencies and district attorney offices should deprioritize enforcement of marijuana possession laws. In addition, police should end racial profiling and unconstitutional stop, frisk, and search practices, and no longer measure success and productivity by the number of arrests they make. Further, states and the federal government should eliminate the financial incentives and rewards that enable and encourage law enforcement to make large numbers of arrests, including for low-level offenses such as marijuana possession.

In sum, it is time to end marijuana possession arrests.

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The Internet references cited in this publication were valid as of June 2013. Given that URLs and web sites are in constant flux, the ACLU cannot vouch for their current validity.

I. INTRODUCTION

Over the past 40 years, the United States has fought a losing domestic drug war that has cost one trillion dollars, resulted in over 40 million arrests, consumed law enforcement resources, been a key contributor to jaw-dropping rates of incarceration, damaged countless lives, and had a disproportionately devastating impact on communities of color. The ferocity with which the United States has waged this war, which has included dramatic increases in the length of prison sentences, and has resulted in a 53% increase in drug arrests, a 188% increase in the number of people arrested for marijuana offenses, and a 52% increase in the number of people in state prisons for drug offenses, between 1990 and 2010.[1] Indeed, the United States now has an unprecedented and unparalleled incarceration rate: while it accounts for 5% of the world's population, it has 25% of the world's prison population.[2]

Despite costing billions of dollars,[3] the War on Drugs has polluted the nation's social and public health while failing to have any marked effect on the use or availability of drugs.[4] Indeed, the United States is the

Despite costing billions, the War on Drugs has polluted the nation's social and public health and failed to curb the use or availability of drugs.

1 *See* Allen J. Beck & Paige M. Harrison, U.S, Dep't of Just., Bureau of Just. Statistics, Prisoners in 2000 1 & 12 (Aug. 2001), *available at* http://bjs.gov/content/pub/pdf/p00.pdf (reporting the state prison population at 708,370 in 1990 and that 22% of that population, or 155,843 people, were incarcerated for drug offenses); Paul Guerino, Paige M. Harrison & William J. Sabol, U.S, Dep't of Just., Bureau of Just. Statistics, Prisoners in 2010 2 (Dec. 2011), *available at* http://bjs.gov/content/pub/pdf/p10.pdf (reporting the state prison population at 237,000 in 2010).

2 *See* Jenifer Warren, One in 100: Behind Bars in America 2008, Pew Ctr. on the States 35, tbl. A-7 (2008), *available at* http://www.pewstates.org/uploadedFiles/PCS_Assets/2008/one%20in%20100.pdf; *see also* Adam Liptak, *U.S. Prison Population Dwarfs that of Other Nations*, N.Y. Times, April 23, 2008, *available at* http://www.nytimes.com/2008/04/23/world/americas/23iht-23prison.12253738.html?pagewanted=all&_r=3&.

3 The incarceration of drug users comes at a heavy price—the average annual operating cost per state inmate in 2010 was $28,323, or $77.60 per day. *See* Tracey Kyckelhahn, U.S. Dep't of Just., Bureau of Just. Statistics, State Corrections Expenditures, FY 1982-2010 4 (2012), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/scefy8210.pdf; *see also* Christian Henrichson & Ruth Delaney, Vera Inst. Of Just., The Price of Prisons: What Incarceration Costs Taxpayers 10 (2012), *available at* http://www.vera.org/pubs/price-prisons-what-incarceration-costs-taxpayers (follow "The Price of Prisons report" hyperlink) (reporting that it costs an average of $31,286 per year to incarcerate an inmate based on additional cost drivers such as underfunded contributions to retiree health care for corrections employees, states' contributions to retiree health care on behalf of their corrections departments, employee benefits, such as health insurance, and hospital and other health care for the prison population).

4 A World Health Organization survey of 17 countries in 2008, including the Netherlands and other countries with less stringent drug laws, found that the United States has the highest level of illegal drug use in the world. *See* Louisa Degenhardt et al., *Toward a Global View of Alcohol, Tobacco, Cannabis, and Cocaine Use: Findings from the WHO World Mental Health Surveys*, 5 PLoS Medicine 1053, 1061 & 1065 (2008) [hereinafter *Toward a Global View*], *available at* http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0050141 (follow "download" hyperlink). Americans report the highest level of cocaine and marijuana use — Americans were 4 times more likely to have tried cocaine in their lifetime than the next closest country, the Netherlands, while 42.2% of Americans admitted to having used marijuana.

world's largest consumer of illegal drugs.[5] On the 40th anniversary of the War on Drugs, former President Jimmy Carter declared it a total failure, noting that global drug use for all drugs had increased in the years since the drug war started.[6]

The first half of the War on Drugs focused largely on relentless enforcement of heroin and crack cocaine laws in poor communities of color.[7] But with the ebb of the crack epidemic in the late 1980s, law enforcement agencies began shifting to an easy target: marijuana. As a result, over the past 20 years police departments across the country have directed greater resources toward the enforcement of marijuana laws. Indeed, even as overall drug arrests started to decline around 2006, marijuana arrests continued to rise, and now make up over half of all drug arrests in the United States. In 2010, there were more than 20,000 people incarcerated on the sole charge of marijuana possession.[8]

Stated simply, marijuana has become the drug of choice for state and local police departments nationwide. Between 2001 and 2010, there were 8,244,943 marijuana arrests, of which 7,295,880, or 88%, were for marijuana possession. In 2010 alone, there were 889,133 marijuana arrests — 300,000 more than arrests for all violent crimes

5 U.S. Senate Caucus on Int'l Narcotics Control, Reducing The U.S. Demand For Illegal Drugs 11 (2012), *available at* http://www.feinstein.senate.gov/public/index.cfm/files/serve/?File_id=81b53476-64a3-4088-9bae-254a84b95ddb (citing Ctr. For Behavioral Health Statistics & Quality, Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Dep't of Health & Human Services, Results From The 2010 National Survey on Drug Use and Health (NSDUH): Summary of National Findings (Sept. 2011)) ("According to the National Survey on Drug Use and Health, in 2010, about 22.6 million Americans aged 12 and older were current (in the past month) illegal drug users, representing 8.9 percent of the population. This represents the largest proportion in the past decade of people aged 12 and older identified as current illegal drug users.").

6 Jimmy Carter, Op-Ed., *Call Off the Global Drug War*, N.Y. Times, June 16, 2011, *available at* http://www.nytimes.com/2011/06/17/opinion/17carter.html?_r=3&. Further evidence that the War on Drugs has been a global failure is a 2012 report by the Global Commission on Drug Policy that found that the "global war on drugs is driving the HIV/AIDS pandemic among people who use drugs and their sexual partners." Global Comm'n on Drug Pol'y, The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic 2 (2012), *available at* http://globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/GCDP_HIV-AIDS_2012_REFERENCE.pdf. The Commission points to research that shows that repressive drug law enforcement practices result in driving drug users away "from public health services and into hidden environments where HIV risk becomes markedly elevated." *Id.* Furthermore, the mass incarceration of nonviolent drug offenders increases HIV risk—in the United States as many as 25% of Americans infected with HIV may pass through correctional facilities annually, and higher rates of incarceration for African Americans may be one reason for markedly higher HIV rates among African Americans. *Id.*

7 Blacks have borne the disproportionate brunt of the broader War on Drugs. Although Blacks comprise only 13% of the general population, 33% of all drug arrests are of Blacks, and they are more likely to be incarcerated upon conviction for drug offenses. Jamie Fellner et al., Human Rights Watch, Decades of Disparity: Drug Arrests and Race in the United States 4 & 16 (2009), *available at* http://www.hrw.org/sites/default/files/reports/us0309web_1.pdf. Blacks' likelihood of being arrested for drugs at ages 17, 22, and 27 are approximately 13%, 83%, and 235% greater than that of whites. *See* Ojmarrh Mitchell & Michael S. Caudy, Examining Racial Disparities in Drug Arrests, Just. Q., 1 (2013) [hereinafter Mitchell & Caudy]. While some have suggested that such disparities can be explained by differences in drug use, drug offending, or neighborhood residence, a recent study examining these severe racial disparities in drug arrests found that the disparities cannot be accounted for by differences in such factors. *Id*. Specifically, the study found that 87% of Black's higher probability of drug arrests is in fact not attributable to differences in drug use, nondrug offending, or neighborhood context, but instead due to racial bias in law enforcement. *Id*. at 20. These findings are consistent with previous research finding that racial disparities in drug arrests are only partially explained by racial differences in drug offending. *See* Katherine Beckett, ACLU Drug Law Reform Project & The Defender Ass'n, Race and Drug Law Enforcement in Seattle 3-4 (2008), *available at* http://www.aclu.org/files/assets/race20and20drug20law20enforcement20in20seattle_20081.pdf (finding that while the majority of those who use and deliver serious drugs in Seattle are white, the majority of those purposefully arrested for delivering serious drugs in Seattle are Black, and that the focus on crack cocaine is the fundamental cause of such racial disparity and is not a function of race-neutral policy).

8 *See* Nat'l Ctr. On Addiction & Substance Abuse, Behind Bars II: Substance Abuse And America's Prison Population 2, 14 (2010) [hereinafter Behind Bars II], *available at* http://www.casacolumbia.org/articlefiles/575-report2010behindbars2.pdf (reporting that there were 20,291 people incarcerated for marijuana possession as their only offense).

combined — or one every 37 seconds. There were 140,000 more marijuana arrests in 2010 than in 2001, and 784,021 of them, or 88%, were for possession.[9]

In states with the worst disparities, Blacks were on average over six times more likely to be arrested for marijuana possession than whites.

The War on Marijuana has largely been a war on people of color. Despite the fact that marijuana is used at comparable rates by whites and Blacks, state and local governments have aggressively enforced marijuana laws selectively against Black people and communities.[10] In 2010, the Black arrest rate for marijuana possession was 716 per 100,000, while the white arrest rate was 192 per 100,000. Stated another way, a Black person was 3.73 times more likely to be arrested for marijuana possession than a white person — a disparity that increased 32.7% between 2001 and 2010. It is not surprising that the War on Marijuana, waged with far less fanfare than the earlier phases of the drug war, has gone largely, if not entirely, unnoticed by middle- and upper-class white communities.

In the states with the worst disparities, Blacks were on average over six times more likely to be arrested for marijuana possession than whites. In the worst offending counties across the country, Blacks were over 10, 15, even 30 times more likely to be arrested than white residents in the same county. These glaring racial disparities in marijuana arrests are not a northern or southern phenomenon, nor a rural or urban phenomenon, but rather a national one. The racial disparities are as staggering in the Midwest as in the Northeast, in large counties as in small, on city streets as on country roads, in counties with high median family incomes as in counties with low median family incomes. They exist regardless of whether Blacks make up 50% or 5% of a county's overall population. The racial disparities in marijuana arrest rates are ubiquitous; the differences can be found only in their degrees of severity.

Thus, while the criminal justice system casts a wide net over marijuana use and possession by Blacks, it has turned a comparatively blind eye to the same conduct

9 While the broader War on Drugs also often fails to differentiate meaningfully between corner-dealer and kingpin, low-level possessor and major pusher, addicts who sell simply to support their habits and profit-reaping entrepreneurs, its architects at least claimed that it was designed originally to disable larger-scale drug distributors.

10 See *infra* Figures 21–23. Between 2001 and 2010, of individuals surveyed by SAMHSA, each year slightly more Blacks than whites reported using marijuana over the past year; among 18- to 25-year-olds, marijuana use was higher among whites than Blacks over the same time period. Substance Abuse and Mental Health Serv. Admin., Marijuana Use in Lifetime, Past Year, and Past Month among Persons Aged 18 to 25, by Demographic Characteristics: Percentages, 2009 and 2010 tbls. 1.26A & 1.26B, *available at* http://www.samhsa.gov/data/nsduh/2k10NSDUH/tabs/Sect1peTabs1to46.htm.

occurring at the same rates in many white communities. Just as with the larger drug war, the War on Marijuana has, quite simply, served as a vehicle for police to target communities of color.

The War on Marijuana has, quite simply, served as a vehicle for police to target communities of color.

To the extent that the goal of these hundreds of thousands of arrests has been to curb the availability or consumption of marijuana, they have failed.[11] In 2002, there were 14.5 million people aged 12 or older — 6.2% of the total population — who had used marijuana in the previous month; by 2011, that number had increased to 18.1 million — 7.0% of the total population.[12] According to a World Health Organization survey of 17 countries, 42.2% of Americans have tried marijuana in their lifetime.[13] The 2010 National Survey on Drug Use and Health reported similar numbers — 39.26% of Americans surveyed reported having used marijuana in their lifetimes — and over 17.4 million Americans had used marijuana in the past month.[14] Between 2009 and 2010, 30.4% of 18- to 25-year-olds reported having used marijuana at least once in the past month.[15]

All wars are expensive, and this war has been no different. States spent over $3.61 billion combined enforcing marijuana possession laws in 2010. New York and California combined spent over $1 billion in total justice system expenditures just on enforcement of marijuana possession arrests. Had marijuana been regulated like alcohol, and had its

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11 Indeed, one report noted that the increase in marijuana arrests during the 1990s had no measurable impact on price, access, or availability of marijuana. *See* Katherine Beckett & Steve Herbert, ACLU of Wash., The Consequences and Costs of Marijuana Prohibition 18-20 (2008) [hereinafter Beckett & Herbert], *available at* http://www.aclu-wa.org/library_files/BeckettandHerbert.pdf. *See also* Nat'l Drug Intelligence Ctr., Nat'l Drug Threat Assessment 2011 5, 29 (2011), *available at* http://www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf (noting that the demand for marijuana is rising and that availability is high); *id.* at iv ("Despite recent increases in marijuana arrests, the price of marijuana has dropped; its average potency has increased; it has become more readily available; and marijuana use rates have often increased during the decade of increasing arrests. It thus appears that the goals of marijuana prohibition have not been achieved."); *see generally* Craig Reinarman, Peter D.A. Cohen, & L. Kaal, *The Limited Relevance of Drug Policy: Cannabis in Amsterdam and in San Francisco*, 94 Am. J. of Pub. Health 836 (2004), *available at* http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.94.5.836 (comparing the availability and use of marijuana between Amsterdam, where the government adopted de facto decriminalization in 1976, and San Francisco, and finding that the criminalization of marijuana did not reduce use, nor did decriminalization of marijuana increase use). Marijuana use throughout the 1980s, when marijuana arrests were level, actually fell. In 1979, rates of usage began to decline sharply, falling 61%, while arrest rates declined by only 24% for the time period. From 1991 to 2003, marijuana arrest rates increased disproportionately by 127% as compared to the 22% increase in use. Jason Ziedenberg & Jason Colburn, Just. Pol'y Inst., Efficacy & Impact: The Criminal Justice Response to Marijuana Policy in the US 9 (2005) [hereinafter Ziedenberg & Colburn], *available at* http://www.justicepolicy.org/research/2017.

12 *See Drug Facts: Nationwide Trends,* Nat'l Inst. on Drug Abuse, (Dec. 2012), http://www.drugabuse.gov/publications/drugfacts/nationwide-trends (last visited Feb. 25, 2013).

13 *See Toward a Global View, supra* note 4.

14 U.S. Dep't of Health & Human Serv., Substance Abuse & Mental Health Serv. Admin., Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings (2011), *available at* http://www.samhsa.gov/data/NSDUH/2k10NSDUH/2k10Results.htm.

15 U.S. Dep't of Health & Human Serv., Substance Abuse & Mental Health Serv. Admin., State Estimates of Substance Use and Mental Disorders from the 2009-2010 National Surveys on Drug Use and Health 2.2 (last updated 2012), *available at* http://www.samhsa.gov/data/NSDUH/2k10State/NSDUHsae2010/NSDUHsaeCh2-2010.htm#2.2.

use been treated as a public health issue akin to alcohol instead of as a criminal justice issue, this is money that cities, counties, and police departments could have invested in an array of other law enforcement priorities and community initiatives.

States spent over $3.6 billion combined enforcing marijuana possession laws in 2010.

Marijuana arrests, prosecutions, and convictions have wrought havoc on both individuals and communities, not only causing direct harm but also resulting in dire collateral consequences. These include affecting eligibility for public housing and student financial aid, employment opportunities, child custody determinations, and immigration status. Marijuana convictions can also subject people to more severe charges and sentences if they are ever arrested for or convicted of another crime. In addition, the targeted enforcement of marijuana laws against people of color, and the unsettling, if not humiliating, experience such enforcement entails, creates community mistrust of the police, reduces police-community cooperation, and damages public safety.

Concentrated enforcement of marijuana laws based on a person's race or community has not only been a central component of this country's broader assault on drugs and drug users, it has also resulted from shifts in policing strategies, and the incentives driving such strategies. Over the past 20 years, various policing models rooted in the "broken windows" theory, such as order-maintenance and zero-tolerance policing, have resulted in law enforcement pouring resources into targeted communities to enforce aggressively a wide array of low-level offenses, infractions, and ordinances through tenacious stop, frisk, and search practices. Indeed, it seems hard to avoid the conclusion that police tactics of effectuating a high volume of arrests for minor offenses has been a major contributor to the 51% rise in marijuana arrests between 1995 and 2010. Adding further stimuli to such policing strategies are COMPSTAT — a data-driven police management and performance assessment tool — and the Byrne Justice Assistance Grant Program, a federal funding mechanism used by state and local police to enforce drug laws. These programs appear to create incentives for police departments to generate high numbers of drug arrests, including high numbers of marijuana arrests, to meet or exceed internal and external performance measures.

So we stand at a strange crossroads in America with regards to marijuana policy. On the one hand, as of November 2012, two states — Colorado and Washington — have legalized marijuana; 19 jurisdictions (18 states and the District of Columbia) allow

marijuana for medical purposes; a majority of Americans favor both full legalization[16] as well as legalizing marijuana for medicinal purposes;[17] whites and Blacks use marijuana at comparable rates,[18] and many residents of middle- and upper-class white communities use marijuana without legal consequence or even fear of entanglement in the criminal justice system. On the other hand, in 2010 there were over three-quarters of a million arrests for marijuana possession — accounting for almost half of the almost 1.7 million drug arrests nationwide — for which many people were jailed and convicted. Worse yet, Blacks were arrested for marijuana possession at almost four times the rate as whites, with disparities even more severe in several states and counties, and the country spent billions of dollars enforcing marijuana laws.

But the right road ahead for this country is clearly marked: marijuana possession arrests must end. In place of marijuana criminalization, and taking a cue from the failure of alcohol prohibition, states should legalize marijuana, by licensing and regulating marijuana production, distribution, and possession for persons 21 or older. Legalization would, first and foremost, eliminate the unfair race- and community-targeted enforcement of marijuana criminal laws; help reduce overincarceration in our jails and prisons; curtail infringement upon constitutional rights, most notably as guaranteed by the Fourth Amendment's proscription of unreasonable searches and seizures; and allow law enforcement to focus on serious crime.[19]

Furthermore, at a time when states are facing budget shortfalls, legalizing marijuana makes fiscal sense. The licensing and taxation of marijuana will save states millions of dollars currently spent on enforcement of marijuana criminal laws. It will, in turn, raise millions more in revenue to reinvest in public schools and substance abuse

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16 *Majority Now Supports Legalizing Marijuana*, Pew Research Ctr for the People & the Press (Apr. 4, 2013), http://www.people-press.org/2013/04/04/majority-now-supports-legalizing-marijuana/. A 2012 Rasmussen poll of likely voters revealed that 56% favored legalizing and regulating marijuana in a similar manner to alcohol and tobacco regulation, while 36% opposed. *56% Favor Legalizing, Regulating Marijuana*, Rasmussen Reports (May 17, 2012), http://www.rasmussenreports.com/public_content/lifestyle/general_lifestyle/may_2012/56_favor_legalizing_regulating_marijuana. Other polls have produced similar results. *Record High of 50% of Americans Favor Legalizing Marijuana Use*, Gallup Politics (Oct. 27, 2011), http://www.gallup.com/poll/150149/record-high-americans-favor-legalizing-marijuana.aspx.

17 A Gallup poll in 2010 found that 70% of Americans favored making marijuana legally available for doctors to prescribe to reduce pain and suffering. Elizabeth Mendes, *New High of 46% of Americans Support Legalizing Marijuana*, Gallup Politics (Oct. 28, 2010), http://www.gallup.com/poll/144086/New-High-Americans-Support-Legalizing-Marijuana.aspx.

18 See *infra* Figures 21–23.

19 A retired deputy chief of the Los Angeles Police Department criticized the drug war's diversion of police resources, citing the reassignment of Los Angeles police officers to oversee the constant transfer of prisoners to county correctional facilities as well as the fact that police laboratories were inundated with drug samples to test, which slowed the testing of rape kits and evidence related to other serious crimes. *See* Stephen Downing, Op-Ed, *Drug War: What Prohibition Costs Us [Blowback]*, L.A. Times, Oct. 6, 2011, *available at* http://opinion.latimes.com/opinionla/2011/10/drug-war-blowback.html. Drug law enforcement "is believed to have redirected law enforcement resources that have resulted in more drunk driving, and decreased investigation and enforcement of violent crime laws." Bryan Stevenson, *Drug Policy, Criminal Justice and Mass Incarceration* 4 (Global Comm'n on Drug Policies, Working Paper, 2011), *available at* http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Bryan_Stevenson.pdf. In Illinois, for example, a 47% increase in drug arrests corresponded with a 22.5% decrease in drunk driving arrests. Mark Mauer & Ryan S. King, The Sentencing Project, A 25-Year Quagmire: The War on Drugs and Its Impact on American Society 5 (2007) [hereinafter Mauer & King], *available at* http://www.sentencingproject.org/doc/publications/dp_25yearquagmire.pdf.

prevention, as well as general funds and local budgets, research, and public health, to help build stronger, safer communities.[20] Indeed, Washington State's Office of Financial Management projects that Initiative 502, which legalized the possession of marijuana for people 21 or older under tight regulations, will generate more than half a billion dollars in new revenue each year through a 25% marijuana excise tax, retail sales, and business and occupation taxes.[21] The state will direct 40% of the new revenues toward the state general fund and local budgets and 60% toward education, health care, substance abuse prevention, and research.[22] At the national level, a CATO Institute study estimated that federal drug expenditures on marijuana prohibition in 2008 were $3.4 billion, and that legalization would generate $8.7 billion in annual revenue.[23]

If legalizing marijuana through taxation, licensing, and regulation is unobtainable, states should significantly reduce marijuana arrests by removing all criminal and civil penalties for authorized marijuana use and possession for persons 21 or older. Under depenalization, there would be no arrests, prosecutions, tickets, or fines for marijuana use or possession as long as such activity complies with existing regulations governing such activities. If depenalization is unobtainable, states should decriminalize marijuana possession for personal use by reclassifying all related criminal laws as civil offenses only, with a maximum penalty of a small fine.

In addition to ending marijuana possession arrests, police departments should reform order-maintenance policing strategies that focus on low-level offenses. Instead, law enforcement should address public health questions and safety concerns in ways that minimize the involvement of the criminal justice system by moving toward non-punitive, transparent, collaborative community- and problem-oriented policing strategies. These strategies should aim to serve, protect, and respect all communities. In addition, the federal government should end inclusion of marijuana possession arrests as a performance measure of law enforcement agencies' use of or application for federal funds, and redirect such funds currently designated to fight the War on Drugs toward drug treatment, research on treatment models and strategies, and public education.

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20 For example, Colorado's Amendment 64 directs $24 million to the state's Building Excellent Schools Today program, which is projected to create 372 new jobs from school construction projects by 2017. *See* Christopher Stiffler, Colo. Ctr. for Law and Pol'y, Amendment 64 Would Produce $60 million in New Revenue and Savings for Colorado 9 (2012) [hereinafter Stiffler], *available at* http://www.cclponline.org/postfiles/amendment_64_analysis_final.pdf.

21 *See* Washington State Office of Fin. Mgmt., Fiscal Impact Statement (I-502) (2012), *available at* http://www.ofm.wa.gov/initiatives/2012/502_fiscal_impact.pdf.

22 Wash. Initiative 502 (I-502) (2012), *available at* http://sos.wa.gov/_assets/elections/initiatives/i502.pdf.

23 Jeffrey A. Miron & Katherine Waldock, Cato Inst., The Budgetary Impact of Ending Drug Prohibition 1 (2010) [hereinafter Miron & Waldock, Budgetary Impact], *available at* http://www.cato.org/sites/cato.org/files/pubs/pdf/DrugProhibitionWP.pdf. *See* Fiscal Cost Analysis *infra* pp. 68-71 (explaining the methodology used in the Miron and Waldock study).

II. FINDINGS

FINDING #1 Marijuana Arrests — 88% of Which Are for Possession Offenses — Have Risen Since 2001 and Accounted for Over Half (52%) of All Drug Arrests in America in 2010

- Between 2001 and 2010, there were over 7 million arrests (7,295,880) for marijuana possession. In 2010 alone, of the 1,717,064 drug arrests in America, over three-quarters of a million — 784,021 — were for marijuana possession.

- While overall drug arrests rose steadily between 1990 and 2006, between 2006 and 2010 they had fallen by over 200,000. Marijuana possession arrests have not only been rising since 1990, when there were just over 250,000 marijuana possession arrests, but increased between 2006 and 2010. There were 100,000 more marijuana possession arrests in 2010 than in 2001, an 18% increase; 200,000 more than in 1995, a 51% increase; and over 500,000 more than in 1990, a 193% increase.

- In 2010, nearly half (46%) of all drug arrests in America were for marijuana possession, an increase from 34% in 1995. Between 2005 and 2010, the percentage of all drug arrests accounted for by marijuana possession arrests increased 21%. In Alaska, 81% of all drug arrests were for marijuana possession in 2010; in Nebraska and Montana, 73% and 70%, respectively; in Wyoming, Georgia, Iowa, Wisconsin, and Colorado, 60% or more of all drug arrests were for marijuana possession.

- Of all marijuana arrests in 2010, 784,021, or 88%, were for possession. Similarly, 88% of all marijuana arrests between 2001 and 2010 — 7,295,880 out of 8,244,943 — were for possession.

- In New York and Texas, the two states with the most marijuana arrests in 2010, 97% were for possession. In nearly half of all states, over 90% of marijuana arrests were for possession. In only seven states did possession

arrests account for less than 80% of all marijuana arrests, and in only two (Massachusetts and Minnesota) was the figure below 65%.

- The 12 states with the most marijuana possession arrests in 2010 made over half a million total arrests: New York, which alone made over 100,000 arrests, Texas, Florida, California, Illinois, Georgia, Maryland, New Jersey, Pennsylvania, North Carolina, Ohio, and Virginia. In total numbers, the states with the greatest increase in annual marijuana possession arrests between 2001 and 2010 were Texas (20,681 more arrests in 2010 than in 2001), New York (16,173), Illinois (12,406), Florida (12,796), and Georgia (9,425).

- The national marijuana possession arrest rate in 2010 was 256 per 100,000 people. The jurisdictions with the highest overall marijuana possession arrest rates per 100,000 residents were:

D.C.	**846**
New York	**535**
Nebraska	**417**
Maryland	**409**
Illinois	**389**

- Twenty-nine states and the District of Columbia had higher marijuana possession arrest rates in 2010 than in 2001.[24] The states with the greatest percentage increases in marijuana possession arrest rates were Montana (146%), Delaware (102%), Nevada (96%), the District of Columbia (62%), and Oregon (45%).

- Cook County, IL (includes Chicago) made the most marijuana possession arrests in 2010 with over 33,000, or 91 per day.[25] The five counties (or boroughs) of New York City made a total of 59,451 marijuana possession arrests, or 163 per day; Kings County (Brooklyn) made over 20,000,

24 In addition to the 50 states, this report has analyzed marijuana arrest and fiscal data for the District of Columbia. While the District of Columbia is obviously not a state, the report includes the data for the District of Columbia when presenting both state and county data. Thus, there are instances when the report presents state data (e.g., "the states with the highest" or "list of states"), particularly in the graphs, charts, and tables, and includes the District of Columbia.

25 It is worth noting that in 2012 the Chicago City Council overwhelmingly voted to decriminalize marijuana possession, opting to allow police to issue tickets rather than make arrests. Kristen Mack, *Chicago OKs Pot Tickets*, Chi. Tribune, June 28, 2012 [hereinafter Mack], *available at* http://articles.chicagotribune.com/2012-06-28/news/ct-met-chicago-city-council-0628-20120628_1_pot-possession-possession-of-small-amounts-pot-tickets.

Bronx County over 16,000. Los Angeles County, CA, made over 15,600 such arrests and Harris County, TX (includes Houston), almost 12,000. There were another combined 30,000 arrests for marijuana possession in Maricopa County, AZ (includes Phoenix), Fulton County, GA (includes Atlanta), Clark County, NV (includes Las Vegas), and Baltimore City, MD; and there were 40,000 more combined in San Diego and Orange Counties, CA, Suffolk (part of Long Island) and Erie (includes Buffalo) Counties, NY, St. Louis City, MO, Philadelphia County, PA, Milwaukee County, WI, Bexar County, TX (includes San Antonio), and the District of Columbia.

- The counties with the highest marijuana possession arrest rates per 100,000 residents were:

Worcester, MD	**2,132**
Kleberg, TX	**1,294**
Cole, MO	**1,230**
Bronx, NY	**1,154**
Baltimore City, MD	**1,136**

- Teenagers and young adults bear the brunt of marijuana possession arrests: 62% of marijuana possession arrests in 2010 were of people 24 years old or younger, and more than 34% were of teenagers or younger.

FINDING #2 Extreme Racial Disparities in Marijuana Possession Arrests Exist Across the Country: Blacks Are 3.73 Times More Likely Than Whites to Be Arrested for Marijuana Possession

- In 2010, nationwide the white arrest rate was 192 per 100,000 whites, and the black arrest rate was 716 per 100,000 blacks.

- Racial disparities in marijuana possession arrests are widespread and exist in every region in the country. In the Northeast and Midwest, Blacks are over four times more likely to be arrested for marijuana possession than whites. In the South, Blacks are over three times more likely, and in the West, they are twice more likely. In over one-third of the states, Blacks are more than four times likelier to be arrested for marijuana possession than whites.

- Racial disparities in marijuana possession arrests exist regardless of county household income levels, and are greater in middle income and more affluent counties. In the counties with the 15 highest median household incomes (between $85K–$115K), Blacks are two to eight times more likely to be arrested for marijuana possession than whites. In the 15 counties in the middle of the household income range (between $45K–$46K), Blacks are over three times more likely to be arrested for marijuana possession than whites. In the poorest 15 counties (median household incomes between $22K–$30K), Blacks are generally 1.5 to five times more likely to be arrested.

Racial disparities in marijuana possession arrests exist regardless of county household income levels, though they are worse in middle income and more affluent communities.

Racial Disparities at the State Level

- The states (plus the District of Columbia) with the largest racial disparities in marijuana possession arrest rates per 100,000 are:

	Black Arrest Rate	White Arrest Rate	Times More Likely Blacks Arrested
Iowa	1,454	174	8.34
D.C.	1,489	185	8.05
Minnesota	835	107	7.81
Illinois	1,526	202	7.56
Wisconsin	1,285	215	5.98
Kentucky	697	117	5.95
Pennsylvania	606	117	5.19

Even at the "lower end" of the spectrum, the disparities persist. In Oregon, for example, the state with the fifth *lowest* disparity, the Black arrest rate (563) is still more than double the white arrest rate (271).

The states, plus the District of Columbia, with the highest Black arrest rates per 100,000 for marijuana possession were:

	Black Arrest Rate
Nebraska	1,699
Illinois	1,526
D.C.	1,489
Iowa	1,454
Wisconsin	1,285
Nevada	1,272
Wyoming	1,223
New York	1,192

- While the Black arrest rate for marijuana possession was *under* 300 in only two states, Hawaii (179) and Massachusetts (61)(following decriminalization), the white arrest rate was *over* 300 in only three states: Wyoming (376), Nebraska (365), and Alaska (318). In only 10 states was the Black arrest rate *under* 500, while in no state was the white arrest rate *over* 400.

- Of marijuana possession arrests in the District of Columbia, a staggering 91% were of Blacks. In Mississippi, 69% of all marijuana possession arrests were of Blacks. In Georgia and Louisiana, the numbers are 64% and 61%, respectively. These figures are further illuminated when taking into account the difference between Blacks' percentage of marijuana arrests and Blacks' percentage of state populations. In Illinois, for instance, Blacks make up 15% of the population, but account for 58% of the marijuana possession arrests. Similarly, in Alabama, 60% of the marijuana possession arrests are of Blacks, yet Blacks account for less than 25% of the population. In Kentucky and Minnesota, Blacks represent only 8% and 5% of the respective states, but 36% and 31% of the marijuana possession arrests.

Racial Disparities at the County Level

- This report examined 945 counties in the United States with at least 30,000 residents and where Blacks make up at least 2% of the population; these 945 counties represent 78% of the total United States population.[26] Of these counties, in only 37 (or 3.9%) is the white arrest rate for marijuana possession higher than the Black arrest rate. In other words, in over 96% of the counties examined in this report, Blacks are more likely than whites to be arrested for marijuana possession.

- The counties with the largest racial disparities in arrest rates for marijuana possession are not necessarily in the states with the largest racial disparities in arrest rates. For instance, Missouri has the 40th largest Black-white arrest ratio (2.63) of all the states, but in St. Louis City, MO, one white person is arrested for every 18.4 Black persons arrested. Georgia has the 21st largest racial disparity (3.69), but in Gordon, GA, the ratio is one white arrest for every 14.1 Black arrests (or 136 white arrests per 100,000 as compared to 1,921 Black arrests per 100,000). Ohio is 16th on the racial disparity list (4.11), but in Allen, OH, Blacks are 13.2 times more likely to be arrested than whites. Kings County (Brooklyn), New York has the 10th largest racial disparity in marijuana possession arrests at 4.52); 161 whites per 100,000 are arrested, whereas 1,554 Blacks per 100,000 are arrested — a ratio of 9.68.

26 When reporting the national and state data regarding marijuana possession arrests, this report considers all 3,143 counties and 100% of the population of the United States.

- The counties with the highest Black arrest rates for marijuana possession are spread throughout the country, from Campbell and Kenton, KY, to Worcester, MD; from Dare, NC, to Livingston and Montgomery, IL; from Onondaga, Broome, and Chautauqua, NY, to Chambers, Kleberg, Hopkins, Cooke, and Van Zandt, TX.

- 92% of marijuana possession arrests in Baltimore City, MD, were of Blacks; 87% in Fulton, GA (includes Atlanta); 85% in Prince George's, MD; 83% in Shelby, TN (includes Memphis); and 82% in Philadelphia, PA.

- These staggering racial disparities in marijuana possession arrests exist in many counties irrespective of the overall Black population. For example, in Lycoming and Lawrence, PA, and in Kenton County, KY, Blacks make up less than 5% of the population, but are between 10 and 11 times more likely than whites to be arrested. In Hennepin County, MN (includes Minneapolis), and Champaign and Jackson Counties, IL, Blacks are 12%, 13%, and 15% of the population, respectively, but are 9 times more likely to be arrested than whites. In Brooklyn, NY, and St. Louis City, MO, Blacks comprise 37% and 50% of the residents, respectively, and are 12 and 18 times more likely to be arrested than whites. In Chambers, AL, and St. Landry, LA, Blacks account for more than twice as many marijuana arrests (90% and 89%, respectively) than they do of the overall population (39% and 42%, respectively). In Morgan and Pike Counties, AL, Blacks make up just over 12% and 37% of the population, respectively, but account for 100% of the marijuana possession arrests.

FINDING #3 While There Were Pronounced Racial Disparities in Marijuana Arrests Ten Years Ago, the Disparities Have Increased

- As the overall number of marijuana arrests has increased over the past decade, the white arrest rate has remained constant at around 192 per 100,000, whereas the Black arrest rate has risen from 537 per 100,000 in 2001 (and 521 per 100,000 in 2002) to 716 per 100,000 in 2010. Hence, it appears that the increase in marijuana arrest rates overall is largely a result of the increase in the arrest rates of Blacks.

- Racial disparities in marijuana possession arrests have increased in 38 of the 50 states (and in the District of Columbia) over the past decade. The states where the disparities have increased the most since 2001 are:

	Black/White Arrest Ratio		% Change in Disparity
	2001	2010	
Alaska	0.3	1.6	+384%
Minnesota	2.4	7.8	+231%
Wisconsin	2.4	6.0	+153%
Michigan	1.3	3.3	+149%
Kentucky	2.4	6.0	+146%
Tennessee	1.8	4.0	+122%
Ohio	1.9	4.1	+118%

FINDING #4 Blacks and Whites Use Marijuana at Similar Rates

- Marijuana use is roughly equal among Blacks and whites. In 2010, 14% of Blacks and 12% of whites reported using marijuana in the past year; in 2001, the figure was 10% of whites and 9% of Blacks. In every year from 2001 to 2010, more whites than Blacks between the ages of 18 and 25 reported using marijuana in the previous year. In 2010, 34% of whites and 27% of Blacks reported having last used marijuana more than one year ago — a constant trend over the past decade. In the same year, 59% of Blacks and 54% of whites reported having never used marijuana. Each year over the past decade more Blacks than whites reported that they had never used marijuana.

- The relentless criminalization of marijuana has not had a noticeable deterrent effect on usage rates, which have remained constant over time. Notably, marijuana use reached an all-time low around 1990, when there

were far fewer arrests for marijuana possession. As law enforcement has increasingly prioritized marijuana possession arrests, usage rates have risen. Generally, from 1980 to 2000 there was no upward trend in the number of people using marijuana. Since 2000, however, marijuana use has generally increased among persons aged 18 or older and has remained approximately the same for persons aged 12 to 17.

FINDING #5 Money Wasted on Marijuana Arrests: States Spent Over $3.6 Billion on Marijuana Possession Enforcement in 2010

- The ACLU estimates the total national expenditure of enforcing marijuana possession laws at approximately $3.613 billion. In 2010, states spent an estimated $1,747,157,206 policing marijuana possession arrests, $1,371,200,815 adjudicating marijuana possession cases, and $495,611,826 incarcerating individuals for marijuana possession.

- New York and California combined spent over $1 billion to enforce their marijuana laws in 2010.[27] Add the amount of money that Texas, Illinois, Florida, New Jersey, Georgia, and Ohio spent, and the total is over $2 billion.

- Over half of the states (27) each spent over $30 million in 2010 enforcing marijuana possession laws.

- Even when discounting entirely all state fiscal spending on prison facilities, corrections expenditures associated with marijuana possession enforcement are significant — California, Florida, Illinois, New York, and Texas, for example, each spent more than an estimated $20 million of state taxpayer money in 2010 housing individuals in local jail and county

27 Note that California's expenditures in 2011 would be lower following decriminalization of possession of 28.5 grams or less of marijuana in 2010 and the accompanying drop in marijuana arrests. *See* Kamala D. Harris, Cal. Dep't of Just. Crim. Just. Statistics Ctr., Crime in California: 2011 2 & 26 (2012), *available at* http://oag.ca.gov/sites/all/files/pdfs/cjsc/publications/candd/cd11/cd11.pdf? (noting the decline in misdemeanor marijuana arrests after reclassification).

correctional facilities for possession of marijuana, with New York and California spending more than $65 million apiece.

- The states, including the District of Columbia, that had the highest per capita fiscal expenditures enforcing marijuana possession laws in 2010 were, in order: the District of Columbia, New York, Maryland, Illinois, and Wyoming, followed closely by Nevada, Delaware, New Jersey, and Connecticut.

Exhibit F

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URL of this page: http://www.nlm.nih.gov/medlineplus/ency/article/002598.htm

Acetaminophen overdose

Acetaminophen (Tylenol) is a pain medicine. Acetaminophen overdose occurs when someone accidentally or intentionally takes more than the normal or recommended amount of this medication.

Acetaminophen overdose is one of the most common poisonings worldwide. People often think that this medicine is very safe. However, it may be deadly if taken in large doses.

This is for information only and not for use in the treatment or management of an actual poison exposure. If you have an exposure, you should call your local emergency number (such as 911) or 1-800-222-1222 for a local poison control center near you.

Where Found

Acetaminophen is found in a variety of over-the-counter and prescription pain relievers.

Tylenol is a brand name for acetaminophen. Other medicines that contain acatominophen include:

- Anacin-3
- Liquiprin
- Panadol
- Percocet
- Tempra
- Various cold and flu medicines

Note: This list is not all inclusive.

Common dosage forms and strengths:

- Suppository: 120 mg*, 125 mg, 325 mg, 650 mg
- Chewable tablets: 80 mg
- Junior tablets: 160 mg
- Regular strength: 325 mg
- Extra strength: 500 mg
- Liquid: 160 mg/teaspoon
- Drops: 100 mg/mL, 120 mg/2.5 mL

*mg = milligrams

You should not take more than 4000 mg of acetaminophen a day. Taking more, especially 7000 mg or more, can lead to a severe overdose if not treated.

Symptoms

- Abdominal pain
- Appetite loss
- Coma

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- Convulsions
- Diarrhea
- Irritability
- Jaundice
- Nausea
- Sweating
- Upset stomach
- Vomiting

Note: Symptoms may not occur until 12 or more hours after the acetaminophen was swallowed.

Home Care

There is no home treatment. Seek immediate medical help.

Before Calling Emergency

Determine the following information:

- Patient's age, weight, and condition
- Name of the product (ingredients and strengths, if known)
- Time it was swallowed
- Amount swallowed

Poison Control

In the United States, call 1-800-222-1222 to speak with a local poison control center. This hotline number will let you talk to experts in poisoning. They will give you further instructions.This is a free and confidential service.

All local poison control centers in the United States use this national number. You should call if you have any questions about poisoning or poison prevention. You can call 24 hours a day, 7 days a week.

What to Expect at the Emergency Room

The health care provider will measure and monitor the patient's vital signs, including temperature, pulse, breathing rate, and blood pressure. Blood tests will be done to check how much acetaminophen is in the blood. The patient may receive:

- Medicines to treat symptoms
- Activated charcoal
- Laxative
- Medicine (antidote) to reverse the effect of the poison

Outlook (Prognosis)

If treatment is received within 8 hours of the overdose, there is a very good chance of recovery.

However, without rapid treatment, a very large overdose of acetaminophen can lead to liver failure and death in a few days.

Alternative Names

Tylenol overdose; Paracetamol overdose

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Exhibit G

New Tylenol cap will have warning label

By CNN Staff
updated 7:37 AM EDT, Fri August 30, 2013

CNN.com

(CNN) -- Bottles of Extra Strength Tylenol will soon have a new warning on their caps: "Contains acetaminophen. Always read the label."

The bright red lettering is an effort by Tylenol's parent company, Johnson & Johnson, to reduce the number of accidental acetaminophen overdoses that occur each year.

"Acetaminophen overdose is one of the most common poisonings worldwide," according to the National Institutes of Health.

Taking too much of this pain reliever can cause severe liver damage. The Food and Drug Administration sets the maximum limit for adults at 4,000 milligrams per day. One gel tablet of Extra Strength Tylenol contains 500 mg.

People should keep their doctor and pharmacist informed about all the medications they are taking to ensure that they are not consuming more than the daily limit, according to the FDA. They should also avoid taking acetaminophen with alcohol.

"With more than 600 (over the counter) and prescription medications containing acetaminophen on the market, this is an important step because it will help remind consumers to always read the label," Johnson & Johnson said in a statement about the new caps, which will arrive in October.

Gupta: Let's end the prescription drug death epidemic

CNN's Jacque Wilson and John Bonifield contributed to this story.

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Exhibit H

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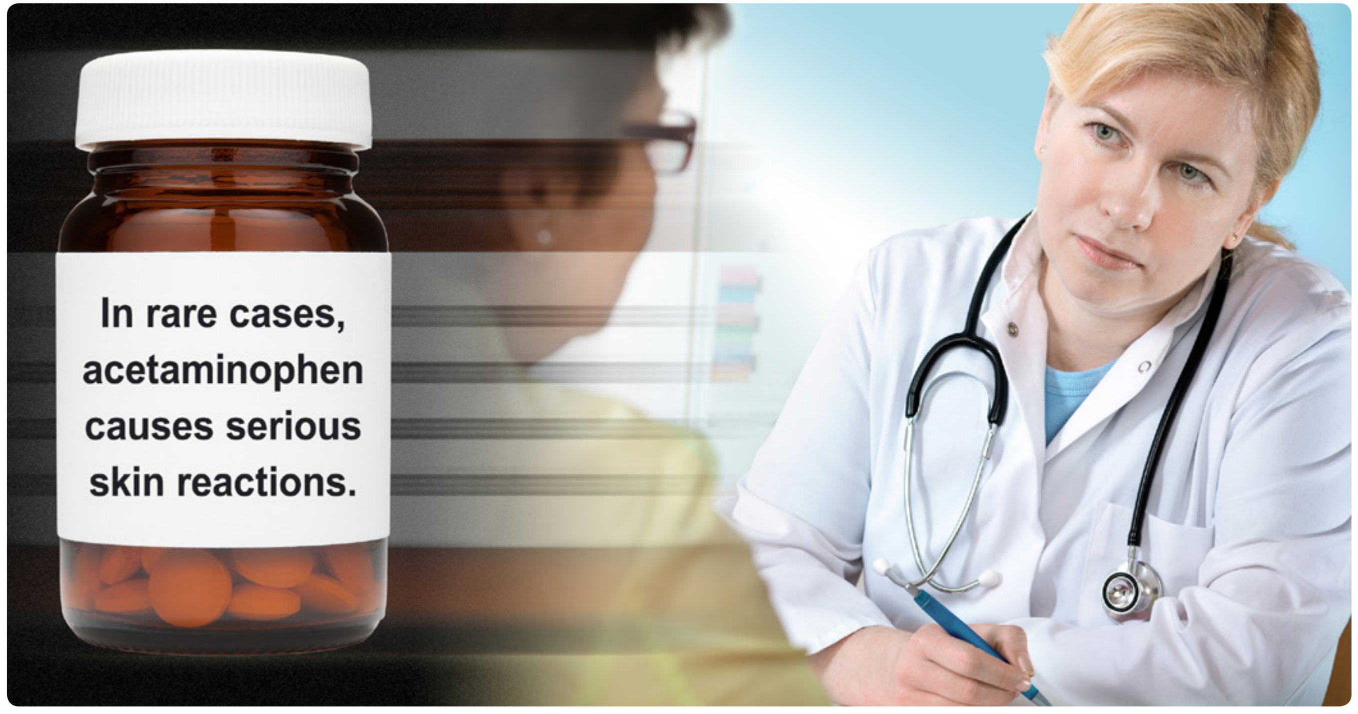
FDA Warns of Rare Acetaminophen Risk



If you've ever had a skin reaction when taking acetaminophen, don't take the drug again and discuss alternate pain relievers/ fever reducers with your health care professional.

Acetaminophen, a fever and pain reliever that is one of the most widely used medicines in the U.S., can cause rare but serious skin reactions, warns the Food and Drug Administration (FDA).

Although rare, possible reactions to acetaminophen include three serious skin diseases whose symptoms can include rash, blisters and, in the worst case, widespread damage to the surface of skin. If you are taking acetaminophen and develop a rash or other skin reaction, stop taking the product immediately and seek medical attention right away.

Used for decades by millions of people, acetaminophen is the generic name of a common active ingredient included in numerous prescription and non-prescription medicines. Tylenol is one brand name of the pain reliever sold over the counter, but acetaminophen is also available as a generic under various names. It is also used in combination with other medicines, including opioids for pain and medicines to treat colds, coughs, allergy, headaches and trouble sleeping.

"This new information is not intended to worry consumers or health care professionals, nor is it meant to encourage them to choose other medications," says Sharon Hertz, M.D., deputy director of FDA's Division of Anesthesia, Analgesia and Addiction. "However, it is extremely important that people recognize and react quickly to the initial symptoms of these rare but serious, side effects, which are potentially fatal."

Other drugs used to treat fever and pain, such as nonsteroidal anti-inflammatory drugs including ibuprofen and naproxen, already carry warnings about the risk of serious

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Stevens-Johnson Syndrome (SJS) and toxic epidermal necrolysis (TEN) are the two most serious skin reactions linked in rare cases to acetaminophen. They usually require hospitalization and can cause death.

skin reactions. Advil and Motrin are among the common brand names that include ibuprofen as an active ingredient. Aleve and Midol Extended Relief are among the best-known brand names that include naproxen as an active ingredient.

FDA is requiring that a warning about these skin reactions be added to the labels of all prescription medicines containing acetaminophen. FDA will work with manufacturers to get the warnings added to the labels of over-the-counter medicines containing acetaminophen.

On OTC medicines, the word "acetaminophen" appears on the front of the package and on the Drug Facts label's "active ingredients" section. On prescription medications, the label may spell out the ingredient or use a shortened version such as "APAP,'' "acet," "acetamin" or "acetaminoph."

Ingredient Linked to Several Conditions

Stevens-Johnson Syndrome (SJS) and toxic epidermal necrolysis (TEN) are the two most serious skin reactions linked in rare cases to acetaminophen. They usually require hospitalization and can cause death.

Problems usually begin with flu-like symptoms followed by rash, blistering and extensive damage to the surfaces of the skin. Recovery can take weeks or months, and possible complications include scarring, changes in skin pigmentation, blindness and damage to internal organs.

A third skin reaction, acute generalized exanthematous pustulosis (AGEP), usually resolves within two weeks of stopping the medication that caused the problem.

A serious skin reaction can occur at any time, even if you've taken acetaminophen previously without a problem. There is currently no way of predicting who might be at higher risk.

If you've ever had a skin reaction when taking acetaminophen, don't take the drug again and discuss alternate pain relievers/fever reducers with your health care professional.

Evidence of Link

Prior to deciding to add a warning about skin reactions to products containing acetaminophen, FDA reviewed medical literature and its own database, the FDA Adverse Event Reporting System (FAERS).

A search of FAERS uncovered 107 cases from 1969 to 2012, resulting in 67 hospitalizations and 12 deaths. Most cases involved single-ingredient acetaminophen products; the cases were categorized as either probable or possible cases associated with acetaminophen.

A small number of cases, just over two dozen, are documented in medical literature, with cases involving people of various ages.

FDA has examined—and continues to examine—acetaminophen for safety issues, just as it does with all approved drugs. The warning comes two years after FDA took new steps to reduce the risk of liver injury from acetaminophen. In that case, FDA asked all makers of prescription products to limit acetaminophen to 325 milligrams per tablet or capsule. FDA also required all prescription acetaminophen products to include a Boxed Warning—FDA's strongest warning, used for calling attention to serious risks.

The agency continues to consider the benefits of this medication to outweigh the risks.

"FDA's actions should be viewed within the context of the millions who, over generations, have benefited from acetaminophen," says Hertz. "Nonetheless, given the severity of the risk, it is important for patients and health care providers to be aware of it." FDA

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Exhibit I

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DEXTROMETHORPHAN

(Street Names: DXM, CCC, Triple C, Skittles, Robo, Poor Man's PCP)

July 2012
DEA/OD/ODE

Introduction:

Dextromethorphan (DXM) is an over-the-counter (OTC) cough suppressant commonly found in cold medications. DXM is often abused in high doses by adolescents to generate euphoria and visual and auditory hallucinations. Illicit use of DXM is referred to on the street as "Robo-tripping" or "skittling." These terms are derived from the most commonly abused products, Robitussin and Coricidin.

Licit Uses:

DXM is an antitussive found in more than 120 OTC cold medications either alone or in combination with other drugs such as analgesics (e.g. acetaminophen), antihistamines (e.g. chlorpheniramine), decongestants (e.g., pseudoephedrine) and/or expectorants (e.g., guaifenesin). The typical antitussive adult dose is 15 or 30 mg taken three to four times daily. The anticoughing effects of DXM persist for 5 to 6 hours after oral administration. When taken as directed, side-effects are rarely observed. IMS Health® reports a decrease in total dispensed DXM medications from 13.2 million in 2008 to 10.8 million in 2011. In the first quarter of 2012, there were 3.1 million DXM medications dispensed.

Illicit Use:

DXM is abused by individuals of all ages but its abuse by teenagers and young adults is of particular concern. This abuse is fueled by DXM's OTC availability and extensive "how to" abuse information on various web sites. The sale of the powdered form of DXM over the Internet poses additional risks due to the uncertainty of composition and dose.

DXM abusers report a heightened sense of perceptual awareness, altered time perception, and visual hallucinations. The typical clinical presentation of DXM intoxication involves hyperexcitability, lethargy, ataxia, slurred speech, sweating, hypertension, and/or nystagmus. Abuse of combination DXM products also results in health complications from the other active ingredient(s), which include increased blood pressure from pseudoephedrine, potential delayed liver damage from acetaminophen, and central nervous system toxicity, cardiovascular toxicity and anticholinergic toxicity from antihistamines. The use of high doses of DXM in combination with alcohol or other drugs is particularly dangerous and deaths have been reported.

Abusers of DXM describe the following four dose-dependent "plateaus:"

Plateau	Dose (mg)	Behavioral Effects
1st	100–200	Mild stimulation
2nd	200–400	Euphoria and hallucinations
3rd	300– 600	Distorted visual perceptions Loss of motor coordination
4th	500-1500	Dissociative sedation

According to the American Association of Poison Control Centers, there were 43,642 poison exposures related to dextromethorphan in 2010.

The 2011 Monitoring the Future (MTF) Report indicated that the annual prevalence of non-medical use of cough and cold medicines among students in 8th, 10th, and 12th grades was 2.7%, 5.5%, and 5.3%, respectively.

Chemistry/Pharmacology:

Dextromethorphan (DXM) (d-3-methoxy-N-methyl-morphinan) is the dextro isomer of levomethorphan, a semisynthetic morphine derivative. Although structurally similar to other narcotics, DXM does not act as a mu receptor opioid (e.g. morphine, heroin). DXM and its metabolite, dextrorphan, act as potent blockers of the N-methyl-d-aspartate (NMDA) receptor. At high doses, the pharmacology of DXM is similar to the controlled substances phencyclidine (PCP) and ketamine that also antagonize the NMDA receptor. High doses of DXM produce PCP-like behavioral effects. DXM may cause a false-positive test result with some urine immunoassays for PCP.

Approximately 5-10% of Caucasians are poor DXM metabolizers which increases their risk for overdoses and deaths. DXM should not be taken with antidepressants due to the risk of inducing a life threatening serotonergic syndrome.

Illicit Distribution:

DXM abuse has traditionally been with the OTC liquid cough preparations. More recently, abuse of tablet and gel capsule preparations has increased. DXM powder sold over the Internet is also a source of DXM for abuse. DXM is also distributed in illicitly manufactured tablets, containing only DXM or mixed with other illicit drugs such as ecstasy or methamphetamine.

According to DEA's National Forensic Laboratory Information System (NFLIS) and System to Retrieve Information from Drug Evidence (STRIDE), federal, state and local forensic laboratories analyzed 201 dextromethorphan exhibits that were submitted in 2010 and 190 exhibits that were submitted in 2011. During the first three months of 2012, 45 DXM exhibits were submitted to forensic laboratories.

Control Status:

DXM is not scheduled under the Controlled Substances Act (CSA). However, the CSA indicated that DXM could be added to the CSA, in the future, through the traditional scheduling process, if warranted.

Comments and additional information are welcomed by the Drug and Chemical Evaluation Section; Fax 202-353-1263, telephone 202-307-7183 or Email ODE@usdoj.gov.

Exhibit J

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Marijuana stops child's severe seizures

By Saundra Young , CNN
updated 4:51 PM EDT, Wed August 7, 2013

CNN.com

Is marijuana bad, or could it be good for some? CNN chief medical correspondent Dr. Sanjay Gupta spent a year traveling around the world to shed light on the debate. Catch his groundbreaking documentary "WEED" at 8 p.m. ET August 11 on CNN.

(CNN) -- By most standards Matt and Paige Figi were living the American dream. They met at Colorado State University, where they shared a love of the outdoors. After getting married, the couple bought a house and planned to travel the world.

They did travel, but their plans changed when their first child was born in 2004.

Max was 2 when they decided to have another child. The couple got the surprise of their lives when an ultrasound revealed not one but two babies. Charlotte and Chase were born October 18, 2006.

"They were born at 40 weeks. ... Charlotte weighed 7 pounds, 12 ounces," Paige said. "They were healthy. Everything was normal."

Seizures and hospital stays begin

The twins were 3 months old when the Figis' lives changed forever.

Charlotte had just had a bath, and Matt was putting on her diaper.

"She was laying on her back on the floor," he said, "and her eyes just started flickering."

The seizure lasted about 30 minutes. Her parents rushed her to the hospital.

"They weren't calling it epilepsy," Paige said. "We just thought it was one random seizure. They did a million-dollar work-up -- the MRI, EEG, spinal tap -- they did the whole work-up and found nothing. And sent us home."

A week later, Charlotte had another seizure. This one was longer, and it was only the beginning. Over the next few months, Charlotte -- affectionately called Charlie -- had frequent seizures lasting two to four hours, and she was hospitalized repeatedly.

Doctors were stumped. Her blood tests were normal. Her scans were all normal.

"They said it's probably going to go away," Paige recalled. "It is unusual in that it's so severe, but it's probably something she'll grow out of."

But she didn't grow out of it. The seizures continued. The hospital stays got longer. One of the doctors treating Charlotte thought there were three possible diagnoses.

The worse-case scenario? Dravet Syndrome, also known as myoclonic epilepsy of infancy or

SMEI.

Dravet Syndrome is a rare, severe form of intractable epilepsy. Intractable means the seizures are not controlled by medication. The first seizures with Dravet Syndrome usually start before the age of 1. In the second year, other seizures take hold: myoclonus, or involuntary, muscle spasms and status epilepticus, seizures that last more than 30 minutes or come in clusters, one after the other.

At that time, the Figis said, Charlotte was still developing normally, talking and walking the same day as her twin. But the seizures continued to get worse. The medications were also taking a toll. She was on seven drugs -- some of them heavy-duty, addictive ones such as barbiturates and benzodiazepines. They'd work for a while, but the seizures always came back with a vengeance.

"At 2, she really started to decline cognitively," Paige said. "Whether it was the medicines or the seizures, it was happening, it was obvious. And she was slipping away."

When Charlotte was 2½, the Figis decided to take her to Children's Hospital Colorado. A neurologist tested her for the SCN1A gene mutation, which is common in 80% of Dravet Syndrome cases. After two months, the test came back positive.

"I remember to this day it was a relief," Paige said. "Even though it was the worst-case scenario, I felt relief just to know."

Matt, a Green Beret, decided to leave the military.

"Every mission, every training I was going to do I was called home because she was in the pediatric ICU again or in the hospital again."

They were quickly running out of options. They considered a drug from France. Doctors suggested an experimental anti-seizure drug being used on dogs.

Paige took her daughter to Chicago to see a Dravet specialist, who put the child on a ketogenic diet frequently used to treat epilepsy that's high in fat and low in carbohydrates. The special diet forces the body to make extra ketones, natural chemicals that suppress seizures. It's mainly recommended for epileptic patients who don't respond to treatment.

The diet helped control Charlotte's seizures but had a lot of side effects. She suffered from bone loss. Her immune system plummeted. And new behavioral problems started popping up.

"At one point she was outside eating pine cones and stuff, all kinds of different things," Matt said. "As a parent you have to say, let's take a step back and look at this. Is this truly beneficial treatment because of these other things?"

Two years into the diet, the seizures came back.

The end of the rope

In November 2000, Colorado voters approved Amendment 20, which required the state to set up

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a medical marijuana registry program.

Pot activists divided over new cannabis club

There are eight medical conditions for which patients can use cannabis -- cancer, glaucoma, HIV/AIDS, muscle spasms, seizures, severe pain, severe nausea and cachexia or dramatic weight loss and muscle atrophy.

The average patient in the program is 42 years old. There are 39 patients under the age of 18.

Paige had consistently voted against marijuana use. That was before Dravet Syndrome entered their lives.

Matt, now a military contractor spending six months a year overseas, used his spare time scouring the Internet looking for anything that would help his little girl.

He found a video online of a California boy whose Dravet was being successfully treated with cannabis. The strain was low in tetrahydrocannabinol, or THC, the compound in marijuana that's psychoactive. It was also high in cannabidiol, or CBD, which has medicinal properties but no psychoactivity. Scientists think the CBD quiets the excessive electrical and chemical activity in the brain that causes seizures. It had worked in this boy; his parents saw a major reduction in the boy's seizures.

By then Charlotte had lost the ability to walk, talk and eat.

She was having 300 grand mal seizures a week.

Her heart had stopped a number of times. When it happened at home, Paige did cardiopulmonary resuscitation until an ambulance arrived. When it happened in the hospital, where they'd already signed a do-not-resuscitate order, they said their goodbyes. Doctors had even suggested putting Charlotte in a medically induced coma to give her small, battered body a rest.

She was 5 when the Figis learned there was nothing more the hospital could do.

That's when Paige decided to try medical marijuana. But finding two doctors to sign off on a medical marijuana card for Charlotte was no easy feat. She was the youngest patient in the state ever to apply.

Scientists don't fully understand the long-term effects early marijuana use may have on children. Studies that show negative effects, such as diminished lung function or increased risk of a heart attack, are primarily done on adult marijuana smokers. But Charlotte wouldn't be smoking the stuff.

Childhood is also a delicate time in brain development. Preliminary research shows that early onset marijuana smokers are slower at tasks, have lower IQs later in life, have a higher risk of stroke and increased incidence of psychotic disorders, leaving some scientists concerned.

Is medical marijuana safe for children?

"Everyone said no, no, no, no, no, and I kept calling and calling," Paige said.

She finally reached Dr. Margaret Gedde, who agree to meet with the family.

"(Charlotte's) been close to death so many times, she's had so much brain damage from seizure activity and likely the pharmaceutical medication," Gedde said. "When you put the potential risks of the cannabis in context like that, it's a very easy decision."

The second doctor to sign on was Alan Shackelford, a Harvard-trained physician who had a number of medical marijuana patients in his care. He wasn't familiar with Dravet and because of Charlotte's age had serious reservations.

"(But) they had exhausted all of her treatment options," Shackelford said. "There really weren't any steps they could take beyond what they had done. Everything had been tried -- except cannabis."

Paige found a Denver dispensary that had a small amount of a type of marijuana called R4, said to be low in THC and high in CBD. She paid about $800 for 2 ounces -- all that was available -- and had a friend extract the oil.

She had the oil tested at a lab and started Charlotte out on a small dose.

"We were pioneering the whole thing; we were guinea pigging Charlotte," Paige said. "This is a federally illegal substance. I was terrified to be honest with you."

But the results were stunning.

"When she didn't have those three, four seizures that first hour, that was the first sign," Paige recalled. "And I thought well, 'Let's go another hour, this has got to be a fluke.' "

The seizures stopped for another hour. And for the following seven days.

Paige said she couldn't believe it. Neither could Matt. But their supply was running out.

Charlotte's Web

Paige soon heard about the Stanley brothers, one of the state's largest marijuana growers and dispensary owners. These six brothers were crossbreeding a strain of marijuana also high in CBD and low in THC, but they didn't know what to do with it. No one wanted it; they couldn't sell it.

Still, even they had reservations when they heard about Charlotte's age. But once they met her, they were on board.

"The biggest misconception about treating a child like little Charlotte is most people think that we're getting her high, most people think she's getting stoned," Josh Stanley said, stressing his plant's low THC levels. "Charlotte is the most precious little girl in the world to me. I will do anything for her."

The brothers started the Realm of Caring Foundation, a nonprofit organization that provides cannabis to adults and children suffering from a host of diseases, including epilepsy, cancer, multiple sclerosis and Parkinson's, who cannot afford this treatment.

People have called them the Robin Hoods of marijuana. Josh Stanley said it's their calling. They use the money they make from medical marijuana patients and get donations from sponsors who believe in their cause. They only ask patients such as the Figis to donate what they can.

"We give (cannabis) away for next to free," Stanley said. "The state won't allow us to actually give it away, so we give it away for pennies really."

Charlotte gets a dose of the cannabis oil twice a day in her food.

Gedde found three to four milligrams of oil per pound of the girl's body weight stopped the seizures.

Today, Charlotte, 6, is thriving. Her seizures only happen two to three times per month, almost solely in her sleep. Not only is she walking, she can ride her bicycle. She feeds herself and is talking more and more each day.

"I literally see Charlotte's brain making connections that haven't been made in years," Matt said. "My thought now is, why were we the ones that had to go out and find this cure? This natural cure? How come a doctor didn't know about this? How come they didn't make me aware of this?"

The marijuana strain Charlotte and now 41 other patients use to ease painful symptoms of diseases such as epilepsy and cancer has been named after the little girl who is getting her life back one day at a time.

It's called Charlotte's Web.

"I didn't hear her laugh for six months," Paige said. "I didn't hear her voice at all, just her crying. I can't imagine that I would be watching her making these gains that she's making, doing the things that she's doing (without the medical marijuana). I don't take it for granted. Every day is a blessing."

Matt added, "I want to scream it from the rooftops. I want other people, other parents, to know that this is a viable option."

Readers debate future of pot laws

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Exhibit K

The Salt Lake Tribune

Families migrating to Colorado for a medical marijuana miracle

The waiting list for the cannabis extract includes about 30 kids in Utah whose parents hope to import what they consider an 'herbal' remedy.

BY KIRSTEN STEWART

THE SALT LAKE TRIBUNE

PUBLISHED: NOVEMBER 11, 2013 03:57PM
UPDATED: NOVEMBER 11, 2013 04:45PM

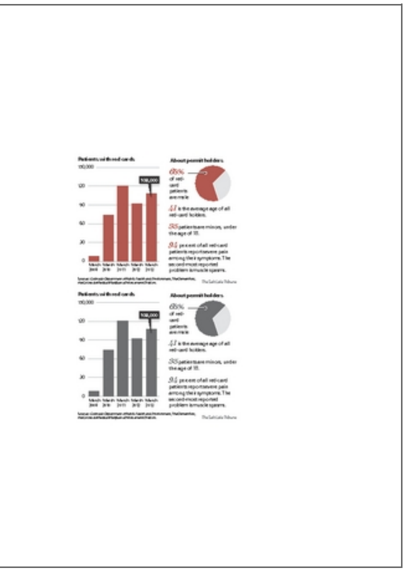
Denver • Piper rolls back and forth across a large blanket on the living room floor, windmilling her arms and kicking her legs.

“Who’s a happy girl?” asks her mom, Annie Koozer, kneeling over the 2-year-old with a small, oil-filled syringe. Piper fusses as Annie squirts a tiny amount into the side of her mouth.

“What do you think about that? That’s not too bad, especially if it makes you feel better,” says Annie.

It could take days or weeks before Annie and her husband, Justin Koozer, know whether the medicine controls Piper’s debilitating seizures. But waiting is familiar ground for the young Tennessee family that has tried virtually every pharmaceutical fix available, traveled 1,300 miles to get here and waited more than two months for what may be their best and final hope: cannabis.

The Koozers are part of a migration of families uprooting their lives and moving to Colorado, where the medicinal use of marijuana is permitted. More than medical tourists, they are medical refugees, forced to flee states where cannabis is off limits.



Red cards indicate growing use Marijuana use continues to soar. The number of Coloradans with red cards permitting them to use medical marijuana exploded from 6,000 in 2009 to 108,000 by March 2013. One reason for the increase, say Colorado health officials, is the federal government's "Ogden memo," which declared drug enforcement would not focus on marijuana-using patients.

“This is just the first wave,” said Margaret Gedde, a Colorado Springs physician with a doctorate from Stanford who prescribes marijuana and has compiled case studies of children using cannabis-infused oil. “These families are going to keep coming as awareness spreads because the results are real.”

Gedde has been monitoring 11 children with seizure disorders who are taking the same cannabis extract Piper is receiving, and she will present her findings at the annual meeting of the American Epilepsy Association in December.

Nine of the children have had a 90 to 100 percent reduction in their seizures, she said. The parents of one child aren’t sure the oil has helped, but it hasn’t hurt. And the other had a 50 percent reduction.

“It’s absolutely remarkable,” she said.

Medical marijuana is currently legal in 20 states, plus D.C. and Portland, Maine. But Colorado has become the go-to place for an extract from a plant that’s high in cannabidiol (CBD) but low in tetrahydrocannabinol (THC), the psychoactive chemical component of marijuana that creates a high in users.

Marijuana entrepreneurs and cultivators Joel, Jesse, Jonathan, Jordan, Jared and Josh Stanley call it Charlotte’s Web, named for the Colorado Springs girl who tried it first and went from having 300 seizures a week to about two a month. Videos showing a once-catatonic Charlotte Figi now talking, running on a beach and horseback riding have lured families from far and wide.

The number of children younger than 14 with marijuana “red cards” tripled in the last five months from seven in March to 21 in August, according to the Colorado Department of Health and Environment.

A waiting list the Stanleys keep for their CBD extract numbers about 200 and growing, said Josh Stanley, the oldest of the six brothers running the non-profit Realm of Caring Foundation.

The list includes about 30 kids in Utah whose parents, instead of relocating, are lobbying for permission to import the “herbal” remedy, which they’ve dubbed Alepsia. Since it’s so low in THC, they argue, it meets U.S. agricultural standards for hemp, which is used in products such as clothing and lotions.

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Next week they hope to receive the blessing of Utah's Controlled Substance Advisory Committee, which makes recommendations on the scheduling, or classification, of drugs.

—

'My heart is heavy' • The Koozers believe Piper is the first child with Aicardi syndrome to try Charlotte's Web.

Aicardi is a rare chromosomal disorder characterized by infantile spasms, or seizures, and the partial or complete absence of a structure in the brain called the corpus callosum.

Doctors discovered Piper was missing the thick band of nerve fibers that divides her cerebrum into left and right hemispheres when she was in the womb, during a 20-week ultrasound.

"We went to find out if we were having a girl or boy … Ten minutes later we learned there was something wrong with how her brain was developing," Annie wrote on a blog she keeps to update friends and family.

Almost all the cases have been girls. There is no cure; most children die either before the age of 1 or in their early teens.

For months after she was born Piper seemed to develop normally, cooing, making eye contact and flashing dimpled grins right on cue.

"She is already trying to roll over," Annie blogged on Sept. 12, 2011. "We are amazed at what she can do already, and she is just 3.5 weeks old!"

The doctor suggested that, unless she suffered delays, to wait until she turned 2 to put her through the stress of testing.

A month later she had her first seizures and her first long stint in a hospital.

"My heart is heavy and my mind, body and spirit are tired … I am trying to give my worry to God but it is easier said than done. I'm not sure I will ever feel like myself again," Annie wrote on November 11, 2011.

—

'So helpless and frustrated' • That year was a blur of doctor visits and brain scans as the Koozers searched for a drug to calm the seizures.

To date, they have tried nine therapies, including phenobarbital. It left Piper like a zombie, said Annie. "She was sedated and lost muscle tone. She stopped smiling for nine months."

While weaning her from the barbituate the family sought approval to use vigabatrin, then an investigational treatment known as a "wonder drug" in the Aicardi community.

One of the side effects, however, is permanent vision loss. Already Piper's retinas are dotted with small holes, one of the markers of her disease. She has good vision but probably sees the world as if she's looking through Swiss cheese, Annie surmises.

"Last night we had a particularly bad night. She wasn't able to fall asleep until 4 a.m. because she just had cluster after cluster [of seizures]…250 in a 6 hour period," Annie blogged on Valentine's Day in 2012, days before receiving approval. "I felt so helpless and frustrated I would have done anything to help her (like give her vigabatrin). I guess God is giving me a sign."

It cut her seizures in half, but the Koozers wanted a better therapy with less harsh side effects. They were out of options.

Their neurologist in Tennessee supports the couple's decision to try cannabis, which they learned about through support groups on Facebook.

"He understands we've reached the end of the line. There's one more drug, but it has a high chance of liver failure and he recommended waiting to try it when Piper is older," said Justin.

—

CBD mystery • Scientists are still learning how CBD works. One theory is that it modulates the transmission of electrical signals in the brain.

The human body makes endocannnabaniods similar, but not identical, to cannabinoid compounds in marijuana, said Gedde. "We have receptors to cannabinoids all throughout our bodies."

In our brains and nervous systems, messages are sent through electricity from cell to cell, directing them to perform activities. With epilepsy, those signals get out of control, like an electrical storm.

The research is incomplete but some studies suggest cannabinoids, when released, have a dampening effect on those signals, calming the seizures, Gedde said. "So kids with epilepsy, it could be that their natural cannabinoid system is insufficient."

But Igor Grant, director of the Center for Medicinal Cannabis Research at the University of California, San Diego, urges caution.

"What we don't know is, do most children benefit or is there some subset who uniquely benefit?" he said. "We also don't know if it's doing some harm … CBD is not psychoactive, but that doesn't mean it's harmless."

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Another big question is how long CBD's curative effects will last.

"What can happen with any new anti-seizure medicine is you get seizure reduction for awhile — they call it the honeymoon — but then it stops working," said Gedde.

Realm has documented two children — Charlotte and Zaki (pronounced Za-chai) — who have used the oil successfully for more than a year. And both children are not only virtually seizure-free, they're gaining developmental ground as their brains appear to be forming new connections.

"It works really well, it appears to keep working and it doesn't have the side effects and toxicity of other anti-seizure meds," Gedde said.

Evidence of cannabinoids' anti-seizure potential dates back to the 1840s, including studies in labs, animals and humans. And GW Pharmaceuticals is running clinical trials of a purified form of CBD.

The 11 children Gedde has been monitoring all have "convulsive-type seizures and severe [developmental] delays," she said. "We focused on them because they are the most severe and we wanted the results to be comparable to [GW Pharmaceuticals'] studies."

Some of the children have genetic disorders, she said, and "others had brain damage from not getting enough oxygen at birth. Another family had a storage disease where metabolytes build up in the body and become toxic."

—

'Stay objective' • It could take years for GW's drug to win federal approval and Gedde wonders if it will work as well as the whole plant extract, which also contains trace amounts of other cannabinoids.

And for families like the Koozers, time is brain matter.

Piper is about 4 to 5 months of age developmentally. She can't talk but is pretty easygoing, said Annie. "She gets that from her Dad."

On a bad day Piper has three to four 10-minute clusters of seizures. She's unable to sleep through the night and as she's gotten older, they seem to upset her more, said Annie. "It could mean she's developing. Since she turned 2 she has things that she really dislikes, such as having her clothes changed or brushing her hair. But it's hard to see her scream and cry."

The Stanley brothers feel the urgency, too.

On Oct. 25 they moved 20 patients off the waiting list, including Piper, providing them with their first batch at one of their dispensaries in Colorado Springs.

On any given morning, there's a line of customers waiting to be buzzed inside, some in pin-stripe shirts, others covered in tattoos — and lately, moms pushing strollers and wheelchairs.

After they show their red card and sign in, they're escorted to a glass case in the back filled with jars of bud with names such as Orange Kush and Choco-lope, pre-rolled joints and pot brownies.

Parents receive bottles of liquid medicine mixed to order, based on their child's weight.

"We tell parents not to expect miracles, to stay objective and have no loyalty to the medicine and to stop using it if it doesn't work or they see any ill side effects," said Joel Stanley. "It's just like any other medicine."

—

Found by parents • The waiting list for Charlotte's Web is carefully managed because once someone comes off, Realm of Caring guarantees them a future supply. They reserve Charlotte's Web, the highest of their high-CBD strains, for children so they don't run out.

They sell the oil to parents for children at about cost, $6 per dose, and provide it free to families who can't afford it.

Raised in Colorado Springs, a conservative military town with strong Protestant leanings, the Stanley brothers were educated at a Christian prep school. Josh Stanley started growing marijuana about five years ago and later convinced his brothers to help expand operations.

"There were times where we worked without pay. We were spending no time with our families; we had no life," said Jordan Stanley. "I was just about to throw in the towel when we discovered Charlotte."

The brothers are uncomfortable with the idea that some customers feign symptoms to get red cards. Marijuana is abused by some people, acknowledges Joel Stanley. "But it's those people who subsidize patients like Piper."

The Stanley brothers aren't the only source of high-CBD strains of cannabis. In fact, Charlotte Figi's mom, Paige, decided to try it after seeing a video of a child in California who used a strain called R4, said Gedde.

But they grow the highest CBD strain that Figi has been able to find. The oil has helped Charlotte, now 7, behaviorally and intellectually.

Her autism-like behaviors of self-injury, crying and violence are a thing of the past and she is clear-headed and bright-eyed, said Paige Figi. “We are almost two years into this. We hit our peak seizure control at about six months but she’s gaining skills and learning new words every week,” she said.

“Most moms take for granted that when you look in your baby’s eyes they’ll hold your gaze. To see that happen for the first time is just…” she said, searching for a word to convey the depth of that emotion.

Figi now advises other parents and helps raise money for Realm of Caring, which is exploring an expansion to California to meet growing demand for its oil there.

She and an epileptologist are co-authoring an article for the journal Neurology in which they debate with other researchers the benefits of whole plant CBD extracts versus pharmaceutical-grade CBD.

The argument that long-term effects are unknown doesn’t hold water for Figi, who hasn’t seen negative side effects in Charlotte. “But I’m happy to check that box and work with scientists to prove it. The answer to ‘We don’t know enough’ is going to be found, and it’s going to be found by parents.”

—

The ‘what-ifs’ • The Koozers arrived in Denver in August and made speedy work of applying for a red card. But it’s a big change from Tennessee, where no pro-marijuana movement exists, though they hope to stir debate by sharing their story.

They’ve had to downsize, having moved from a four-bedroom home to a cramped, two-bedroom apartment in Denver, located near the airport so Justin can commute to work and close to a hospital in case of emergencies.

Annie, now 30 weeks pregnant with their second child, a boy, spends long stretches of time alone changing diapers, hand-feeding Piper and monitoring her seizures while Justin, a manager for a supplier to the mining industry, travels for work.

“You’re completely re-establishing your whole life,” said Justin, 28. “We don’t have a support system. We don’t have friends. We had to find a new church, new doctors and therapists.”

Family can visit, but the Koozers are staying indefinitely. “We can’t leave the state with the extract or it would be a federal offense,” said Annie, 33. “We just felt like if we knew something was out there that might work and we didn’t try it we’d be doing the ‘what if’s’ our whole life.”

The Koozers were given a two-month supply of oil, which they’ll introduce gradually, starting with three .1 milliliter doses a day. If they see improvements, they’ll start weaning Piper off her other medications.

A neurologist is monitoring Piper’s progress and the Koozers document her seizures.

But there is no playbook to follow. Some kids, like Charlotte, have stopped seizing immediately and others have taken months to see results.

The night of her first dose Piper got 10 hours of sleep. Two weeks later, she is still seizing. “It’s been up and down,” Annie said last week.

But on Halloween the Koozers got a glimpse of a hoped-for future.

“It was the best day she’s ever had her whole life,” Annie said. Piper was happy and alert, laughing at appropriate intervals during a game of peek-a-boo with Justin, who had just returned from a trip, she explained. “It was almost like she knew he was back. Most of the time he comes home and she doesn’t even notice.”

Annie tries to keep expectations in check.

“I’m not expecting her to stand up and walk,” she said. “But it’s kind of like she’s waking up a little bit, more able to experience things, laugh and be a kid. That would be really huge for us.”

—

Join us for a Trib Talk

On Monday at 12:15 p.m., reporter Kirsten Stewart, marijuana grower Josh Stanley and others join Jennifer Napier-Pearce to discuss Colorado’s experience with medical refugees.

You can join the discussion by sending questions and comments using the hashtag #TribTalk on Twitter and Google+.

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Exhibit L

From: CDER Trade Press <CDERTradePress@fda.hhs.gov>
Subject: **FW: CBD legal status - CDER Response 7/29/2013**
Date: July 29, 2013 8:51:08 AM PDT
To: Fred Gardner

Hello Fred,

Your inquiry was forwarded to me in CDER Trade Press.

CBD meets the definition of Schedule I under the Controlled Substances Act. The DEA is the regulatory agency.

Best regards,
Lisa

Lisa Kubaska, PharmD
LCDR, U.S. PHS
Food and Drug Administration
CDER Trade Press
301-796-3654

Exhibit M

THE DAILY WASHINGTON
Law Reporter

Established 1874

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D.C. Superior Court

CRIMINAL LAW & PROCEDURE
Medical Necessity

Defendant is not guilty of possession of marijuana because of defense of medical necessity where he shows that ingestion of marijuana smoke had beneficial affect on his eye condition, normalizing intraocular pressure and lessening visual distortions.

UNITED STATES v. RANDALL, Super. Ct. D.C. Crim. No. 65923-75, November 24, 1976. *Opinion* per Washington, J. *John Karr* for defendant. *Richard Stolker* for United States.

WASHINGTON, J.: On August 27, 1975, defendant Robert C. Randall was arrested and charged with possession of a dangerous drug, LSD, and of a narcotic, marijuana, in violation of Sections 33-702(a)(4) and 33-402 respectively of the District of Columbia Code. Defendant moved to suppress these items as evidence, alleging that they were the fruit of an illegal search. After argument, the motion was granted with respect to the LSD, and the associated charge subsequently dismissed; the motion was denied with respect to the marijuana. An additional pre-trial request, a motion to dismiss on constitutional grounds, was withdrawn. The case came for trial by the Court on July 20 and 22, 1976, after the completion of which this matter was taken under advisement. Post trial briefs were invited, and a memorandum on behalf of the defendant was received on September 14. Having been recessed between September 17 and October 20, and after further delay occasioned by the illness of the trial judge, the Court pursuant to due deliberation and upon consideration of defendant's post trial submission, now renders this decision.

FACTS

The facts are not in dispute. The government has established, and the defendant has not attempted to refute, that on or about August 21, 1975, police officers in the course of their normal duties noticed what they believed to be cannabis plants on the rear porch and in the front windows of defendant's residence. On the basis of these observations and a field test which confirmed the presence of THC, the active ingredient of marijuana, a warrant was issued and a search of the premises conducted on August 23, 1975. Several plants and a dried substance later identified as marijuana were seized, and defendant's arrest followed.

At trial, the government's evidence demonstrated that the substance seized at defendant's residence was marijuana, possession of which is prohibited[1] by D.C. Code Section 33-402, thus establishing all the elements of the crime charged. Moreover, defendant admitted that he had grown the marijuana in question and that it was intended for his personal consumption. He further testified that he knew that possession and use of this narcotic are restricted by law.

Defendant nonetheless sought to exonerate himself through the presentation of evidence tending to show that his possession of the marijuana was the result of medical necessity. Over government objection of irrelevancy, defendant testified that he had begun experiencing visual difficulties as an undergraduate in the late 1960's. In 1972 a local ophthalmologist, Dr. Benjamin Fine, diagnosed defendant's condition as glaucoma, a disease of the eye characterized by the excessive accumulation of fluid causing increased intraocular pressure, distorted vision and, ultimately, blindness. Dr. Fine treated defendant with an array of conventional drugs, which stabilized the intraocular pressure when first introduced but became increasingly ineffective as defendant's tolerance increased. By 1974, defendant's intraocular pressure could no longer be controlled by these medicines, and the disease had progressed to the point where defendant had suffered the complete loss of sight in his right eye and considerable impairment of vision in the left.

Despite the ineffectiveness of traditional treatments, defendant during this period nonetheless achieved some relief through the inhalation of marijuana smoke. Fearing the legal consequences, defendant did not inform Dr. Fine of his discovery, but after his arrest defendant participated in an experimental program being conducted by ophthalmologist Dr. Robert Hepler under the auspices of the United States Government. Dr. Hepler testified that his examination of the defendant revealed that treatment with conventional medications was ineffective, and also that surgery, while offering some hope of preserving the vision which remained to defendant, also carried significant risks of immediate blindness. The results of the experimental program indicated that the ingestion of marijuana smoke had a beneficial effect on defendant's condition, normalizing intraocular pressure and lessening visual distortions.

OPINION

This is a case of first impression in this jurisdiction, one which raises significant issues. Consequently, the Court recognizes its responsibility to set forth clearly and in some depth its understanding of the applicable law. The legal questions presented by this case can be stated as follows:

1. Does the common law recognize the defense of necessity in criminal cases? If so, what are its parameters?
2. Have the elements of a necessity defense been established here?

These questions will be dealt with separately in the discussion which follows.

I. *Does the common law recognize the defense of necessity in criminal cases? If so, what are its parameters?*

Although the defense of necessity was seldom raised successfully at common law,[2] the existence of such a defense has been recognized by legal scholars since the turn of the twentieth century. Professor Courtney Kenny has noted, for example, that the same logic which prevents the imposition of civil liability in situations in which one has harmed the person or property of another in order to avoid a greater harm may also be applicable in certain criminal cases.[3]. Similarly, Clark and Marshall in their treatise on criminal law note several situations in which the necessity defense may be raised to criminal charges.[4] This common law defense is also recognized by such legal scholars as William L. Burdick,[5] Rollin F. Perkins,[6] and M. Cherif Bassouini.[7] More recently, the necessity defense has been considered in leading law reviews,[8] in modern reference works,[9] cases,[10] the Model Penal Code and the various state laws which have been revised under its influence.[11] While a consensus has not been reached concerning the specific contours of the defense, there is substantial unanimity in the belief that such a defense exists.

As Clark and Marshall, *supra*, note:

> An act which would otherwise be a crime may be excused if the person accused can show that it was done only in order to avoid consequences which could not otherwise be avoided, and which, if they had followed, would have inflicted upon him, or upon others whom he was bound to protect, inevitable and irreparable evil.[12]

Necessity is the conscious, rational act of one who is not guided by his own free will. It arises from a determination by the individual that any reasonable man in his situation would find the personal consequences of violating the

(Cont'd. on p. 2251 - Necessity)

1. As noted hereinafter, marijuana is not totally prohibited under D.C. Code 33-402 *et seq.* However, in view of the federal proscription, the Court notes that marijuana cannot be possessed legally in the District of Columbia.

2. As Judge Leventhal noted in *United States v. Moore*, 486 F.2d 1139, 158 U.S. App. D.C. 375, 417 (D.C. Cir. 1973), the common law defense of necessity has been "more discussed than litigated".

3. C. Kenny, *Outlines of Criminal Law* 68-70 (1907).

4. W. Clark and W. Marshall, *Treatise on the Law of Crimes* 104 et seq. (4th ed. 1940).

5. W. Burdick, *The Law of Crime* 260 (1946).

6. R. Perkins, *Perkins on Criminal Law* 951 (2nd ed. 1969).

7. M. Bassouini, *Criminal Law and its Processes* 106 et seq. (1969).

8. See, for example, Fletcher, *The Individualization of Excusing Conditions*, 47 S. Cal. L. Rev. 1274 (1974), and Note, *Justification: The Impact of the Model Penal Code on Statutory Reform*, 75 Colum. L. Rev. 914 (1975).

9. See, for example, 1 R. Anderson, Wharton's Criminal Law and Procedure 403-406 (1957), 21 Am Jr 2d *Criminal Law* §99.

10. Some sample cases will be discussed hereinafter.

11. Model Penal Code, §3.01 and 3.02, and Comment (Tent. Draft No. 8, 9, 10, 1958).

12. W. Clark and W. Marshall, note 4, *supra*.

TABLE OF CASES

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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

UNITED STATES MAGISTRATES' SCHEDULE FOR JANUARY, 1977

U.S. Magistrate LAWRENCE S. MARGOLIS
Civil trials, pretrials and motions; probation violation hearings; sentences; counsel appointments, arraignments and sub-arraignments.

U.S. Magistrate JEAN F. DWYER
Preliminary hearings, misdemeanor pleas, trials and sentences; civil trials, pretrials, and motions as available; Federal Reservation Sanity Hearings; traffic summons and trials; back-up Magistrate for emergency arrest and search warrants.

U.S. Magistrate HENRY H. KENNEDY, JR.
Bail in felony and misdemeanor cases and bail for Judges' Bench Warrants; civil trials, pretrials, and motions as available; Magistrate for arrest and search warrants including emergency night and weekend warrants; probation violation hearings and misdemeanor sentences.
BELL BOY NUMBER 626-2206

No preliminary hearings are scheduled for January 7th and 10th.

DISPOSITIONS

Number, Parties, Demand Amount, Action Taken and Attorneys

BY THE CLERK

CA8596-75 Knoll International, Inc. v. Yettekov Wilson. Acct., $1,510.61. Default judg., $1,420.61. Baylinson & Kudysh

FAMILY DIVISION
DOMESTIC RELATIONS BRANCH
NEW CASES

Number, Parties, Grounds and Attorney for Plaintiff

D3931-76 Sidberry, Barbara v. Lionell Dwight. Vol. Sep. A. T. Moss
D3932-76 Jackson, Lonie M. v. Marcellus W. Vol. Sep. A. T. Moss
D3933-76 Alabi, Jewyll R. v. Rasheed. Vol. Sep. R. W. Johnson
D3934-76 Baumgardner, Cornelius v. Angela. Vol. Sep. R. C. Liotta
D3935-76 Syring, David Lee v. Jean K. Vol. Sep. H. A. Calevas
D3936-76 Weisberg, Paul S. v. Tamara Levin. Vol. Sep. J. W. Karr
D3937-76 Matthews, Brenda R. v. John T. Vol. Sep. E. Sayles
D3938-76 Grey, Sterion v. Patricia R. Vol. Sep. E. Sayles
D3939-76 Hall, Alma Marie v. Robt. V. Vol. Sep. J. D. Green
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D3944-76 Sias, Willie Mae v. Joseph O. Vol. Sep. J. E. Lappin
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D3946-76 Jackson, Brenda J. v. Jerome Ray. Vol Sep. S. C. Jackson
D3947-76 Haney, Sandra L. v. Gregory F. Vol. Sep. S. H. Lang
D3948-76 Moore, Alonzo v. Sanders, Hattie. Vol. Sep. S. J. Levine
D3949-76 Moore, Alonzo v. Cantey, Lizzie Ruth. Vol. Sep. S. J. Levine

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NOTICE

The REAL PROPERTY LAW COMMITTEE will hold an EAT-N-LEARN Luncheon at 12:00 noon on Wednesday, January 19, 1977. The luncheon will be held in the Board of Directors room of the Bar Association, 1819 H Street, N.W., Room 300.

Our guest will be:

LOUIS W. COYNE, President
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His topic will be:

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DIXON INTRODUCES LOTTERY LEGISLATION

Councilman Arrington Dixon, D-Four, has announced his introduction of the Quick Buck and Tax Relief Act of 1976, a bill to legalize several forms of gambling, including, but not limited to bingo, numbers, on and off track betting, raffles and similar games of chance in the District.

This bill does not create a separate lottery commission as in many states, but would create a District of Columbia Lottery Administration which would be managed by an Administrator housed within the Department of Finance and Revenue. The purpose of this legislation, says Dixon, "is to provide an additional source of revenue for the District Government while providing a sound form of tax relief for District Residents."

Generally, the bill follows Maryland Lottery Law. Advised that the Maryland Lottery reached a record $2 million per week sales in September, Dixon expressed his concern that D.C. was losing thousands of dollars in possible revenue to neighboring jurisdictions.

The Director of the Department of Finance and Revenue is authorized to promulgate rules and regulations to carry out the purpose of the legislation and also delegate this authority to the Administrator of the Lottery Administration. All monies received from the gross sales of lottery tickets less the commission of authorized selling agents are placed in a special account known as the Lottery Fund. Under a scheme to be devised by the administrator, all ticket sales will be split between the District Government and the winners. Both daily and non-daily tickets are authorized to be sold, and ticket agents are directed to receive up to 5% of the purchase price of their gross sales and are also entitled to a special 1% windfall in certain cases to encourage sales.

Citing this as, "an effort to substantively address the grave and burdensome tax crisis currently facing District Residents," Dixon admits, "I realize that this does not provide the plenary answer to our tax problem, but everyone can use a 'quick buck' now and then, even the District Government."

NECESSITY

(Cont'd. from p. 2249)

law less severe than the consequences of compliance.[13] While the act itself is voluntary in the sense that the actor consciously decides to do it, the decision is dictated by the absence of an acceptable alternative. Unlike compulsion or duress, necessity arises from the press of events rather than through the imposition on the actor of the will of another person.[14]

Traditionally, the defense of necessity has been characterized as being either a justification of or an excuse for criminal activity.[15] As a justification, the concept has been used to negate the criminal nature of a prohibited activity. This position is based upon a conception of criminality as a combination of a prohibited act and an evil state of mind.[16] Where the criminal act was compelled by outside circumstances rather than through the exercise of the actor's free will, the requisite criminal intent is considered to be lacking. Thus, although the prohibited act has been committed, the elements of the crime are incomplete and the actor as well as anyone similarly situated must be relieved of criminal responsibility.

Necessity has also been seen in the law as a form of excuse. Under this view, criminal responsibility arises upon the performance of every willed action, regardless of the underlying reason for the choice.[17] The actor may be excused from punishment for public policy reasons, but not because he was without blame. Thus, although guilt is established punishment is not required because of extenuating circumstances which mitigate the seriousness of the offense. Under this theory, the necessity defense must be applied on a case by case basis rather than by reason of a general rule.

Common to both of these views is the belief that punishment should not be visited upon one who did not act of his own free will. Penalizing one who acted rationally to avoid a greater harm will serve neither to rehabilitate the offender nor to deter others from acting similarly when presented with similar circumstances. This point is implicitly recognized by the three traditional limitations on the applicability of the necessity defense. The defense will not shield an actor from criminal responsibility if:

13. C. Kenny, note 3, *supra*.

14. Three situations in which the necessity defense is not applicable should be noted. First, the defense cannot shield one who acts in violation of law out of a belief that the law is morally wrong. The constraints of one's conscience are not sufficient external circumstances for the purposes of this defense. Second, the compelling circumstances must actually exist; a *mistake of fact*, no matter how reasonable, defeats the defense. Thus a person who seeks the shelter of the necessity defense accepts the risk that he has perceived the situation incorrectly. Third, although it has been suggested that this aspect is ripe for change, it is still the law that necessity cannot justify the taking of an innocent human life.

15. See the discussion of justification and excuse in Note, *Justification: The Impact of the Model Penal Code on Statutory Reform*, 75 Colum. L. Rev. 914 (1975).

16. C. Kenny, note 3, *supra*, at p.33.

17. R. Perkins, note 6, *supra*, at p.749.

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1. The duress or circumstance has been brought about by the actor himself;
2. The same objective could have been accomplished by a less offensive alternative which was available to the actor; or
3. The evil sought to be averted was less heinous than that performed to avoid it.[18]

In brief, the necessity defense may not be raised unless the actor was reasonably compelled by circumstances to commit the proscribed act. It is unfair to excuse one who has brought the compelling situation upon himself, and it is violative of public policy to grant an exemption from punishment for behavior more detrimental to society than the consequences the actor seeks to avoid, or for behavior which is not the least offensive alternative. The application of these principles is well illustrated by the case law.

The first limitation, that necessity cannot serve as a defense where the compelling circumstances have been brought about by the accused, is a significant component of the decision in *United States v. Moore*, 486, F.2d 1139, 158 U.S. App. D.C. 375 (D.C. Cir. 1973). Appealing from a conviction in the District Court for possession of heroin in violation of two federal statutes, defendant did not dispute that the government had established all the elements of the offenses charged. Instead, he urged that because of his heroin addiction, he lacked capacity to choose to act otherwise, and therefore that his conviction should be vacated because the requisite criminal intent was absent. While none of the opinions represented a majority of the nine judges, the concurring opinions by Judge Wilkey, joined by Judges MacKinnon and Robb, and by Judge Leventhal joined by Judge McGowan, noted appellant's role in causing his addiction. Since drug dependence was a condition which the appellant had freely brought upon himself, he could not escape criminal sanctions by showing that he had been impelled by addiction to commit the prohibited acts.

The second limitation, that necessity cannot be raised where there is a less stringent alternative, was demonstrated in *Bice v. State*, 109 Ga. 117, 34 S.E. 202 (Ga., 1899). Convicted of a violation of a statute prohibiting the transporting of liquor to a church, defendant appealed, alleging, *inter alia*, medical necessity. Defendant admitted that liquor was contained in his carriage, which was parked in the vicinity of a church while he and his wife attended services, but contended that this proximity was necessary because the intoxicant was being used by his wife, for medicinal purposes pursuant to the instructions of her physician. The court noted the legal use of liquor in the treatment of such disorders as heart disease and colic but upheld the conviction, stating:

> If one should unfortunately be subject to any of these ills, he must either stay at home, or, if he wishes to provide against sudden attacks, take with him some other kind of medicine.[19]

The third limitation, that the harm avoided must be more serious than that performed to escape it, was a factor in the decision in *People v. Brown*, 70 Misc. 2d 224, 333 N.Y.S. 2d 342 (1972). Defendants, inmates at the facility known as the Tombs, had been convicted of rioting and seizing control of the prison. On appeal, the prisoners alleged that they had acted in protest of the crowded and inhumane conditions which prevailed at the facility, and that this justification should shield them from criminal penalties. The court disagreed, however, noting that the harm to society inherent in permitting this transgression among convicted criminals was more potentially damaging than their grievances.

In sum, the necessity defense has been recognized at common law as one which arises where the actor is compelled by external circumstances to perform the illegal act. Provided that the case does not fall within the scope of the three limitations, necessity constitutes a defense to criminal liability.

II. *Has necessity been established in the instant case?*

In the case at bar, defendant alleges that he is suffering from glaucoma, an incurable eye disease which results inevitably in loss of sight. While conventional medications and surgery offer little hope of improvement, defendant contends that the inhalation of marijuana smoke has a beneficial effect on his condition, relieving the symptoms and retarding the progress of the disease. Defendant therefore asserts that he should not be visited with the criminal consequences of possession of the proscribed narcotic marijuana. The Court finds upon these facts that the defendant has established the basic elements of the traditional necessity defense. It remains to consider whether he is barred from asserting it by one of the limitations.

A brief consideration reveals that of the three limitations, only the third poses any threat to this defendant's use of this defense. While the exact cause of defendant's glaucoma is unknown, neither the government nor any of the expert witnesses has suggested that the defendant is in any way responsible for his condition. Similarly, no alternative course of action would have secured the desired result through a less illegal channel. Because of defendant's tolerance, treatment with other drugs has become ineffective, and surgery offers only a slim possibility of favorable results coupled with a significant risk of immediate blindness. Neither the origin of the compelling circumstances nor the existence of a more acceptable alternative prevents the successful assertion of the necessity defense in this case.

The question of whether the evil avoided by defendant's action is less than the evil inherent in his act is more difficult. It requires a balancing of the interests of this defendant against those of the government. While defendant's wish to preserve his sight is too obvious to necessitate further comment, the government's interests require a more detailed examination.

One of the oldest recognized drugs, marijuana was not regulated in the United States until the Pure Food and Drug Act of 1906, which required that the presence of marijuana be indicated on the labels of products of which it was a component.[20] The modern prohibition began in 1937, in response to primarily economic pressures[21] without significant inquiry into its effects on users. More recently, the 1970 Controlled Substances Act[22] continued the prohibition of the use of marijuana, but a Presidential Commission was appointed to study its effects. Pending receipt of this report, marijuana was classified as a non-narcotic and although its use was still prohibited, the penalties were considerably reduced, with first offenders being discharged conditionally. The District of Columbia law, however, was not changed, and retains the narcotic classification based on the 1937 Uniform Narcotics Act.

Medical evidence suggests that the prohibition is not well founded.[23] Reports from the President's Commission and the Department of Health, Education and Welfare have concluded that there is no conclusive scientific evidence of any harm attendant upon the use of marijuana.[24] According to the most recent HEW study,[25] research has failed to establish any substantial physical or mental impairment caused by marijuana. Reports of chromosome damage, reduced immunity to disease, and psychosis are unconfirmed; actual evidence is to the contrary. Furthermore, unlike the so-called hard drugs, marijuana does not generally appear to be physically addictive or to cause the user to develop a tolerance, requiring more and more of the drug for the same effects.[26] The current HEW report also notes the possibility of valid medical uses for this drug. Both the President's Commission and HEW found the current penalties too harsh in view of the relatively inoffensive character of the drug, and recommended decriminalization. Commissions of study in other countries have reached similar conclusions,[27] and several states have taken steps in this direction.[28]

The right of an individual to protect his body has been weighed by several courts

18. C. Kenny, note 3, *supra*.

19. *Bice*, *supra*, at 203.

20. Pure Food and Drug Act of 1906, ch. 3915, 34 Stat. 768.

21. Liquor manufacturers and distributors, still recovering from the effects of Prohibition, were interested in eradicating the potential competition from a drug often used for recreational purposes. Brecher, *Licit and Illicit Drugs*, (Little, Brown, 1972). In addition, criminalizing marijuana simplified the task of eliminating the competition for jobs during the Depression posed by the principal users of the drug, Mexican migrant laborers. Musto, "The Marijuana Tax Act of 1937", Arch. Gen. Psychiat., Vol. 26, Feb., 1972.

22. 21 U.S.C. *801 et seq.*

23. This observation should not be taken as a holding on the medical merits of this drug in general, an issue this Court is not called upon to decide.

24. Testimony of Director of the National Institute of Mental Health, a division of the Department of Health, Education and Welfare, at H. Rep. #91-1444 on P.L. 91-513. "First Report of the National Commission on Marijuana and Drug Abuse: Marijuana: A signal of Misunderstanding." "Second Report of the National Commission on Marijuana and Drug Abuse: Drug Use in America: Problems in Perspective."

25. HEW, "Marijuana and Health, Fifth Annual Report to the U.S. Congress," at 4-7 (1975). This document was entered in evidence as Defendant's Exhibit #1.

26. HEW, "Marijuana and Health", *supra*, note 25, at p.6.

27. See for example the Indian Hemp Drugs Commission of 1894, sponsored by the Indian and British governments, the Baroness Wooton Report of 1968 in the United Kingdom, the LeDain Report of Canada in 1970.

28. Thirty-nine states have adopted all or most of the Uniform Controlled Substances Act, which ceased the classification of marijuana as a narcotic: Alabama, Arkansas, Connecticut, Delaware, Florida, Georgia, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia,

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against the interest of the government in guarding the health and morals of the general public. Most importantly, the Supreme Court addressed this question in *Roe v. Wade*, 410 U.S. 113 (1973) and *Doe v. Bolton*, 410 U.S. 179 (1973), cases which attacked the constitutionality of state statutes restricting abortions. In an opinion which stressed the fundamental nature of the right of an individual to preserve and control her body, the Court held that abortion cannot constitutionally be denied a woman under certain circumstances. These decisions recognize first that a woman may at any stage end a pregnancy which threatens her own existence, her right to life being more significant than that of the fetus, however close to term. The opinions go on to affirm the prerogative of a woman during the first three months of pregnancy to terminate it for any reason whatsoever, establishing that she may control her body at the expense of the life of a fetus less than four months old. The significance of these decisions to the instant case lies in the revelation of how far-reaching is the right of an individual to preserve his health and bodily integrity.

The federal district courts have also dealt with this problem. In *Stowe v. United States*, Civil No. 75-0218-B (W.D. Okla., August 14, 1975), plaintiffs alleged that they or their spouses suffered from cancer, and that they had been successfully treated with laetrile, a drug banned by the Food and Drug Administration on the ground that its effectiveness in the treatment of cancer is still in doubt. In an unreported interim decision, the court found that the plaintiff's right to medical treatment with a substance which had demonstrably favorable effects on their cancers superseded any interest of the government in protecting the general public from a drug whose properties were not conclusively proven. Accordingly, the FDA was enjoined from preventing the plaintiffs from importing stated quantities of laetrile for their own use. See also *Keene v. United States*, Civil No. 76-0249-H (S.D. W.Va., August 17, 1976).

Under these circumstances, the Court finds that this defendant does not fall within the third limitation to the necessity defense. The evil he sought to avert, blindness, is greater than that he performed to accomplish it, growing marijuana in his residence in violation of the District of Columbia Code. While blindness was shown by competent medical testimony to be the otherwise inevitable result of defendant's disease, no adverse effects from the smoking of marijuana have been demonstrated. Unlike the situation in *Roe* and *Doe*, no direct harm will be visited upon innocent third parties; any major ill effects from the inhalation of marijuana smoke will occur to the defendant alone. Furthermore, defendant, by growing marijuana for his own consumption, cannot be said to be contributing to the illegal trafficking in this drug, and thus injuring, however nebulously, innocent members of the public. In any event, it is unlikely that such slight, speculative and undemonstrable harm could be considered more important than defendant's right to sight.[29]

Nonetheless it may be argued that the necessity defense, because it negates the mental element of criminality, cannot shield a defendant charged under a statute which purports to punish only the act, without any specified mental state.[30] Since the philosophical justification for this defense is the unfairness and ineffectiveness of punishing one who did not act through the exercise of his unfettered discretion, its applicability where the offense charged does not involve the wilful commission of an act is open to question. According to Section 33-402(a) of the District of Columbia Code:

> It shall be unlawful for any person to manufacture, possess, have under his control, sell, prescribe, administer, dispense, or compound any narcotic drug, except as authorized in this chapter.[31]

On its face, the statute does not admit of any defenses except those which negate the allegation that the accused committed the act. Liability appears to be absolute, to follow inexorably upon the performance of the proscribed action. The case law, however, supports an alternative view.

In *United States v. Weaver*, 458 F.2d 825, 148 U.S.App.D.C. 3 (1972), the United States Court of Appeals interpreted Section 33-402 as requiring a particular state of mind, the absence of words to this effect in the statutory language notwithstanding. There, defendant appealed from conviction of possession of narcotics in violation of section 33-402, citing the trial court's failure to instruct the jury that only a knowing possession was prohibited. Finding the jury instructions adequate, the appellate court affirmed the conviction, noting:

> Although the statute [D.C. Code Section 33-402] does not contain the term [knowingly], the offense prohibited by the law is a knowing possession of the drug.[32]

The commission of the prohibited act without the requisite mental state is not sufficient for commission of the offense. Similarly, in *McKoy v. United States*, 263 A.2d 649 (1970), defendant appealed from a conviction of possession of implements of a crime in violation of D.C. Code Section 22-3601, alleging insufficient proof of intent to use the items for criminal purposes. Affirming the conviction, the court found that while the statute prohibits only the possession of instruments generally employed in the commission of crime, the government must establish not only possession but also intent to use illegally. A mental element is implied in a statute despite its apparent imposition of criminal penalties for the mere commission of the act. See also *Rosser v. United States*, 313 A.2d 876 (1974).

In other jurisdictions, necessity has been raised successfully as a defense to statutes which contain no element of wilfulness or voluntariness. In *State v. Jackson*, 71 N.H. 552, 53 A. 1021 (1902), defendant appealed from a conviction for violation of the compulsory education law. The statute provided criminal penalties for any parent or guardian who did not send his child to school for designated portions of each year, unless absence was approved by the School Board after application and hearing. Defendant refused to allow his daughter's attendance, believing that the delicate state of her health required that she remain at home. The court held that the parent's interest in the preservation of the health of his child was superior to any interest of the state that its future citizens be educated. Recognizing the time required by the administrative process, the court held that the provision for application for permission from the School Board did not offer the accused a significant alternative. Thus, the preservation of health was deemed a valid defense to a statute which contained no requirement of voluntariness, and which appeared to bring criminal sanctions upon the mere performance of the act. See also *State v. Hall*, 74 N.H. 61, 64 A. 1102 (1906). In *Cross v. Wyoming*, 370 P.2d 371 (Wyo. 1962), the necessity defense was successfully raised to preserve property despite an absolute statutory prohibition. There the court reversed a conviction for violation of a statute providing penalties for the killing of moose out of season or without a license. Defendant, who did not deny knowledge of the absolute statutory ban, admitted killing the animals but interposed the defense of necessity. The moose, defendant alleged, were harming his land, eating forage necessary for his cattle, and frightening his family. Under these circumstances, the court held, the accused should not be criminally responsible for his violation of the statute, its absolute language notwithstanding, because the constitutional right of citizens to defend their lives and property cannot be circumvented by legislation. For similar results, see also *Brewer v. Arkansas*, 72 Ark. 145, 78 S.W. 773 (1904), and *State v. Ward*, 170 Iowa 185, 152 N.W. 501 (1915). Thus, the necessity defense has been raised effectively to protect a variety of interests, both within and without this jurisdiction, in connection with so-called strict liability statutes.

The additional subjects require discussion. While the Court has found no precedents precisely analogous to the case at bar, two recent decisions in this jurisdiction have discussed the necessity defense in connection with drug charges. *Gorham v. United States*, 339 A.2d 401 (D.C. App. 1975), and *United States v. Moore*, *supra*. In *Gorham*, the D.C. Court of Appeals was confronted with appeals from convictions of possession of heroin and of implements of crime in violation of D.C. Code

Washington, West Virginia, Wyoming, New Hampshire and Vermont have enacted legislation similar in purpose to the Controlled Substances Act. Of the seven states still using the Uniform Narcotics Act, five have enacted legislation specifically removing marijuana from the classification of narcotic. In addition, the Supreme Court of Alaska has held in *Ravin v. State*, 537 P.2d 494 (Alaska, 1975), that the federal and state constitutions protect the right of individuals to have marijuana in their homes for their own use.

29. The Court thus does not reach the constitutional issues raised by the defendant in his briefs and argument. However, the Court agrees that a law which apparently requires an individual to submit to deteriorating health without proof of a significant public interest to be protected raises questions of constitutional dimensions. Furthermore, the Court declines to address defendant's motion for an injunction, believing that it is not ripe for decision at present.

30. This proposition appears in Note, *Criminal Liability without Fault: A Philosophical Perspective*, 75 Colum. L. Rev. 1517, 1541 (1975). However, the Court notes that no authority is cited for this position.

31. This chapter later provides that marijuana may be obtained on prescription, but in view of the total prohibition on marijuana possession, sale and use under federal law, the Court takes judicial notice that it is not legally obtainable in the District of Columbia.

32. *Weaver*, *supra*, at 4.

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§33-402 and 22-3601 respectively. It was [argu]ed that because of the defendants' [hero]in addiction, they were incapable of [form]ing the requisite criminal intent and therefore that they should not be held criminally responsible for their actions. Rejecting this defense, the Court held that for reasons of law and public policy, addiction cannot constitute a defense to possession of illegal drugs. [F]aced with a statute designed to control dangerous drugs, and to provide treatment for addicts who might not otherwise seek it, the Court refused to render a decision which would, in effect, completely nullify the law. The opinion also stresses that drug addiction is not a victimless crime, but rather one whose cost is borne by the taxpayers and the victims of the burglaries, robberies and muggings perpetrated to support drug habits.

In *United States v. Moore, supra*, defendant appealed from conviction of possession of heroin in violation of two federal statutes. Without disputing that the government had established each of the elements of the offense, appellant contended that his heroin addiction negated a primary requisite for criminal responsibility, "the capacity to control behavior."[33] Affirming the conviction, the Court noted that since defendant's ingestion of the heroin had been knowing and voluntary, the compulsion brought about by the drug could not be raised as an excuse for his criminal behavior. As Judge Leventhal in his concurring opinion makes clear, to permit such a defense would be to broaden impermissibly the contours of the original common [law] defense. Under the defendant's formula[tion], he argues, court would be constrained to except most drug users from criminal penalties, a consequence in clear violation of the intent of Congress to protect the public. For this reason, and because of the attendant problems of developing objective standards of proof, Judge Leventhal believes that the necessity defense should not be available to this defendant.

Both of these decisions are readily distinguishable from the case at bar. Unlike the defendants in *Moore* and *Gorham*, the accused in the instant case did nothing to bring about the circumstances necessitating his use of the prohibited drug. Recognition by the Court of this defense will not have the effect of nullifying the statute. Medical necessity is difficult to demonstrate, and would not be available to a sufficiently large number of those accused that it would support wholesale use of marijuana. Objective standards of proof can be developed without undue hardship, since the existence of a disease and its response to the drug can be demonstrated scientifically. In addition, permitting this limited use of marijuana, a drug with no demonstrably harmful effects, will not endanger the general public in the way that heroin might. Thus *Moore* and *Gorham* are inapposite: the rulings do not dictate a decision in the instant case.

Finally, it is appropriate here to discuss the burden of proof where the necessity defense is raised. While this issue does not arise in the [case] at bar, the government having contested [only] the applicability of the defense, the Court anticipates that it will be significant in the future. In general, an accused who raises any of the so-called affirmative defenses bears to some extent the risk of nonpersuasion. The weight of the burden in any given case, however, depends on the law's conception of the nature of the defense. Where the defense is actually an attempt to negate an element of the crime, for example, it must be proven beyond a reasonable doubt that the facts alleged by the defendant are not to be believed. Where defendant interposes a justification defense such as duress, necessity, or self-defense, on the other hand, a less stringent requirement, such as the preponderance standard, is employed. This point is well illustrated by the varying uses of the insanity defense. Where sanity is seen as an implied element of the crime, the government usually bears the burden of negating defendant's allegation of insanity beyond a reasonable doubt. Where insanity is considered a justification or an excuse for allowing the accused to escape criminal sanctions, however, it is the defendant who must establish it.

Despite this traditional approach, recent cases suggest that the government bears the burden of negating any defense raised by an accused. In *Mullaney v. Wilbur*, 421 U.S. 684 (1975), the Supreme Court considered an attack on the constitutionality of a Maine statute which required an accused who wished to reduce a charge of murder to manslaughter to prove by a preponderance of the evidence that he had acted in the heat of passion. In an opinion which stressed the importance of the presumption of innocence and the resultant placing on the government of the risk of nonpersuasion, the statute was found to be violative of due process. See also *In re Winship*, 397 U.S. 358 (1969), where the Supreme Court, in extending to juvenile cases the obligation of the government to establish guilt beyond a reasonable doubt, discussed the influence of the presumption of innocence in placing the burden of persuasion on the prosecution.

A case in a neighboring jurisdiction, *Evans v. State*, 28 Md. App. 640, 349 A.2d 300 (1975), has interpreted *Mullaney* as requiring the government to bear the burden of disproving all defenses. The District of Columbia Court of Appeals, however, has rejected this view. In *James v. United States*, 350 A.2d 748 (D.C. App. 1976), defendant appealed from a conviction of possession of implements of crime, alleging constitutional infirmities in the statute. Arguing that the provision allowing an accused to show innocent possession impermissibly shifted the burden of proof, the defendant contended that the statute was unconstitutional in light of the *Mullaney* decision. Affirming defendant's conviction, the Court distinguished *Mullaney* on several grounds, most notably because the *Mullaney* decision was based on a finding that there was no valid justification for placing on the defendant the burden of establishing a "fact so critical to criminal culpability".[34] In *James*, however,

> only the accused could know of possible innocent reasons he may have possessed the implements of a crime, and it does not violate due process to require him to give a satisfactory explanation for otherwise validly presumed criminal possession.[35]

This Court believes that *James*, which is controlling in this jurisdiction, takes the correct approach for cases of necessity. Since the defense does not attempt to disprove any element of the government's case, it should be classified as an affirmative defense which the accused bears the burden of establishing. In addition, the necessity defense, like the innocent possession raised in *James*, is one uniquely within the knowledge of the defendant. Placing the burden of persuasion on the defendant does not conflict with the presumption of innocence, since necessity of its nature arises only in cases where the defendant admits committing the prohibited act. Thus, a defendant who seeks to avail himself of the necessity defense should be required to prove it by a preponderance of the evidence. The defendant in the instant case has carried this evidentiary burden.

CONCLUSION

Upon the basis of the foregoing discussion, the Court finds that defendant Robert C. Randall has established the defense of necessity. Accordingly, it is the finding of this Court that he is not guilty of a violation of D.C. Code §33-402, and that the charge against him must be and hereby is

DISMISSED.

33. *Moore, supra* at 381

34. 421 U.S. at 702.
35. 350 A.2d at 751.

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Exhibit N

PubMed

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Monaldi Arch Chest Dis. 2005 Jun;63(2):93-100.

Smoked marijuana as a cause of lung injury.

Tashkin DP.

Division of Pulmonaiy & Critical Care Medicine, Department of Medicine, David Geffen School of Medicine, UCLA, Los Angeles, CA 90095-1690, USA. dtashkin@mednet.ucla.edu

Abstract

In many societies, marijuana is the second most commonly smoked substance after tobacco. While delta9-tetrahydrocannabinol (THC) is unique to marijuana and nicotine to tobacco, the smoke of marijuana, like that of tobacco, consists of a toxic mixture of gases and particulates, many of which are known to be harmful to the lung. Although far fewer marijuana than tobacco cigarettes are generally smoked on a daily basis, the pulmonary consequences of marijuana smoking may be magnified by the greater deposition of smoke particulates in the lung due to the differing manner in which marijuana is smoked. Whereas THC causes modest short-term bronchodilation, regular marijuana smoking produces a number of long-term pulmonary consequences, including chronic cough and sputum, histopathologic evidence of widespread airway inflammation and injury and immunohistochemical evidence of dysregulated growth of respiratory epithelial cells, that may be precursors to lung cancer. The THC in marijuana could contribute to some of these injurious changes through its ability to augment oxidative stress, cause mitochondrial dysfunction, and inhibit apoptosis. On the other hand, physiologic, clinical or epidemiologic evidence that marijuana smoking may lead to chronic obstructive pulmonary disease or respiratory cancer is limited and inconsistent. Habitual use of marijuana is also associated with abnormalities in the structure and function of alveolar macrophages, including impairment in microbial phagocytosis and killing that is associated with defective production of immunostimulatory cytokines and nitric oxide, thereby potentially predisposing to pulmonary infection. In view of the growing interest in medicinal marijuana, further epidemiologic studies are needed to clarify the true risks of regular marijuana smoking on respiratory health.

PMID: 16128224 [PubMed - indexed for MEDLINE]

Publication Types, MeSH Terms, Substances, Grant Support

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Exhibit O

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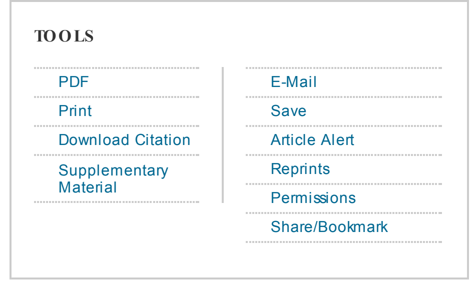

CLINICAL DECISIONS

Medicinal Use of Marijuana — Polling Results

Jonathan N. Adler, M.D., and James A. Colbert, M.D.
N Engl J Med 2013; 368:e30 | May 30, 2013 | DOI: 10.1056/NEJMclde1305159

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Readers recently joined in a lively debate about the use of medicinal marijuana. In Clinical Decisions,[1] an interactive feature in which experts discuss a controversial topic and readers vote and post comments, we presented the case of Marilyn, a 68-year-old woman with metastatic breast cancer. We asked whether she should be prescribed marijuana to help alleviate her symptoms. To frame this issue, we invited experts to present opposing viewpoints about the medicinal use of marijuana. J. Michael Bostwick, M.D., a professor of psychiatry at Mayo Clinic, proposed the use of marijuana "only when conservative options have failed for fully informed patients treated in ongoing therapeutic relationships." Gary M. Reisfield, M.D., from the University of Florida, certified in anesthesiology and pain medicine, and Robert L. DuPont, M.D., a clinical professor of psychiatry at Georgetown Medical School, provide a counterpoint, concluding that "there is little scientific basis" for physicians to endorse smoked marijuana as a medical therapy.

We were surprised by the outcome of polling and comments, with 76% of all votes in favor of the use of marijuana for medicinal purposes — even though marijuana use is illegal in most countries. A total of 1446 votes were cast from 72 countries and 56 states and provinces in North America, and 118 comments were posted. However, despite the global participation, the vast majority of votes (1063) came from the United States, Canada, and Mexico. Given that North America represents only a minority of the general online readership of the *Journal,* this skew in voting suggests that the subject of this particular Clinical Decisions stirs more passion among readers from North America than among those residing elsewhere. Analysis of voting across all regions of North America showed that 76% of voters supported medicinal marijuana. Each state and province with at least 10 participants casting votes had more than 50% support for medicinal marijuana except Utah. In Utah, only 1% of 76 voters supported medicinal marijuana. Pennsylvania represented the opposite extreme, with 96% of 107 votes in support of medicinal marijuana.

Outside North America, we received the greatest participation from countries in Latin America and Europe, and overall results were similar to those of North America, with 78% of voters supporting the use of medicinal marijuana. All countries with 10 or more voters worldwide were at or above 50% in favor. There were only 43 votes from Asia and 7 votes from Africa, suggesting that in those continents, this topic does not resonate as much as other issues.

Where does this strong support for medicinal marijuana come from? Your comments show that individual perspectives were as polarized as the experts' opinions. Physicians in favor of medicinal marijuana often focused on our responsibility as caregivers to alleviate suffering. Many pointed out the known dangers of prescription narcotics, supported patient choice, or described personal experience with patients who benefited from the use of marijuana. Those who opposed the use of medicinal marijuana targeted the lack of evidence, the lack of provenance, inconsistency of dosage, and concern about side effects, including psychosis. Common in this debate was the question of whether marijuana even belongs within the purview of physicians or whether the substance should be legalized and patients allowed to decide for themselves whether to make use of it.

In sum, the majority of clinicians would recommend the use of medicinal marijuana in certain circumstances. Large numbers of voices from all camps called for more research to move the discussion toward a stronger basis of evidence.

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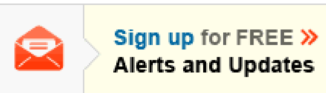

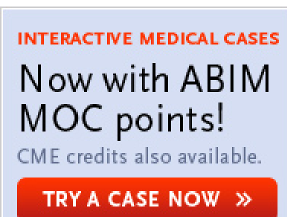

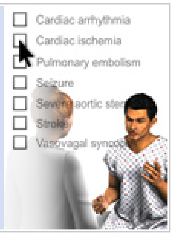

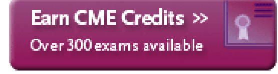

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Exhibit P

MYTHS ABOUT MEDICAL MARIJUANA

by Joycelyn Elders
The Providence Journal (RI)
(Dr. Joycelyn Elders was U.S. Surgeon General in 1993-94 and is Distinguished Professor of Public Health at the University of Arkansas School of Medicine)

THE RHODE ISLAND General Assembly is now considering legislation to permit the medical use of marijuana by seriously ill patients whose physicians have recommended it.

This sensible, humane bill deserves swift passage. The evidence is overwhelming that marijuana can relieve certain types of pain, nausea, vomiting and other symptoms caused by such illnesses as multiple sclerosis, cancer and AIDS -- or by the harsh drugs sometimes used to treat them. And it can do so with remarkable safety. Indeed, marijuana is less toxic than many of the drugs that physicians prescribe every day.

But right now, Rhode Island law subjects seriously ill patients to the threat of arrest and jail for simply trying to relieve some of their misery. There is no good reason that sick people should face such treatment.

Still, foes of the medical-marijuana bill keep raising objections. So let's look at their arguments, one by one:

"There is no evidence that marijuana is a medicine." The truth: The medical literature on marijuana goes back 5,000 years. In a 1999 study commissioned by the White House, the Institute of Medicine reported, "nausea, appetite loss, pain and anxiety . . . all can be mitigated by marijuana." In its April 2003 issue, the British medical journal The Lancet reported that marijuana relieves pain in virtually every test that scientists use to measure pain relief.

"The medical community doesn't support this; just a bunch of drug legalizers do." The truth: Numerous medical and public-health organizations support legal access to medical marijuana. National groups include the American Academy of Family Physicians, the American Public Health Association and the American Nurses Association. Regional groups include the New York State Association of County Health Officials, the California Medical Association and the Rhode Island Medical Society.

I know of no medical group that believes that jailing sick and dying people is good for them.

"Marijuana is too dangerous to be medicine; it's bad for the immune system, endangering AIDS and cancer patients." The truth: Unlike many of the drugs we prescribe every day, marijuana has never been proven to cause a fatal overdose. Research on AIDS patients has debunked the claim of harm to the immune system: In a study at San Francisco General Hospital, AIDS patients using medical marijuana gained immune-system cells and kept their virus under control as well as patients who received a placebo. They also gained more needed weight.

"There are other drugs that work as well as marijuana, including Marinol, the pill containing THC (the main psychoactive chemical in marijuana)." The truth: These other drugs don't work for everyone. The Institute of Medicine noted: "It is well recognized that Marinol's oral route of administration hampers its effectiveness, because of slow absorption and patients' desire for more control over dosing." Inhalation gives a more rapid response and better results. For some very sick people, marijuana simply works better.

"Smoke is not medicine; no real medicine is smoked." The truth: Marijuana does not need to be smoked. Some patients prefer to eat it, while those who need the fast action and dose control provided by inhalation can avoid the hazards of smoke through simple devices called vaporizers. For many who need only a small amount -- such as cancer patients trying to get through a few months of chemotherapy -- the risks of smoking are minor.

"Medical-marijuana laws send the wrong message to kids, encouraging teen marijuana use." The truth: That fear, raised in 1996, when California passed the first effective medical-marijuana law, has not come true. According to the official California Student Survey, teen marijuana use in California rose steadily from 1990 to 1996, but began falling immediately after the medical-marijuana law was passed. Among ninth graders, marijuana use in the last six months fell by more than 40 percent from 1995-96 to 2001-02 (the most recent available figures).

It is simply wrong for the sick and suffering to be casualties in the war on drugs. Let's get rid of the myths and institute sound public-health policy. The Rhode Island General Assembly should pass the medical-marijuana bill immediately.

Exhibit Q

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AUGUST 13, 2013

Americans skeptical of value of enforcing marijuana laws

BY ANDREA CAUMONT (HTTP://WWW.PEWRESEARCH.ORG/AUTHOR/ACAUMONT/)

> 72%
>
> Roughly three–in-four Americans say government efforts to enforce marijuana laws cost more than they are worth.

Attorney General Eric Holder's proposal to rein in mandatory minimum sentences (http://www.washingtonpost.com/world/national-security/holder-seeks-to-avert-mandatory-minimum-sentences-for-some-low-level-drug-offenders/2013/08/11/343850c2-012c-11e3-96a8-d3b921c0924a_story.html) for low-level drug offenders comes at a time when American attitudes toward marijuana use are the most lax they've ever been and Americans are highly skeptical of the value of enforcing marijuana laws.

(http://www.people-press.org/2013/04/04/majority-now-supports-legalizing-marijuana/) A March Pew Research Center survey on changing attitudes about marijuana (http://www.people-press.org/2013/04/04/majority-now-supports-legalizing-marijuana/) found that nearly three-in-four Americans (72%) believed that efforts to enforce marijuana laws cost more than they are worth. And 60% said that the federal government should not enforce federal laws prohibiting the use of marijuana in states where it is legal. (Last fall, voters in two states – Colorado and Washington state

Gov't Enforcement of Marijuana Laws Seen as Not Worth the Cost

Gov't efforts to enforce marijuana laws cost more than they are worth	Agree	Dis-agree	DK
	%	%	%
Total	72	23	6=100
Republican	67	26	6=100
Democrat	71	24	5=100
Independent	78	18	4=100
Should fed gov't enforce fed laws in states that allow marijuana use?	**Should**	**Should not**	**DK**
	%	%	%
Total	35	60	5=100
Republican	40	57	3=100
Democrat	35	59	5=100
Independent	32	64	4=100

PEW RESEARCH CENTER March 13-17, 2013. Figures may not add to 100% because of rounding.

(http://www.brookings.edu/research/papers/2013/05/21-legal-marijuana-colorado-washington) – approved the purchase of small amounts of marijuana for recreational use).

While there are partisan differences over legalizing marijuana use and on whether smoking marijuana is morally wrong, there is broad agreement across partisan and demographic groups that government enforcement of marijuana laws is not worth the cost. Fully 78% of independents, 71% of Democrats and 67% of Republicans say government enforcement efforts cost more than they are worth.

Older Americans are less likely than younger age groups to say government enforcement efforts are too costly: 63% of those over age 65 say this, compared with 72% of those aged 50-64, 73% of those aged 30-49 and 76% of 18- to 29-year-olds.

Public attitudes towards marijuana use have softened over the past few decades. Today, 38% of Americans view marijuana as a "gateway drug," down from 60% recorded in a 1977 Gallup poll. However, older Americans are much more likely to say marijuana use leads to harder drugs: 56% of those ages 65+ say this, compared with only about a third of those in younger age groups.

Andrea Caumont (http://www.pewresearch.org/author/acaumont/) *is an Editorial Web Producer at the Pew Research Center.*

POSTS | EMAIL | @TINYTHINGS

Exhibit R

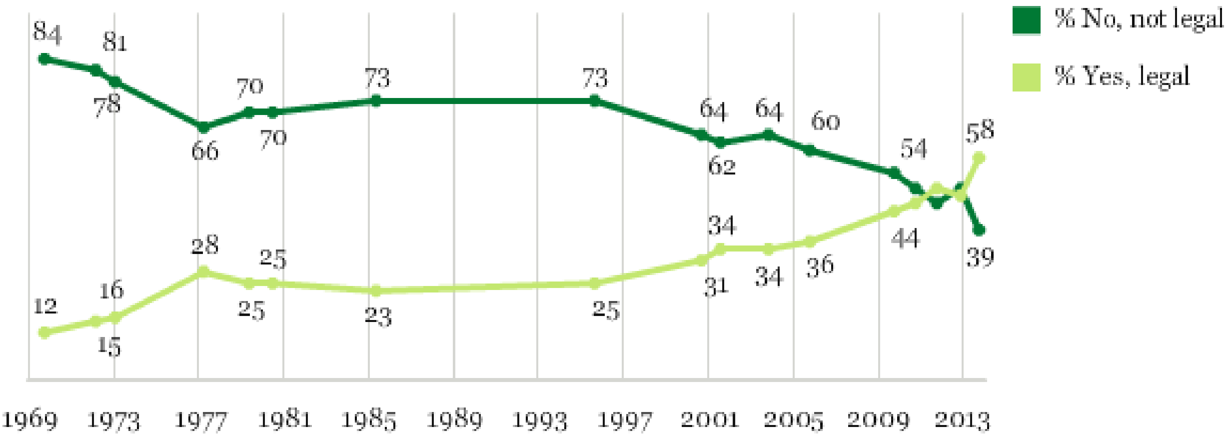
October 22, 2013

For First Time, Americans Favor Legalizing Marijuana

Support surged 10 percentage points in past year, to 58%

by Art Swift

WASHINGTON, D.C. -- For marijuana advocates, the last 12 months have been a period of unprecedented success as Washington and Colorado became the first states to legalize recreational use of marijuana. And now for the first time, a clear majority of Americans (58%) say the drug should be legalized. This is in sharp contrast to the time Gallup first asked the question in 1969, when only 12% favored legalization.



Public support for legalization more than doubled in the 1970s, growing to 28%. It then plateaued during the 1980s and 1990s before inching steadily higher since 2000, reaching 50% in 2011.

A sizable percentage of Americans (38%) this year admitted to having tried the drug, which may be a contributing factor to greater acceptance.

Success at the ballot box in the past year in Colorado and Washington may have increased Americans' tolerance for marijuana legalization. Support for legalization has jumped 10 percentage points since last November and the legal momentum shows no sign of abating. Last week, California's second-highest elected official, Lt. Gov. Gavin Newsom, said that pot should be legal in the Golden State, and advocates of legalization are poised to introduce a statewide referendum in 2014 to legalize the drug.

The Obama administration has also been flexible on the matter. Despite maintaining the government's firm opposition to legalizing marijuana under federal law, in late August Deputy Attorney General James Cole announced the Justice Department would not challenge the legality of Colorado's and Washington's successful referendums, provided that those states maintain strict rules regarding the drug's sale and

distribution.

The movement to legalize marijuana mirrors the relatively recent success of the movement to legalize gay marriage, which voters have also approved now in 14 states. Public support for gay marriage, which Americans also overwhelmingly opposed in the past, has increased dramatically, reaching majority support in the last two years.

Independents Fueling Growth in Acceptance of Legalizing Marijuana

Independents' growing support for legalization has mostly driven the jump in Americans' overall support. Sixty-two percent of independents now favor legalization, up 12 points from November 2012. Support for legalization among Democrats and Republicans saw little change. Yet there is a marked divide between Republicans, who still oppose legalizing marijuana, and Democrats and independents.

Percentage of Americans Who Support Legalizing Marijuana, by Party Identification

Do you think the use of marijuana should be made legal, or not?

	Republicans	Democrats	Independents
Oct 3-6, 2013	35%	65%	62%
Nov 26-29, 2012	33%	61%	50%

GALLUP

Young Adults More Likely to Support Legalization

Americans 65 and older are the only age group that still opposes legalizing marijuana. Still, support among this group has jumped 14 percentage points since 2011.

In contrast, 67% of Americans aged 18 to 29 back legalization. Clear majorities of Americans aged 30 to 64 also favor legalization.

Americans' Views on Legalizing Marijuana, by Age

	% Yes, legal	% No, illegal
18 to 29 years	67	31
30 to 49 years	62	35
50 to 64 years	56	40
65+ years	45	53

Oct. 3-6, 2013

GALLUP

Bottom Line

It has been a long path toward majority acceptance of marijuana over the past 44 years, but Americans' support for legalization accelerated as the new millennium began. This acceptance of a substance that most people might have considered forbidden in the late 1960s and 1970s may be attributed to changing social mores and growing social acceptance. The increasing prevalence of medical marijuana as a socially

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acceptable way to alleviate symptoms of diseases such as arthritis, and as a way to mitigate side effects of chemotherapy, may have also contributed to Americans' growing support.

Whatever the reasons for Americans' greater acceptance of marijuana, it is likely that this momentum will spur further legalization efforts across the United States. Advocates of legalizing marijuana say taxing and regulating the drug could be financially beneficial to states and municipalities nationwide. But detractors such as law enforcement and substance abuse professionals have cited health risks including an increased heart rate, and respiratory and memory problems.

With Americans' support for legalization quadrupling since 1969, and localities on the East Coast such as Portland, Maine, considering a symbolic referendum to legalize marijuana, it is clear that interest in this drug and these issues will remain elevated in the foreseeable future.

Survey Methods

Results for this Gallup poll are based on telephone interviews conducted Oct. 3-6, 2013, on the Gallup Daily tracking survey, with a random sample of 1,028 adults, aged 18 and older, living in all 50 U.S. states and the District of Columbia.

For results based on the total sample of national adults, one can say with 95% confidence that the margin of sampling error is ±4 percentage points.

Interviews are conducted with respondents on landline telephones and cellular phones, with interviews conducted in Spanish for respondents who are primarily Spanish-speaking. Each sample of national adults includes a minimum quota of 50% cellphone respondents and 50% landline respondents, with additional minimum quotas by region. Landline and cell telephone numbers are selected using random-digit-dial methods. Landline respondents are chosen at random within each household on the basis of which member had the most recent birthday.

Samples are weighted to correct for unequal selection probability, nonresponse, and double coverage of landline

and cell use[illegible] of gender, age, race, Hispanic ethnicity, education, region, population density, and phone status (cellphone only/landline only/both, and cellphone mostly). Demographic weighting targets are based on the March 2012 Current Population Survey figures for the aged 18 and older U.S. population. Phone status targets are based on the July-December 2011 National Health Interview Survey. Population density targets are based on the 2010 census. All reported margins of sampling error include the computed design effects for weighting.

In addition to sampling error, question wording and practical difficulties in conducting surveys can introduce error or bias into the findings of public opinion polls.

View methodology, full question results, and trend data.

For more details on Gallup's polling methodology, visit www.gallup.com.

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Exhibit S

Testimony of Sheriff John Urquhart
Senate Judiciary Committee
September 10, 2013

Good afternoon members of the committee, Mr. Chairman. Thank you for having me today. My name is John Urquhart, and I am the Sheriff of King County, WA.

Seattle is located in King County, and with almost 2 million residents, we are the 14th largest county by population in the United States. I have over 1000 employees in the Sheriff's Office and a budget exceeding $160 million.

As Sheriff, I am therefore the top law enforcement official in the largest jurisdiction in the country that has legalized marijuana.

I have been a police officer for 37 years, and I was elected as King County's Sheriff last year. During my career I've investigated everything from shoplifts to homicides. But I've also spent 12 years as a narcotics detective. My experience shows the War on Drugs has been a failure. We have not significantly reduced demand over time, but we have incarcerated generations of individuals, the highest incarceration rate in the world.

So the citizens of the state of Washington decided it was time to try something new. In November of 2012 they passed Initiative 502, which legalized recreational amounts of marijuana and at the same time created very strict rules and laws.

I was a strong supporter of Initiative 502 last year, and I remain a strong supporter today. There are several reasons for that support. Most of all, I support 502 because that's what the people want. They voted for legalized marijuana. We—the government—have failed the people and now they want to try something else. Too often the attitude of the police is "We're the cops and you're not. Don't tell us how to do our job." That is the wrong attitude and I refuse to fall into that trap.

While the title of this hearing is conflict between state and federal marijuana laws. I don't see a huge conflict.

The reality is we do have complimentary goals and values. We all agree we don't want our children using marijuana. We all agree we don't want impaired drivers. We all agree we don't want to continue enriching criminals. Washington's law honors these values by separating consumers from gangs, and diverting the proceeds from the sale of marijuana toward furthering the goals of public safety.

Is legalizing and regulating the possession and sale of marijuana a better alternative? I think it is, and I'm willing to be proven wrong. But the only way we'll know is if we are allowed to try.

DOJ's recent decision provides clarity on how we in Washington can continue to collaborate with the federal government to enforce our drug laws while at the same time respecting the will of the voters.

It's a great interim step, but more needs to be done.

For example, we are still limited by not knowing the role of banking institutions as we go forward.

Under federal law, it is illegal for banks to open checking, savings, or credit card accounts for marijuana businesses. The result is that marijuana stores will be operated as cash-only businesses, creating two big problems for us: (1) Cash-only businesses are prime targets for armed robberies; and (2) cash-only businesses are very difficult to audit, leading to possible tax evasion, wage theft, and the diversion of resources we need to protect public safety.

I am simply asking that the Federal government allow banks to work with legitimate marijuana businesses who are licensed under state law.

In closing let me make one thing absolutely clear. What we have in Washington State is not the Wild Wild West. And as Sheriff, I am committed to continued collaboration with the DEA, FBI, and DOJ for robust enforcement of our respective drug laws. For example, I have detectives right now assigned to Federal task forces, including a DEA HIDTA Task Force. It's been a great partnership for many years and that partnership will continue.

Furthermore the message to my deputies has been very clear: You *will* enforce our new marijuana laws. You *will* write someone a ticket for smoking in public. You *will* enforce age limits. You will put unlicensed stores out of business. In other words, the King County Sheriff's Office *will* abide by the standards and laws voted on and adopted by the citizens of the state of Washington, and the guidance provided by the Department of Justice on August 29th.

Mr. Chairman, I say to you and the members of this committee, I do appreciate the deference the federal government has shown to my constituents, and I look forward to continuing that cooperation. Thank you.