Steven Kadonsky
807236B 2-Right
New Jersey State Prison
P.O. Box 861
Trenton, New Jersey 08625

November 27, 2017

Carl Olsen
130 NE Aurora Ave.
Des Moines, Iowa 50313-3654

Re: Marijuana Rescheduling Petition

Dear Mr. Olsen:

Thank you for the information you sent on your efforts to reschedule marijuana in Iowa. I found it very interesting. I have enclosed a copy of the original petition I filed in 2014.

Good luck with your efforts.

Very truly yours,

Steven Kadonsky

Encl.

STEVEN J. KADONSKY
P.O. Box 861 - 807236B
Trenton, New Jersey 08625

January 28, 2014

Eric T. Kanefsky
Acting Director
Division of Consumer Affairs
124 Halsey Street, 7th Floor
P.O. Box 45027
Newark, New Jersey 07101

Re: Letter-Petition, Rescheduling of Marijuana under the New Jersey Controlled Dangerous Substances Act

Dear Mr. Kanefsky:

I respectfully submit this Letter-Petition in support of my request to have marijuana rescheduled from its current position in Schedule I, N.J.S.A. 24:21-5, to Schedule IV, N.J.S.A. 24:21-8. As indicated below, N.J.S.A. 24:21-3 and 24:25-5 mandate a rescheduling of marijuana.

N.J.S.A. 24:21-3a provides the Director of the Division of Consumer Affairs with the authority and the duty to "add substances to or delete or reschedule all substances enumerated in the schedules..." Furthermore, N.J.S.A. 24:21-3d requires that "[t]he director shall update and republish the schedules [], as amended and supplemented [] periodically."

N.J.S.A. 24:21-5a is unambiguous and requires that marijuana be rescheduled. 24:21-5a (2) only permits,

> substances in Schedule I if [the Director] finds that the substance: ... (2) has no accepted medical use in treatment in the United States; or lacks accepted safety for use in treatment under medical supervision.

N.J.S.A. 24:21-5b requires that,

[t]he controlled dangerous substances listed in this section are included in Schedule I, subject to any revision and republishing by the director pursuant to subsection d [].

As you are aware, the New Jersey Legislature found that marijuana has substantial beneficial medical properties and has "accepted medical use in treatment" of certain diseases. In January 2010, Governor Jon S. Corzine signed into law the limited use of medical marijuana codified at N.J.S.A. 24:6I. Medical Marijuana. Pursuant to N.J.S.A. 24:6I-2. Findings, declarations relative to the medical use of marijuana:

The Legislature finds and declares that:

a. Modern medical research has discovered a beneficial use for marijuana in treating or alleviating the pain or other symptoms associated with certain debilitating medical conditions, as found by the National Academy of Sciences' Institute of Medicine in March 1999[.]

Therefore, in legalizing the use of marijuana for medical purposes, the Legislature clearly held that marijuana does indeed have "accepted medical use in treatment in the United States; [and] accepted safety for use in treatment under medical supervision."

The Act further holds at N.J.S.A. 24:6I-3 that:

"Marijuana" has the meaning given in section 2 of the "New Jersey Controlled Dangerous Substance Acts," P.L. 1970, c.226 C.24:21-2)

This is no impediment to the rescheduling of marijuana as N.J.S.A. 24:21-2 simply states, inter alia:

"Marijuana" means all parts of the plant Genus Cannabis L., whether growing or not; the seeds thereof; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant or its seeds, except those containing resin extracted from such plant; but shall not include the mature stalks of such plant, fiber produced from such stalks, oil or cake made from the seeds of such plant, any other compound, manufacture, salt, derivative, mixture, or preparation of such mature stalks, fiber, oil, or cake, or the sterilized seed of such plant which is incapable of germination.

Although the Legislature did not reschedule marijuana under N.J.S.A. 24:6I, courts have held that the Legislature is cognizant of its own laws, see e.g. State v. Pierre, 329 N.J. Super. 588 (Law. Div. 1999), and statutes are to be strictly construed, State v. Edwards, 28 N.J. 292 (1958). Also, in the absence of a special meaning, the words in a statute are to be given their ordinary and well-understood meaning. Fahey v. Jersey City, 52 N.J. 103 (1968). Therefore, the dictates of N.J.S.A. 24:21-3a & d, and N.J.S.A. 24:21-5a & b must be strictly adhered to.

It should be noted that the provisions of N.J.S.A. 24:21d and N.J.S.A. 24:21-5a & b are not discretionary, but mandatory.

However, N.J.S.A. 24:21-3c provides:

> [i]f any substance is designed, rescheduled or deleted as a controlled dangerous substance under federal law and notice thereof is given to the director, the director shall similarly control the substance under P.L.1970, c.226, as amended and supplemented, after the expiration of 30 days from publication in the federal Register of a final order designating a substance as a controlled dangerous substance or rescheduling or deleting a substance, unless within that 30-day period, the director objects to inclusion, rescheduling, or deletion.

Marijuana is listed in the United States Controlled Substances Act at Section 811(c) as a Schedule I drug. This is not an impediment to the rescheduling of marijuana in New Jersey. Pursuant to N.J.S.A. 24:21-3c, as listed above, following the federal Schedule of Controlled Substances is not mandatory, but rather discretionary. However, N.J.S.A. 24:21-5a (2) is unambiguous and mandatory, no substance may be included in New Jersey's Schedule I, unless the substance "(2) has no accepted medical use in treatment in the United States; or lacks accepted safety for use in treatment under medical supervision."

Clearly, marijuana in New Jersey does not comport to a Schedule I drug. At this time, it is illegal for marijuana to be listed in N.J.S.A. 24:21-5a as a Schedule I drug.

Any conflicts between the provisions of N.J.S.A. 24:21-3a, c & d must be resolved in favor of the mandatory language of subsection a, and not the discretionary subsection d.

Furthermore, the provisions of N.J.S.A. 24:21-5a (2) are considered "substantive law" whereas the provision of N.J.S.A. 24:21-3c are considered "procedural." Suchit v. Baxt, 176 N.J. Super. 407 (Law. Div. 1980). Accord New Jersey Dist. Interest of J.M., 273 N.J. Super. 593 (Ch. Div. 1994). The substantive provision of N.J.S.A. 24:21-5a (2) takes precedence over, and trumps the procedural provisions of N.J.S.A. 24:21-3c. Id.

In light of the above, I respectfully submit the following:

Schedule I, N.J.S.A. 24:21-5, not appropriate for marijuana.

N.J.S.A. 24:21-5a. and b states,

> a. Tests. The director shall place a substance in Schedule I if he finds that the substance: (1) has high potential for abuse; **and** (2) **has no accepted medical use in treatment in the United States; or lacks accepted safety for use in treatment under medical supervision.**
>
> b. The controlled dangerous substances listed in this section are included in Schedule I, subject to any revision and republishing by the director pursuant to subsection d[].

The following twenty states and the District of Columbia have enacted laws legalizing the medical use of marijuana (Colorado and Washington legalized marijuana for recreational use):

Alaska	Maine	New Mexico
California	Massachusetts	New York
Colorado	Michigan	Oregon
Connecticut	Montana	Rhode Island
Delaware	Nevada	Vermont
Hawaii	New Hampshire	Washington
Illinois	New Jersey	

(See Petitioner's Appendix, Page 1 (hereinafter "Pa1").

Cannabis's accepted medical use in the United States is increasingly recognized by health care professionals and the medical community, including the Institute of Medicine. Pa2. (See

also N.J.S.A. 24:6I-1, et. seq.). By any reasonable definition, marijuana has "accepted safety for use in treatment under medical supervision." Id.; N.J.S.A. 24:21-5a (2).

Well over 100 organizations representing health care professionals, the medical community, and the general public support granting access to medical cannabis for patients in need and recognizing explicitly marijuana's medical use both in the United States and in the international community. Pa2 to Pa4.

The Israeli Ministry of Health (IMH) has been researching the medical benefits of marijuana for years. It has concluded that marijuana can kill cancer cells. Furthermore, the IMH has also determined that marijuana protects the brain after brain injuries. The Colorado Department of Health has found that marijuana has reduced seizures in all of the test group of 40 children with seizures. Some children had seizures reduced from hundreds per week down to one or two.

As indicated above, Schedule I currently includes marijuana at N.J.S.A. 24:21-5e (10). In January 2008, the American College of Physicians called for the rescheduling of cannabis in its position paper entitled "Supporting Research into the Therapeutic Role of Marijuana." It stated therein: "Position 4: ACP urges review of marijuana's status as a schedule I controlled substance and its reclassification into a more appropriate schedule, given the scientific evidence regarding marijuana's safety and efficacy in some clinical conditions." (See American College of Physicians (http://www.acponline.org/acp_news/medmarinews.htm)).

Although not a criteria for consideration in which schedule to include marijuana (N.J.S.A. 24:21-5a. et seq.), all recent legitimate studies show that marijuana is not a "gateway drug." Pa31 to Pa41.

Clearly, since medical marijuana is now legal medicine for the treatment of certain diseases in New Jersey, as well as in the twenty aforementioned other states and the District of Columbia, and has widespread accepted medical use, it must no longer be included in Schedule I. In addition, as indicated above, it is the Director's responsibility and duty to reschedule marijuana at this time.

Schedule II, N.J.S.A. 24:21-6, not appropriate for marijuana.

N.J.S.A. 24:21-6a. states:

> a. Tests. The director shall place a substance in Schedule II if he finds that the substance: (1) has high potential for abuse; (2) has currently accepted medical use in treatment in the United States, or currently accepted medical use with severe restrictions; and (3) abuse may lead to severe psychic or physical dependence.

Currently there are only three categories of controlled dangerous substances included in Schedule II: opium, opiates, and cocaine. N.J.S.A. 24:21-6. Each of these drugs is considered a "narcotic drug." However, marijuana is not considered a "narcotic drug." N.J.S.A. 24:21-2; State v. Carus, 118 N.J. Super. 159 (App. Div. 1972).

A review of the pharmacological effects of opium, opiates, and cocaine immediately shows the propriety of having these drugs included in Schedule II.

As indicated in the attached scientific studies of the pharmacological side effects of these drugs, opium, opiates and cocaine,

- are highly addictive, Pa8 to Pa23;
- use results in severe psychic and physical dependence, Id.;
- are extremely dangerous as overdose presents serious threat to life, Id.;
- users may become severely psychically and/or physically addicted with a single use, Id.;
- cannot be used even intermittently by most people without being severely addicted psychically and/or physically, Id.;

- addicts have high likelihood of permanent neurological damage, Id.;
- are powerful narcotic drugs, Pa9;
- may lead to coma, respiratory depression leading to coma, Pa9
- repeated use alters the physiology of the brain, Pa16;
- extended use results in full-blown paranoid psychosis, Pa16;
- ingestion can result in bowel gangrene, Pa17
- use causes loss of appetite, Pa17
- users are at an extremely high risk of contracting HIV/AIDS and Hepatitis, Pa17;
- use during pregnancy has been proven to cause severe damage to the fetus, Pa18; and,
- destruction of lives and family is always associated with addiction to these drugs, Pa8 to Pa23.

However, pursuant to all generally accepted current scientific studies, marijuana does not possess these same severe effects.

Marijuana,

- has minimal addictive properties, Pa24 to Pa41;
- use rarely results in even moderate psychic and/or physical dependence, Id.;
- overuse presents no serious threat to life ("overdose" is statistically impossible), there has never been a death attributed to marijuana "overdose", Id.;
- even prolonged use does not cause neurological damage, Id.;
- addiction cannot occur with a single use, Id.; and,
- can be used intermittently by most people without causing a noticeable social psychological dysfunction or dependence, Id.

Scientific studies now show that marijuana affects the brain differently than opium and cocaine.

Opiates are powerful painkillers that cause the brain to shut down and cocaine is a strong central nervous system stimulant. Pa9. These narcotic drugs affect the levels of dopamine, a neurotransmitter associated with pleasure and movement centers in the brain. Certain brain cells, or neurons, use dopamine to communicate. Cocaine acts by preventing the dopamine from being recycled, causing excessive amounts of neurotransmitter to build up, amplifying the message to, and response of the receiving neuron, and ultimately disrupting normal communication. It is this excessive dopamine that is responsible for cocaine's euphoric effect. Pa21.

However, studies of the brain cannabinoid receptor system conducted by the National Institute of Mental Health "using a lesion-technique, established that there are no cannabinoid receptor in the dopamine-producing areas of the brain." (See Dopamine and the Dependence Liability of Marijuana"). (http://www.ukcia.org/research/gettman.htm). Other studies have shown that cannabis has only an indirect effect of dopamine transmission. (See "Dopamine and the Dependence Liability of Marijuana")(Id.). These studies show that cannabis's psychoactive effects are produced by a different mechanism than addictive drugs such as amphetamine, cocaine, ethanol, nicotine, and opiates.

Therefore, opium, opiates, and cocaine are without question properly categorized as Schedule II narcotics, and equally as obvious is that marijuana should not be classified as a Schedule II controlled dangerous substance. In addition, no legitimate scientific authority holds that marijuana is even remotely in the same category as opium, opiates, and cocaine.

Whether marijuana should be included in Schedule III, IV, or V becomes much more subjective. After thorough review of the attached exhibits, other pharmacological scientific

evidence and a plethora of other information, I respectfully submit that marijuana should be included in Schedule IV.

Schedule III, N.J.S.A. 24:21-7, not appropriate for marijuana.

> N.J.S.A. 24:21-7a. states,
>
> a. Tests. The director shall place a substance in Schedule III if he finds that the substance: (1) has a potential for abuse less that substance listed in Schedule I and II; (2) has current accepted medical use in the United States; and (3) abuse may lead to moderate or low physical dependence or high psychological dependence.

Schedule III includes the following controlled dangerous substances:

Amphetamine
Phenmetrazine
Methamphetamine
Methylphenidate
Barbituric acid
Chlohexadol
Glutethimide
Lysergic acid
Lysergic acid amide
Methyprylon
Phencyclidine
Sulfondiethylmethane
Sulfonethylmethane
Sulfonmethane
Ketamine hydrochloride
Nalorphine.

A proportionality review of the drugs listed in Schedule III with that of marijuana demonstrates that the implications of Schedule III drugs are far worse than marijuana. The pharmacological scientific evidence relating to a sample of these drugs follows:

The Schedule III drugs Lysergic acid (LSD) and Phencyclidine (PCP or "angel dust") are extremely powerful hallucinogens, and Methamphetamine (crystal meth) is a powerful central nervous system stimulant. Marijuana is neither of these. Pa9.

LSD: LSD distorts auditory and visual sensations. The chief dangers of using LSD are the psychological effects and impaired judgment they produce, which can lead to dangerous decision-making or accidents. For example, a user might think he can fly and may even jump out of a window to prove it. Pa42 to Pa54; (see also, "The Merck Manual of Medical Information," Simon & Schuster, Inc.).

Users often develop extreme anxiety and panic attacks even after the drug has worn off. With continued use, prolonged psychosis is more likely. Id.

Prolonged use may lead to permanent neurological damage and is likely to cause severe psychical and/or physical addiction. Id.

Overdose presents a serious threat to life. Id.

Crystal meth: Crystal meth is extremely addictive. Users develop a tolerance quickly, needing larger amounts to get high. Many users forgo food and sleep and take more meth every few hours for days, "bingeing" until they run out of the drug or become too disorganized to continue. Chronic use can cause paranoia, hallucinations, repetitive behavior (such as compulsively cleaning, grooming or disassembling and assembling objects), and delusions of parasites or insects crawling under the skin. User can obsessively scratch their skin to get rid of these imagined insects. Pa63.

Long-term use, high dosages, or both can bring on full-blown psychosis (often exhibited as violent aggressive behavior). This violent, aggressive behavior is usually coupled with extreme paranoia. Id.

Crystal meth use and overdose can cause strokes and death even in young healthy athletes. Id.

Crystal meth is easily produced in clandestine laboratories or "meth labs." "Cooking" a batch of meth can be extremely dangerous due to the fact that the chemicals used are volatile and the by-products are very toxic. Meth labs present a danger to the meth cook, the community surrounding the lab, and the law enforcement personnel who discover the lab. Pa58.

PCP or "Angel dust": Even in moderate dosages, PCP use causes auditory hallucination, image distortion, severe mood disorder, and amnesia. The drug may cause acute anxiety and a feeling of impending doom, or paranoia and violent hostility. It may cause a psychosis indistinguishable from schizophrenia. Pa64.

High doses of PCP cause seizures, coma, and death. Suicide is common during PCP intoxications. Id.

PCP is highly addictive physically and psychically. Id.

Prolonged use causes memory loss, difficulties with speech and learning, depression, and weight loss. Pa65

PCP use in adolescents may interfere with hormones related to normal growth and development. Id.

Marijuana however, possesses none of these extreme adverse liabilities. (See this Letter-Petition, supra).

Furthermore, no legitimate scientific authority recommends that marijuana should be included in the same schedule as lysergic acid (LSD), methamphetamine (crystal meth), and phencyclidine (PCP, angel dust).

Schedule IV, N.J.S.A. 24:21-8, appears appropriate for marijuana.

N.J.S.A. 24:21-8a. states,

a. Tests. The director shall place a substance in Schedule IV if he finds that the substance: (1) has low potential for abuse relative to the substances listed in Schedule III; (2) has currently accepted medical use in the United States; and (3) may lead to limited physical dependence or psychological dependence relative to the substances listed in Schedule III.

The drugs listed in Schedule IV include,

Barbital
Chloral betaine
Chloral hydrate
Ethchlorovynol
Ethinamate
Methohexital
Meprobamate
Methylphenobarbital
Paraldehyde
Petrichloral
Phenobarbital

Although a proportionality review of the potential harmful effects of Schedule IV drugs with the potential harmful effects of marijuana indicates that these Schedule IV drugs are potentially much more harmful than marijuana, nevertheless, I respectfully suggest that Schedule IV is appropriate for marijuana.

The pharmacological liability of several Schedule IV drugs is listed below:

Chloral hydrate: Chloral hydrate is an antianxiety drug. It is an addictive drug and prolonged use results in psychic and physical dependence. Tolerance and psychologic dependence may develop by the second week of continued administration. Pa66.

Addicts may suffer from gastritis and skin eruptions. Parenchymatous renal injury is not uncommon. Pa67.

Furthermore, overdose may result in death. Id.

Meprobamate: Meprobamate is a carbamate derivative which has been shown in animal studies to have effects at multiple sites in the central nervous system including the thalamus and limbic system. Pa69. It is addictive both physically and psychologically. Pa70.

Meprobamate overdose may result in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, respiratory collapse, and even death. Pa72.

As indicated earlier in this Letter-Petition, over use of marijuana on the other hand, has never resulted in death, which is quite remarkable considering the extent of its use.

All of the current scientific evidence relating to marijuana taken as a whole, including all studies which indicate that marijuana, in limited situations, may lead to limited physical dependence or limited psychological dependence, appears to support that Schedule IV is the appropriate Schedule for marijuana. (See this Letter-Petition, supra).

Having said that, it should be noted that the criteria for a Schedule V classification indicates that Schedule V may be more proper for marijuana.

N.J.S.A. 24:21-8.1, Schedule V, states,

> a. Tests. The director shall place a substance in Schedule V if he finds that the substance: (1) has low potential for abuse relative to the substances listed in Schedule IV; (2) has currently accepted medical use and treatment in the United States; and (3) has limited physical dependence or psychological dependence liability relative to the substances listed in Schedule IV.

As discussed in the above Schedule IV comparison, marijuana does indeed have a "limited physical dependence or psychological dependence liability relative to the substances listed in Schedule IV." Therefore, Schedule V may actually be the exact right schedule for marijuana. In fact, Alaska has rescheduled marijuana to a Schedule VI drug. Pa7.

For the foregoing reasons, I respectfully suggest that marijuana be rescheduled to a Schedule IV or perhaps Schedule V controlled dangerous substance, as soon as possible.

Please contact me at your earliest convenience to give me your thoughts on the above and a general idea of when you may have a decision as to the appropriate schedule in which to place marijuana.

Also, please send a copy of this Letter-Petition marked "Received" to me in the enclosed self addressed stamped envelope. I have provided a copy of this Letter-Petition for that purpose.

Thank you for your time and consideration.

Respectfully submitted,

Steven Kadonsky

C: John P. Pieroni, Esq.

New Jersey Office of the Attorney General
Division of Consumer Affairs
Director's Office

Received
2/12/14

From the desk of: ERIC T. KANEFSKY
Director

To: Steve Kaplowitz Date: 2/12/14

Subject: Lilla Petition - Rescheduling Marijuana under NJ CDS Act

- ☐ Handle
- ☐ Signature required
- ☐ Per our conversation
- ☐ For your information
- ☐ Complete folder required
- ☒ Per your request
- ☐ For your review
- ☐ Other
- ☐ Reply directly, for my signature
- ☐ Retain for your file
- ☐ Note and return
- ☐ Please fax
- ☐ Email me
- ☐ See me
- ☐ Prepare reply for my signature

Comments:

Copy marked "Received"

Act

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substances in Schedule I if [the Director] finds that the substance: ... (2) has no accepted medical use in treatment in the United States; or lacks accepted safety for use in treatment under medical supervision.

N.J.S.A. 24:21-5b requires that,

STEVEN J. KADONSKY
P.O. Box 861 - 807236B
Trenton, New Jersey 08625

June 2, 2014

Eric T. Kanefsky, Director
Division of Consumer Affairs
124 Halsey Street, 7th Floor
P.O. Box 45027
Newark, New Jersey 07101

Re: Request for Status of
Marijuana Rescheduling Letter-Petition

Dear Mr. Kanefsky:

On January 28, 2014, I sent to Your Honor a Letter-Petition seeking to have marijuana rescheduled to a more appropriate schedule; a copy was marked "Received - February 12, 2014" and returned to me. Thank you.

I understand that my petition needs to pass through various hands before a determination is made. Would you be so kind as to give me a status up-date and a rough estimate as to when you would have a decision. If necessary, I would like to proceed to the Appellate Division as soon as possible.

I have enclosed a SASE for your convenience.

Thank you for your assistance.

Respectfully submitted,

Steven Kadonsky

Encl.

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mailed 11/7/14
Recd 11/10/14

Steven Kadonsky
807236B 7-Up
New Jersey State Prison
P.O. Box 861
Trenton, NJ 08625
Appellant/ Pro-se

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO.

STEVEN KADONSKY, Appellant, v. ERIC T. KANEFSKY, DIRECTOR OF DIV. OF CONSUMER AFFAIRS, Respondent.	CIVIL ACTION NOTICE OF APPEAL

TO: John J. Hoffman, Esq.
Acting Attorney General
P.O. Box 112
Trenton, New Jersey 08625

Eric T. Kanefsky, Director
Div. of Consumer Affairs
124 Halsey Street, 7th Floor
P.O. Box 45027
Newark, NJ 07101

Please Take Notice the appellant Steven Kadonsky, Pro se hereby appeals from administrative inaction. On January 28, 2014, Appellant sent a conforming Letter-Petition to Eric T. Kanefsky, Director, Division of Consumer Affairs seeking to have marijuana rescheduled from a Schedule I drug, as required by N.J.S.A. 24:21-3 & 24:21-5. The Letter-Petition was marked "Received 2/12/14" by Director Kanefsky. (Pa1). A follow-up letter was sent to Director Kanefsky on June 2, 2014. (Pa2). The January 28, 2014 Letter-Petition and the June 2, 2014 follow-up letter have both gone unanswered.

There is no verbatim record on this matter and therefore no transcripts have been ordered.

Dates: July 1, 2014

Steven Kadonsky
Appellant Pro se

CERTIFICATION OF SERVICES

I hereby certify that the forgoing notice of appeal on behalf of Steven Kadonsky was sent via first class mail on July 1, 2014 to:

TO: John J. Hoffman, Esq.
Acting Attorney General
P.O. Box 112
Trenton, New Jersey 08625

Eric T. Kanefsky, Director
Div. of Consumer Affairs
124 Halsey Street, 7th Floor
P.O. Box 45027
Newark, NJ 07101

Dates: July 1, 2014

Steven Kadonsky

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

New Jersey Office of the Attorney General

Division of Consumer Affairs
Office of the Director
124 Halsey Street, 7th Floor, Newark NJ 07102

JOHN J. HOFFMAN
Acting Attorney General

STEVE C. LEE
Acting Director

Mailing Address:
P.O. Box 45027
Newark, NJ 07101

June 27, 2014

Steven J. Kadonsky
P.O. Box 861 – 807236B
Trenton, NJ 08625

Dear Mr. Kadonsky:

This letter is in response to your letter of June 2, 2014 in which you inquired as to the status of the Division's review of your January 28, 2014 letter regarding the rescheduling of marijuana.

I have recently been appointed Acting Director of the Division of Consumer Affairs. I am currently reviewing your request and supporting documentation. I will contact you if I have any questions or need additional information.

Sincerely,

Steve C. Lee
Acting Director

SCL/ftf

a17

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

State of New Jersey
OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF LAW
PO Box 45029
Newark, NJ 07101

JOHN J. HOFFMAN
Acting Attorney General

JEFFREY S. JACOBSON
Director

July 21, 2014

Mr. Steven J. Kadonsky
807236B 7-Up
New Jersey State Prison
P.O. Box 861
Trenton, New Jersey 08625

Re: Kadonsky v. Kanefsky

Dear Mr. Kadonsky:

I am a Deputy Attorney General and I represent the Division of Consumer Affairs and Acting Director Steve Lee in connection with the referenced appeal. In your July 7, 2014 letter to Acting Director Lee, you note that your appeal is moot because the Division has advised that it intends to respond substantively to your petition. I would request that instead of staying the existing appeal, you agree to withdraw your appeal pursuant to Rule 2:8-2. Withdrawal in that fashion would not prejudice your ability to challenge any determination by the Acting Director in the event that you are not satisfied with the response to your petition.

Sincerely yours,

JOHN J. HOFFMAN
ACTING ATTORNEY GENERAL OF NEW JERSEY

By: Jodi C. Krugman
Jodi C. Krugman
Deputy Attorney General

Copy to: Marijean Stevens, Esq.

124 Halsey Street • TELEPHONE: (973) 648-7093 • FAX: (973) 648-3879

RAB. Pa 20

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

State of New Jersey
OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF LAW
PO Box 45029
Newark, NJ 07101

JOHN J. HOFFMAN
Acting Attorney General

JEFFREY S. JACOBSON
Director

September 5, 2014

Mr. Steven J. Kadonsky
807236B 7-Up
New Jersey State Prison
P.O. Box 861
Trenton, New Jersey 08625

Re: Kadonsky v. Kanefsky

Dear Mr. Kadonsky:

I have received your letter dated July 25, 2014 and the legal memorandum in support of your petition to reschedule marijuana. The Division of Consumer Affairs is reviewing the materials you have provided and will provide a response to your petition after that review is completed.

Thank you for your courtesies in this matter.

Sincerely yours,

JOHN J. HOFFMAN
ACTING ATTORNEY GENERAL OF NEW JERSEY

By: _____
Jodi C. Krugman
Deputy Attorney General

Recd 9/9/14

Pa 21

124 Halsey Street • TELEPHONE: (973) 648-7093 • FAX: (973) 648-3879

Congress of the United States
Washington, DC 20515

The Honorable Barack Obama
President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

February 12, 2014

Dear Mr. President:

We were encouraged by your recent comments in your interview with David Remnick in the January 27, 2014 issue of the New Yorker, about the shifting public opinion on the legalization of marijuana. We request that you take action to help alleviate the harms to society caused by the federal Schedule I classification of marijuana.

Lives and resources are wasted on enforcing harsh, unrealistic, and unfair marijuana laws. Nearly two-thirds of a million people every year are arrested for marijuana possession. We spend billions every year enforcing marijuana laws, which disproportionately impact minorities. According to the ACLU, black Americans are nearly four times more likely than whites to be arrested for marijuana possession, despite comparable marijuana usage rates.

You said that you don't believe marijuana is any more dangerous than alcohol: a fully legalized substance, and believe it to be less dangerous "in terms of its impact on the individual consumer." This is true. Marijuana, however, remains listed in the federal Controlled Substances Act at Schedule I, the strictest classification, along with heroin and LSD. This is a higher listing than cocaine and methamphetamine, Schedule II substances that you gave as examples of harder drugs. This makes no sense.

Classifying marijuana as Schedule I at the federal level perpetuates an unjust and irrational system. Schedule I recognizes no medical use, disregarding both medical evidence and the laws of nearly half of the states that have legalized medical marijuana. A Schedule I or II classification also means that marijuana businesses in states where adult or medical use are legal cannot deduct business expenses from their taxes or take tax credits due to Section 280E of the federal tax code.

We request that you instruct Attorney General Holder to delist or classify marijuana in a more appropriate way, at the very least eliminating it from Schedule I or II. Furthermore, one would hope that that your Administration officials publicly reflect your views on this matter. Statements such as the one from DEA chief of operations James L.

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Capra that the legalization of marijuana at the state level is "reckless and irresponsible[1]" serve no purposes other than to inflame passions and misinform the public.

Thank you for your continued thoughtfulness about this important issue. We believe the current system wastes resources and destroys lives, in turn damaging families and communities. Taking action on this issue is long overdue.

Sincerely,

Earl Blumenauer
Member of Congress

Steve Cohen
Member of Congress

Sam Farr
Member of Congress

Raúl Grijalva
Member of Congress

Mike Honda
Member of Congress

Jared Huffman
Member of Congress

Barbara Lee
Member of Congress

Zoe Lofgren
Member of Congress

Alan Lowenthal
Member of Congress

James P. McGovern
Member of Congress

[1] http://www.washingtonpost.com/national/dea-operations-chief-decries-legalization-of-marijuana-at-state-level/2014/01/15/17af548a-7e38-11e3-9556-4a4bf7bcbd84_story.html

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James P. Moran
Member of Congress

Beto O'Rourke
Member of Congress

Jared Polis
Member of Congress

Mike Quigley
Member of Congress

Dana Rohrabacher
Member of Congress

Jan Schakowsky
Member of Congress

Eric Swalwell
Member of Congress

Peter Welch
Member of Congress

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Treatment Episode Data Set (TEDS)[21]

Primary marijuana abuse accounted for 18.1 percent of all 2011 TEDS[22] admissions. Individuals admitted for primary marijuana abuse were nearly three-quarters (73.4 percent) male, and almost half (45.2 percent) were white. The average age at admission was 24 years old, and 31.1 percent of individuals admitted for primary marijuana abuse were under the age of 18. The reported frequency of marijuana use was 24.3 percent reporting daily use. Almost all (96.8 percent) primary marijuana users utilized the substance by smoking. Additionally, 92.9 percent reported using marijuana for the first time before the age of 18.

An important aspect of TEDS admission data for marijuana is of the referral source for treatment. Specifically, primary marijuana admissions were less likely than all other admissions to either be self-referred or referred by an individual for treatment. Instead, the criminal justice system referred more than half (51.6 percent) of primary marijuana admissions.

Since 2003, the percent of admissions for primary marijuana abuse increased from 15.5 percent of all admissions in 2003 to 18.1 percent in 2011. This increase is less than the increase seen for admissions for primary opioids other than heroin, which increased from 2.8 percent in 2003 to 7.3 percent in 2011. In contrast, the admissions for primary cocaine abuse declined from 9.8 percent in 2003 to 2.0 percent in 2011.

[21] The TEDS system is part of SAMHSA's Drug and Alcohol Services Information System (Office of Applied Science, SAMHSA). The TEDS report presents information on the demographic and substance use characteristics of the 1.8 million annual admissions to treatment for alcohol and drug abuse in facilities that report to individual state administrative data systems. Specifically, TEDS includes facilities licensed or certified by the states to provide substance abuse treatment and is required by the states to provide TEDS client-level data. Facilities that report TEDS data are those receiving State alcohol and drug agency funds for the provision of alcohol and drug treatment services. Since TEDS is based only on reports from these facilities, TEDS data do not represent the total national demand for substance abuse treatment or the prevalence of substance abuse in the general population. The primary goal for TEDS is to monitor the characteristics of treatment .episodes for substance abusers. Importantly, TEDS is an admissions-based system, where admittance to treatment is counted as an anonymous tally. For instance, a given individual who is admitted to treatment twice within a given year would be counted as two admissions. The most recent year with complete data is 2011.

[22] 2011; *http://www.samhsa.gov/data/DASIS.aspx?qr=t#TEDS.*

5. The Scope, Duration, and Significance of Abuse

Under the fifth factor, the Secretary must consider the scope, duration, and significance of marijuana abuse. According to 2012 data from NSDUH and 2013 data from MTF, marijuana remains the most extensively used illegal drug in the United States, with 42.8 percent of U.S. individuals over age 12 (111.2 million) and 45.5 percent of 12th graders having used marijuana at least once in their lifetime. Although the majority of individuals over age 12 (83.1 percent) who have ever used marijuana in their lifetime do not use the drug monthly, 18.9 million individuals (7.3 percent of the U.S. population) report that they used marijuana within the past 30 days. An examination of use among various age cohorts through NSDUH demonstrates that monthly use occurs primarily among college-aged individuals, with use dropping off sharply after age 25. Additionally, NSDUH data show the number of individuals reporting past-month use of marijuana has increased by 4.3 million individuals since 2004. Data from MTF shows that annual prevalence of marijuana use declined for all three grades from 2005 through 2007, then began to rise through 2013. Additionally, in 2013, 1.1 percent of 8th graders, 4.0 percent of 10th graders, and 6.5 percent of 12th graders reported daily use of marijuana, defined as use on 20 or more days within the past 30 days.

The 2011 DAWN data show that marijuana use was mentioned in 455,668 ED visits, which amounts to approximately 36.4 percent of all illicit drug-related ED visits.[23]

TEDS data for 2011 show that 18.1 percent of all admissions were for primary marijuana abuse.[24] Between 2003 and 2011, there was a 2.6 percent increase in the number of TEDS admissions for primary marijuana use. Approximately 61.5 percent of primary marijuana admissions in 2011 were for individuals under the age of 25 years.

[23] Many factors can influence the estimates of ED visits, including trends in the reasons for ED usage. For instance, some drug users may visit EDs for life-threatening issues while others may visit to seek care for detoxification because they needed certification before entering treatment. Additionally, DAWN data do not distinguish the drug responsible for the ED visit from other drugs that may have been used concomitantly. As stated in a DAWN report, "Since marijuana/hashish is frequently present in combination with other drugs, the reason for the ED visit may be more relevant to the other drug(s) involved in the episode."

[24] An important aspect of TEDS admission data for marijuana is of the referral source for treatment. Specifically, primary marijuana admissions were less likely than all other admissions to either be self-referred or referred by an individual for treatment. Instead, the criminal justice system referred more than half (51.6 percent) of primary marijuana admissions.

6. WHAT, if Any, Risk There Is to the Public Health

Under the sixth factor, the Secretary must consider the risks posed to the public health by marijuana. Factors 1, 4, and 5 include a. discussion of the risk to the public health as measured by emergency room episodes and drug treatment admissions. Additionally, Factor 2 includes a discussion of marijuana's central nervous system, cognitive, cardiovascular, autonomic, respiratory, and immune system effects. Factor 6 focuses on the health risks to the individual user in terms of the risks from acute and chronic use of marijuana, as well as the "gateway hypothesis."

Risks From Acute Use of Marijuana

Acute use of marijuana impairs psychomotor performance, including complex task performance, which makes operating motor vehicles or heavy equipment after using marijuana inadvisable (Ramaekers et al., 2004; Ramaekers et al., 2006a). A meta-analysis conducted by Li et al. (2011) showed an association between marijuana use by the driver and a significantly increased risk of involvement in a car accident. Additionally, in a minority of individuals who use marijuana, some potential responses include dysphoria and psychological distress, including prolonged anxiety reactions (Haney et al., 1999).

Risks From Chronic Use of Marijuana

A distinctive marijuana withdrawal syndrome following long term or chronic use has been identified. The withdrawal syndrome indicates that marijuana produces physical dependence that is mild, short-lived, and comparable to tobacco withdrawal (Budney et al., 2008). Marijuana withdrawal syndrome is described in detail below under Factor 7.

The following states how the DSM–V (2013) of the American Psychiatric Association describes the consequences of *Cannabis*[25] abuse:

Individuals with cannabis use disorder may use cannabis throughout the day over a period of months or years, and thus may spend many hours a day under the influence. Others may use less frequently, but their use causes recurrent problems related to family,

[25] *Cannabis* is the term used in the DSM–V to refer to marijuana. In the following excerpt the term *Cannabis* is interchangeable for the term *marijuana.*

school, work, or other important activities (*e.g.*, repeated absences at work; neglect of family obligations). Periodic cannabis use and intoxication can negatively affect behavioral and cognitive functioning and thus interfere with optimal performance at work or school, or place the individual at increased physical risk when performing activities that could be physically hazardous (*e.g.*, driving a car; playing certain sports; performing manual work activities, including operating machinery). Arguments with spouses or parents over the use of cannabis in the home, or its use in the presence of children, can adversely impact family functioning and are common features of those with cannabis use disorder. Last, individuals with cannabis use disorder may continue using marijuana despite knowledge of physical problems (*e.g.*, chronic cough related to smoking) or psychological problems (*e.g.*, excessive sedation or exacerbation of other mental health problems) associated with its use.

Marijuana as a "Gateway Drug"

Kandel (1975) proposed nearly 40 years ago the hypothesis that marijuana is a "gateway drug" that leads to the use or abuse of other illicit drugs. Since that time, epidemiological research explored this premise. Overall, research does not support a direct causal relationship between regular marijuana use and other illicit drug use. The studies examining the gateway hypothesis are limited. First, in general, studies recruit individuals influenced by a myriad of social, biological, and economic factors that contribute to extensive drug abuse (Hall & Lynskey, 2005). Second, most studies that test the hypothesis that marijuana use causes abuse of illicit drugs use the determinative measure *any use of an illicit drug*, rather than DSM–5 criteria for drug abuse or dependence on an illicit drug (DSM–5, 2013). Consequently, although an individual who used marijuana may try other illicit drugs, the individual may not regularly use drugs, or have a diagnosis of drug abuse or dependence.

Little evidence supports the hypothesis that initiation of marijuana use leads to an abuse disorder with other illicit substances. For example, one longitudinal study of 708 adolescents demonstrated that early onset marijuana use did not lead to problematic drug use (Kandel & Chen, 2000). Similarly, Nace et al. (1975) examined Vietnam-era soldiers who extensively abused marijuana and heroin while they were in the military, and found a lack of correlation of a causal relationship demonstrating marijuana use leading to heroin addiction. Additionally, in another longitudinal study of 2,446 adolescents, marijuana dependence was uncommon but when it did occur, the common predictors of marijuana dependence were the following: Parental death, deprived socio-economic status, and baseline illicit drug use other than marijuana (von Sydow et al., 2002).

When examining the association between marijuana and illicit drugs, focusing on drug use versus abuse or dependence, different patterns emerge. For example, a study examining the possible causal relationship of the gateway hypothesis found a correlation between marijuana use in adolescents and other illicit drug use in early adulthood and, adjusting for age-linked experiences, did not effect this correlation (Van Gundy and Rebellon, 2010). However, when examining the association in terms of development of drug abuse; age-linked stressors and social roles moderated the correlation between marijuana use in adolescents and other illicit drug abuse. Similarly, Degenhardt et al. (2009) examined the development of drug dependence and found an association that did not support the gateway hypothesis. Specifically, drug dependence was significantly associated with the use of other illicit drugs prior to marijuana use.

Interestingly, the order of initiation of drug use seems to depend on the prevalence of use of each drug, which varies by country. Based on the World Health Organization (WHO) World Mental Health Survey that includes data from 17 different countries, the order of drug use initiation varies by country and relates to prevalence of drug use in each country (Degenhardt et al., 2010). Specifically, in the countries with the lowest prevalence of marijuana use, use of other illicit drugs before marijuana was common. This sequence of initiation is less common in countries with higher prevalence of marijuana use. A study of 9,282 households in the United States found that marijuana use often preceded the use of other illicit drugs; however, prior non-marijuana drug dependence was also frequently correlated with higher levels of illicit drug abuse (Degenhardt et al., 2009). Additionally, in a large 25-year longitudinal study of 1,256 New Zealand children, the author concluded that marijuana use correlated to an increased risk of abuse of other drugs, including cocaine and heroin (Fergusson et al., 2005).

Although many individuals with a drug abuse disorder may have used marijuana as one of their first illicit drugs, this fact does not correctly lead to the reverse inference that most individuals who used marijuana will inherently go on to try or become regular users of other illicit drugs. Specifically, data from the 2011 NSDUH survey illustrates this issue (SAMHSA, 2012). NSDUH data estimates 107.8 million individuals have a lifetime history of marijuana use, which indicates use on at least one occasion, compared to approximately 36 million individuals having a lifetime history of cocaine use and approximately 4 million individuals having a lifetime history of heroin use. NSDUH data do not provide information about each individual's specific drug history. However, even if one posits that every cocaine and heroin user previously used marijuana, the NSDUH data show that marijuana use at least once in a lifetime does not predict that an individual will also use another illicit drug at least once.

Finally, a review of the gateway hypothesis by Vanyukov et al. (2012) notes that because the gateway hypothesis only addresses the order of drug use initiation, the gateway hypothesis does not specify any mechanistic connections between drug "stages" following exposure to marijuana and does not extend to the risks for addiction. This concept contrasts with the concept of a common liability to addiction that involves mechanisms and biobehavioral characteristics pertaining to the entire course of drug abuse risk and disorders.

7. Its Psychic or Physiologic Dependence Liability

Under the seventh factor, the Secretary must consider marijuana's psychic or physiological dependence liability.

Psychic or psychological dependence has been shown in response to marijuana's psychoactive effects. Psychoactive responses to marijuana are pleasurable to many humans and are associated with drug-seeking and drug-taking (Maldonado, 2002). Moreover, high levels of psychoactive effects, notably positive reinforcement, are associated with increased marijuana use, abuse, and dependence (Scherrer et al., 2009; Zeiger et al., 2010). Epidemiological data support these findings through 2012 NSDUH statistics that show that of individuals years 12 or older who used marijuana in the past month, an estimated 40.3 percent used marijuana on 20 or more days within the past month. This equates to approximately 7.6 million individuals aged 12 or older who used marijuana on a daily or almost daily basis.

Additionally, the 2013 MTF data report the prevalence of daily marijuana use, defined as use on 20 or more days within the past 30 days, in 8th, 10th, and 12th graders is 1.1 percent, 4.0 percent, and 6.5 percent, respectively.

Tolerance is a state of adaptation where exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time (American Academy of Pain Medicine, American Pain Society and American Society of Addiction Medicine consensus document, 2001). Tolerance can develop to some, but not all, of marijuana's effects. Specifically, tolerance does not seem to develop in response to many of marijuana's psychoactive effects. This lack of tolerance may relate to electrophysiological data demonstrating that chronic delta^9-THC administration does not affect increased neuronal firing in the ventral tegmental area, a region known to play a critical role in drug reinforcement and reward (Wu and French, 2000). In the absence of other abuse indicators, such as rewarding properties, the presence of tolerance or physical dependence does not determine whether a drug has abuse potential.

However, humans can develop tolerance to marijuana's cardiovascular, autonomic, and behavioral effects (Jones et al., 1981). Tolerance to some of marijuana's behavioral effects seems to develop after heavy marijuana use, but not after occasional marijuana use. For instance, following acute administration of marijuana, heavy marijuana users did not exhibit impairments in tracking and attention tasks, as were seen in occasional marijuana users (Ramaekers et al., 2009). Furthermore, a neurophysiological assessment administered through an electroencephalograph (EEG) which measures event-related potentials (ERP) conducted in the same subjects as the previous study, found a corresponding effect in the P100[26] component of ERPs. Specifically, corresponding to performance on tracking and attention tasks, heavy marijuana users showed no changes in P100 amplitudes following acute marijuana administration, although occasional users showed a decrease in P100 amplitudes (Theunissen et al., 2012). A possible mechanism underlying tolerance to marijuana's effects may be the down-regulation of cannabinoid receptors (Hirvonen et al., 2012; Gonzalez et al., 2005; Rodriguez de Fonseca et al., 1994; Oviedo et al., 1993).

Importantly, pharmacological tolerance alone does not indicate a drug's physical dependence liability. In order for physical dependence to exist, evidence of a withdrawal syndrome is needed. Physical dependence is a state of adaptation, manifested by a drug-class specific withdrawal syndrome produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist (*ibid*). Many medications not associated with abuse or addiction can produce physical dependence and withdrawal symptoms after chronic use.

Discontinuation of heavy, chronic marijuana use has been shown to lead to physical dependence and withdrawal symptoms (American Psychiatric Association DSM–V, 2013; Budney and Hughes, 2006; Haney et al., 1999). In heavy, chronic marijuana users, the most commonly reported withdrawal symptoms are sleep difficulties, decreased appetite or weight loss, irritability, anger, anxiety or nervousness, and restlessness. Some less commonly reported withdrawal symptoms are depressed mood, sweating, shakiness, physical discomfort, and chills (Budney and Hughes, 2006; Haney et al., 1999). The occurrence of marijuana withdrawal symptoms in light or non-daily marijuana users has not been established. The American Psychiatric Association's DSM–V (2013) includes a list of symptoms of "cannabis withdrawal." Most marijuana withdrawal symptoms begin within 24–48 hours of discontinuation, peak within 4–6 days, and last for 1–3 weeks. Marijuana withdrawal syndrome has been reported in adolescents and adults admitted for substance abuse treatment.

Based on clinical descriptions, this syndrome appears to be mild compared to classical alcohol and barbiturate withdrawal syndromes, which can include more serious symptoms such as agitation, paranoia, and seizures. Multiple studies comparing marijuana and tobacco withdrawal symptoms in humans demonstrate that the magnitude and time course of the two withdrawal syndromes are similar (Budney et al., 2008; Vandrey et al., 2005, 2008).

8. Whether the Substance Is an Immediate Precursor of a Substance Already Controlled Under This Article

Under the eight factor analysis, the Secretary must consider whether marijuana is an immediate precursor of a controlled substance. Marijuana is not an immediate precursor of another controlled substance.

Recommendation

After consideration of the eight factors discussed above, FDA recommends that marijuana remain in Schedule I of the CSA. NIDA concurs with this scheduling recommendation. Marijuana meets the three criteria for placing a substance in Schedule I of the CSA under 21 U.S.C. 812(b)(1):

(1) Marijuana has a high potential for abuse:

A number of factors indicate marijuana's high abuse potential, including the large number of individuals regularly using marijuana, marijuana's widespread use, and the vast amount of marijuana available for illicit use. Approximately 18.9 million individuals in the United States (7.3 percent of the U.S. population) used marijuana monthly in 2012. Additionally, approximately 4.3 million individuals met diagnostic criteria for marijuana dependence or abuse in the year prior to the 2012 NSDUH survey. A 2013 survey indicates that by 12th grade, 36.4 percent of students report using marijuana within the past year, and 22.7 percent report using marijuana monthly. In 2011, 455,668 ED visits were marijuana-related, representing 36.4 percent of all illicit drug-related episodes. Primary marijuana use accounted for 18.1 percent of admissions to drug treatment programs in 2011. Additionally, marijuana has dose-dependent reinforcing effects, as demonstrated by data showing that humans prefer relatively higher doses to lower doses. Furthermore, marijuana use can result in psychological dependence.

(2) Marijuana has no currently accepted medical use in treatment in the United States:

FDA has not approved a marketing application for a marijuana drug product for any indication. The opportunity for scientists to conduct clinical research with marijuana exists, and there are active INDs for marijuana; however, marijuana does not have a currently accepted medical use for treatment in the United States, nor does marijuana have an accepted medical use with severe restrictions.

A drug has a "currently accepted medical use" if all of the following five elements have been satisfied:

a. the drug's chemistry is known and reproducible;

b. there are adequate safety studies;

c. there are adequate and well-controlled studies proving efficacy;

d. the drug is accepted by qualified experts; and

e. the scientific evidence is widely available.

[26] The P100 component of ERPs is thought to relate to the visual processing of stimuli and can be modulated by attention.