NEIL ABERCROMBIE
GOVERNOR

TED SAKAI
DIRECTOR

Martha Torney
Deputy Director
Administration

Max Otani
Deputy Director
Corrections

Keith Kamita
Deputy Director
Law Enforcement

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
919 Ala Moana Blvd. 4th Floor
Honolulu, Hawaii 96813

No. _____

TESTIMONY ON HOUSE BILL 668, HOUSE DRAFT 1
A BILL FOR AN ACT RELATING TO HEALTH
By
Ted Sakai, Director
Department of Public Safety

House Committee on Finance
Representative Sylvia Luke, Chair
Representative Scott Y. Nishimoto, Vice Chair
Representative Aaron Ling Johanson, Vice Chair

Friday, February 22, 2013, 1:30 PM
State Capitol, Room 308

Chair Luke, Vice Chairs Nishimoto and Johanson, and Members of the Committee:

The Department of Public Safety (PSD) **supports** House Bill 668, House Draft 1, which transfers the Medical Marijuana Program from PSD to the Department of Health (DOH). The primary focus of this program should be on the health of the qualifying patients and, as such, the DOH is better suited for managing it. We stand ready to assist in the smooth transition of the program from PSD to DOH.

This program is self-sustaining through patient registration fees. Currently, the fee is $25 per year and the annual income is approximately $275,000 per year. Section 329-123, Hawaii Revised Statutes, was amended by Act 73, Session Laws of Hawaii 2011, to allow the fee to increase to $35. The fees are deposited into the Controlled Substances Registration Revolving Fund and commingles with other registration fees allowed under Chapter 329, Uniformed Controlled Substances Act. We recommend that a revolving fund be created or identified within DOH for this purpose.

There is no NED position described and funded solely for the medical marijuana program, nor is there specific equipment dedicated only for this purpose. The work is distributed among staff that perform specific functions related to the enforcement of Chapter 329, such as clerks who maintain data systems, staff who review and approve registrations, and investigators who verify registrants for law enforcement agencies.

We understand DOH is requesting start-up funds and defer to them concerning this request.

Thank you for the opportunity to provide our comments.

NEIL ABERCROMBIE
GOVERNOR

BARBARA A. KRIEG
DIRECTOR

LEILA A. KAGAWA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN RESOURCES DEVELOPMENT
235 S. BERETANIA STREET
HONOLULU, HAWAII 96813-2437

February 21, 2013

TESTIMONY TO THE
HOUSE COMMITTEE ON FINANCE

For Hearing on Friday, February 22 2013
1:30 p.m., Conference Room 308

BY

BARBARA A. KRIEG
DIRECTOR

House Bill No. 668, HD1
Relating to Health

WRITTEN TESTIMONY ONLY

TO CHAIRPERSONS SYLVIA LUKE AND MEMBERS OF THE COMMITTEES:

The Department of Human Resources Development has **comments** on the proposed transfer. As testified to in our testimony to the House Committees on Health and Public Safety, to protect the rights and benefits of the employees to be transferred, the language for the transfer of employees and officers from one agency to another in Section 5 should read:

> "All rights, powers, functions, and duties of the department of public safety relating to the medical use of marijuana under chapter 329, part IX, Hawaii Revised Statute; are transferred to the department of health.
>
> All employees who occupy civil service positions and whose functions are transferred to the department of health by this Act shall retain their civil service status, whether

permanent or temporary. Employees shall be transferred without loss of salary, seniority (except as prescribed by applicable collective bargaining agreement), retention points, prior service credit, any vacation and sick leave credits previously earned, and other rights, benefits, and privileges, in accordance with state personnel laws and this Act, provided that the employees possess the minimum qualifications and public employment requirements for the class or position to which transferred or appointed, as applicable, provided further that subsequent changes in status may be made pursuant to applicable civil service and compensation laws.

Any employee who, prior to this Act, is exempt from civil service and is transferred as a consequence of this Act, may continue to retain the employee's exempt status, but shall not be appointed to a civil service position as a consequence of this Act. An exempt employee who is transferred by this Act shall not suffer any loss of prior service credit, vacation or sick leave credits previously earned, or other employee benefits or privileges as a consequence of this Act, provided that the employees possess legal and public employment requirements for the position to which transferred or appointed, as applicable; provided further that subsequent changes in status may be made pursuant to applicable employment and compensation laws. The director of the department of health may prescribe the duties and qualifications of such employees and fix their salaries without regard to chapter 76, Hawaii Revised Statutes."

The change in language is necessary to avoid a violation of civil services laws and the merit principle as noted in §76-1, Hawaii Revised Statutes.

Thank you for the opportunity to offer comments on this measure.

ESD

TESTIMONY OF THE HAWAI`I POLICE DEPARTMENT

HOUSE BILL 668

RELATING TO HEALTH

BEFORE THE COMMITTEE ON FINANCE

DATE : Friday, February 22, 2013

TIME : 1:30 P.M.

PLACE : Conference Room 308
State Capitol
415 South Beretania Street

PERSON TESTIFYING:

Police Chief Harry S. Kubojiri
Hawai`i Police Department
County of Hawai`i

(Written Testimony Only)

William P. Kenoi
Mayor

Harry S. Kubojiri
Police Chief

Paul K. Ferreira
Deputy Police Chief

County of Hawai`i

POLICE DEPARTMENT
349 Kapiolani Street • Hilo, Hawai`i 96720-3998
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February 20, 2013

Representative Sylvia Luke
Chairperson and Committee Members
Committee On Finance
415 South Beretania Street, Room 308
Honolulu, Hawai`i 96813

Re: House Bill 668 Relating to Health

Dear Representative Luke:

The Hawai`i Police Department strongly opposes House Bill 668 with its purpose being to transfer departmental jurisdiction of the Medical Marijuana laws from the Department of Public Safety (DPS) to the Department of Health and requires the DPS to assist with the transfer.

The Department of Public Safety is best equipped to manage and maintain the Medical Marijuana Program (Program) whereas the Department of Health is not. The Department of Health does not possess law enforcement powers therefore would not be able to enforce the rules set forth in the Program. The Department of Public Safety is best suited to maintain jurisdiction over the Program and has already established and demonstrated their ability to satisfactorily maintain the Program. In addition, the Department of Public Safety has law enforcement powers and possesses the ability and means to properly address those who deviate from the Program's rules.

We believe that Medical Marijuana needs to be overseen in the same light as other Controlled Substances in the State of Hawai`i, that being under the auspices of the Department of Public Safety. Probably more pertinent is that unlike other Controlled Substances which are produced and transported under strict scrutiny, Medical Marijuana is being allowed to be cultivated and processed with little oversight in terms of: quality control, Tetrahydrocannabinol (THC) content, and security to prevent exposure to minors.

Having the Department of Health with their stated mission "to protect and improve the health and environment for all people in Hawai`i", overseeing this Medical Marijuana Program goes against their own mission statement, especially when it is acknowledged there are known health risks associated with marijuana use.

It is for these reasons, as well as a sense of prudence and caution, we urge this committee to disapprove this legislation.

Thank you for allowing the Hawai`i Police Department to provide comments relating to House Bill 668.

Sincerely,

Harry S. Kubojiri

HARRY S. KUBOJIRI
POLICE CHIEF

The Budgetary Implications of Marijuana Decriminalization and Legalization for Hawai`i

Lawrence W. Boyd, Ph.D.
Economist
University of Hawai`i West Oahu
Lboyd@hawaii.edu

Executive Summary

Economic analysis of current public policies on marijuana reveals that Hawaii state and county governments could reap up to $33 million annually in new revenues and cost savings if tax and regulatory policies were to replace law enforcement to control marijuana distribution. Furthermore, research indicates that enforcement expenditures of up to $10 million each year statewide have failed to reduce the amount of marijuana available in Hawaii.

This report focuses on the economic effects of two alternative policies:

Decriminalization of marijuana is a policy that reduces the punishment for its possession to a civil fine rather than criminal penalties or jail time. Trafficking, selling, and distributing to minors, remain subject to standard criminal punishment.

Legalization is a policy that would eliminate criminal and civil penalties for both possession and sale of marijuana and replace them with regulation, which would include restrictions on marijuana use similar to those applicable to alcohol and tobacco. The regulation model uses taxes, minimum age requirements, and licensing to control distribution.

Currently, thirteen states have decriminalized marijuana possession. Spain, Portugal, Luxembourg, Belgium, and Austria have decriminalized marijuana possession; in addition, there are seven other countries either considering decriminalization or having a *de facto* policy that in essence, decriminalizes or legalizes marijuana (e.g. the Netherlands).

The primary cost of the criminalization of marijuana is law enforcement. In Hawai`i, possession of less than one ounce of marijuana is a petty misdemeanor. Approximately 65 percent of the cases are dismissed, not prosecuted, or stricken in any given year. First offenses generally receive probation or a deferred acceptance of a guilty plea. Given the current usage levels, the low risk of arrest, and further risk of punishment, the current criminalization policy is not deterring marijuana use.

The report concludes:

- State and county law enforcement agencies spend $4.1 million per year to enforce marijuana possession laws; an additional $2.1 million is spent by the courts. Enforcement of marijuana distribution laws costs approximately $3 million. The total costs of enforcing all marijuana laws in Hawaii are approximately $9 to 10 million per year.

- Between 1994 and 2003, the price of one ounce of high quality marijuana dropped by 12 percent. The price decline reveals that law enforcement efforts to restrict supply have not been effective.

- Research on the effects of decriminalization has tended to find either no relationship or a weak positive relationship between decriminalization and drug use. Given the current low prosecution levels and small penalties, it is doubtful that decriminalization would have much effect on marijuana use in Hawai`i.

- Decriminalization of marijuana possession in Hawai`i would save state and county governments approximately $5 million per year.

Legalizing, taxing and controlling marijuana would save an additional $5 million per year and would create tax revenues of between $4 million and $23 million.

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Research for this report was underwritten by the Drug Policy Action Group

Introduction

Decriminalization of marijuana is a policy that reduces the punishment for possession of marijuana to a civil fine rather than a criminal offense. Trafficking and selling, or distributing to minors, remain subject to standard criminal punishments. Decriminalization is a policy that has been substantially discussed nationally. A number of states have decriminalized marijuana possession.

In contrast, legalization would decriminalize both possession and sale of marijuana and replace them with a system of regulation and possible taxation. There is also a substantial literature on legalization of various drugs although no state or national government has actually legalized marijuana.

This study addresses three issues related to marijuana decriminalization, and legalization. First, what savings from legalization or decriminalization can be expected to occur in state and local budgets. Second, in the case of legalization, what tax revenues could be projected. Third, what would be the impact of these measures on marijuana use.

The United States, like other countries, has chosen to regulate some substances that are addictive, or potentially addictive, such as cigarettes and alcohol, and ban others.[1] Regulation uses taxes, minimum age requirements, other restrictions on use, and education about harmful effects in order to limit the potential damage these goods can do. Bans involve outlawing the use of certain substances. Taxation and bans both raise the price of these substances; taxation directly raises the price, while bans limit supply. In addition, bans create black markets, encourage illegal activities, and may result in harm to innocent victims.[2]

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[1] Potentially addictive means a relatively small part of the population can become addicted to a substance. Alcoholism, for example, is recognized as a disease, and those addicted to alcohol represent a small percentage of those that consume alcohol on the order of 15 percent. The addictive nature of marijuana is questionable. Those who support its continued ban claim that it is a "gateway drug" whose use leads to more harmful drugs; although recent research disputes that theory.

[2] This discussion follows that of Michael Grossman, "Individual Behaviors and Substance Use the Role of Price," National Bureau of Economic Research Working Paper 1048.

During the 1970's, eleven states decriminalized marijuana possession, as have a number of countries since.[3] Currently thirteen states have decriminalized marijuana possession. Proponents of decriminalization argue that it can have positive outcomes that include savings on enforcement for state and local governments, an improved allocation of criminal justice resources, and expanded funding for prevention education and treatment for marijuana users. Opponents have claimed that decriminalization produces a substantial increase in marijuana use along with increased crime and other negative effects.

Those who favor legalization point to the inefficient use of social resources and argue that policies like those involved in the regulation of alcohol and tobacco are far more effective in limiting the individual and social costs involved. There is also a significant literature that suggests legalization could also be more efficient in limiting the negative consequences of marijuana use. Taxation, for example, can ameliorate whatever social costs occur, and the price effects can significantly reduce its use, especially among adolescents.[4] Furthermore it can be demonstrated that taxation is significantly cheaper in terms of enforcement and outcomes than outlawing substances.

This report reviews evidence and literature that suggest marijuana decriminalization would not lead to a measurable increase in marijuana use. This report does not take a stance on whether, or not, marijuana use is harmful. The conclusion reached below is that decriminalization would save state and local governments in Hawai`i approximately $5

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[3] Alaska, California, Maine, Minnesota, Mississippi, Nebraska, New York, North Carolina, Ohio and Oregon decriminalized. Alaska (1990) voted to recriminalize, but Alaska's state courts have ruled that privacy rights protected marijuana use in the home. A twelfth state, South Dakota decriminalized and then recriminalized within a year. In 1996 Oregon recriminalized, but in 1998 voters rescinded recriminalization and returned to decriminalization. Nevada decriminalized in 2001. Colorado has also decriminalized. See http://www.norml.org/ and http://www.drugpolicy.org/ for details. Countries that have decriminalized are Italy, Spain, Portugal, Luxembourg, Belgium, and Austria. Several other countries have either *de facto* decriminalized or are in the process of decriminalizing. These include Netherlands, Germany, Denmark, France, Switzerland, United Kingdom and Canada. See http://eldd.emcdda.org/.

[4] See Becker, G. S., M. Grossman, et al. (1994). "An Empirical Analysis of Cigarette Addiction." American Economic Review 88(3): 396-418. They find prices have a greater effect on adolescents.

million dollars per year. Legalization would save an additional $5 million per year for a total of $10 million should legalization be adopted. In addition, legalization would create tax revenues between $4 and $23 million. The estimates provided here must make use of approximations in cases where data do not make possible a more detailed analysis. Wherever possible this report has used detailed information and approximations that bias estimated budget effects downward.

Methodology of Estimating Budgetary Implications of Decriminalization and Legalization

By and large this report follows the methodology used by Miron (2003) in his analysis of the effects of decriminalization in Massachusetts.[5] As he suggests, the two major budgetary implications of decriminalization are the savings in criminal justice resources and criminal fines that are shifted to civil fines. The former is the savings that result to the extent that police, prosecutors, forensic laboratories and court personnel are not used for marijuana possession offenses. Miron (2003) suggests that the savings on law enforcement is the predominant one. The amounts and collection of civil as opposed to criminal fines would likely be at about the same level; therefore the second effect would be small. A look at court statistics, reported below tends to confirm this.

The methodology used by Miron involves the following steps:

1. Determine the percentage of all Hawai`i arrests that is for marijuana possession.
2. Determine the criminal justice budget for Hawai`i
3. Multiply the first number by the second

As Miron points out, these steps yield reasonable estimates based on certain assumptions. First, that average costs equal marginal costs. This means that law enforcement is a constant cost industry; increased dollars spent on enforcement leads to

[5] See, Jeffrey A. Miron, "The Effect of Marijuana Decriminalization on the Budgets of Massachusetts Governments, With a Discussion of Decriminalization's Effect on Marijuana Use," Drug Policy Forum of Massachusetts. Also Jeffrey A. Miron, "The Budgetary Implication of Marijuana Decriminalization," June, 2005, The Marijuana Policy Project.

approximately the same increase in arrests. Police also engage in activities unrelated to arrests, such as traffic control, but these sorts of activities are minor in terms of costs relative to the overall law enforcement and arrests.

Miron (2003) focused primarily on police enforcement of marijuana laws and did not quantify costs associated with prosecution within the court system. Because court statistics make it possible to do this in Hawai`i, this report adds these costs to enforcement costs. Court and legal costs, related to prosecution and defense, are reported in addition to enforcement costs.

A second question is what exactly does decriminalization mean? Currently under Hawai`i law marijuana possession is a misdemeanor. Possession of less than one ounce is a petty misdemeanor punishable by 30 days in jail and or a fine up to $1,000. Possession of between one ounce and one pound is a misdemeanor punished by up to one year in jail and up to a $2,000 fine. One proposal, HB 1751 and SB 1056, introduced in the 2005 state legislative session, decriminalizes possession of less than one ounce. Generally, however, the data do not break down arrests by weight, but rather record arrests for possession that include all types of misdemeanors. So the results below are calculated for all misdemeanor marijuana possession charges, although the vast majority of these appear to be for under one ounce.

The statistics on arrest are Uniform Crime Statistics reported by law enforcement agencies to the United State Department of Justice. Other statistics used come from Reports of the Hawai`i State Judiciary and the U. S. Census of Governments.

A difficulty raised by Miron (2003, 2004) is that some arrests are the result of an investigation related to a different crime. Thus these arrests can be broken down into three categories. The first are “stand alone” arrests, where someone is arrested because an officer sees them smoking marijuana. A second type is an arrest made in conjunction with a traffic stop, also referred to as “civil incidental”. A third type is an arrest that occurs because police have detained a suspect for a crime and then find that the suspect possessed marijuana, known as a “criminal incidental” arrest. Generally the police resources saved under decriminalization would correspond to the first two categories.

Miron states, “it is useful to know what fraction of arrests are in these first two

categories 'stand alone' and 'civil incidental' as opposed to the criminal incidental."[6] As a result, Miron finds the proportion of stand alone arrests and reduces the total of arrests by this amount. A review of the data definitions used in reporting Uniform Crime Statistics indicates that in the case of multiple counts the most serious charge is the only one reported. Given the law in Hawai`i and the nature of the arrests, marijuana possession is only more serious than traffic violations. Thus it is more accurate to use the arrest statistics reported for Hawai`i under the Uniform Crime Information System without adjustment. In this instance this report differs from Miron.[7]

Estimating the budgetary implications of legalization is somewhat more difficult. In terms of enforcement costs the same procedure used in analyzing decriminalization is employed. Because additional costs include jail time for offenders, and because actual numbers exist for persons incarcerated and associated costs, these are added. Taxation, which would play a significant role in legalization, requires assumptions about the public policy that would be pursued, the social costs of legalization, and estimates about how much supply would increase. Miron (2004) reports $4 million per year as potential tax revenue from legalization in Hawai`i. A different methodology would be to use per capita tax revenue from alcohol and tobacco as a basis for estimating tax revenue.

Budgetary Effects

Table 1, below contains possession arrests, total arrests, percentage of possession arrests, county police expenditures and the cost of enforcement. Arrests are from the Uniform Crime Statistics of the Department of Justice. County police expenditures are from the United States Census, State and Local Government. These statistics cover 1998 through 2002. The Census does not provide state and local data for every year. Although alternative statistics and budgets are available, using Census data combines state and

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[6] Ibid. p. 4

[7] Miron reduces Massachusetts' arrests by two-thirds as a result of this adjustment. Thus this means there would be significant differences between the two reports. However the difference is data driven. Miron finds 1.7 percent of all arrests in Massachusetts in 2000 would fall into these two categories. In 2000, in Hawai`i 1.72 percent of all arrests were marijuana possession arrests. Given similar marijuana use patterns and risk of arrest this indicates that the results are comparable when the revision is not used.

county police expenditures that include many anti-drug programs such as the state's drug interdiction program at the Honolulu airport. It also facilitates national comparisons.[8] Following the methodology above, the expenditures on enforcement that would be reduced by decriminalization are approximately $4.2 million per year. Note that the data fluctuate around this number over several years. Because Hawai`i does not have the same sort of statewide law enforcement agencies other states do, this is a burden in Hawai`i primarily for county government.[9]

Table 1
State of Hawai`i Possession Arrests, Total Arrest, Percent of Total Arrests, Police Budgets and Cost of Possession Enforcement

Year	Arrests Marijuana Possession	Total Arrests	Percent Marijuana Possession	State and Local Police Budgets	Cost of Possession Enforcement
1997	1,411	70,060	2.01%	$192,287,000	$3,872,637
1998	1,257	63,208	1.99%	$207,743,000	$4,131,328
1998	1,232	61,393	2.01%	$221,151,000	$4,434,331
2000	1,152	64,685	1.72%	$221,899,000	$3,951,884
2001	1,142	60,177	1.90%	NA	NA
2002	1,032	63,021	1.64%	$254,636,000	$4,169,790
2003	1,098	58,722	1.87%	NA	NA
2004	1,054	58,547	1.80%	263,768,000	$4,748,518

Sources: Arrests from Hawai`i State Department of the Attorney General, "Crime in Hawaii," http://hawaii.gov/ag/cpja/main/rs/Folder.2005-12-05.2910; Police Budgets, U. S. Census Bureau, Federal State and Local Governments, State Government Finances, http://www.census.gov/govs/www/state.html

Related to the arrest statistics are the criminal proceedings that follow. The U. S. Census Bureau reports that during the fiscal year 2001-2002 the budget for state and county judicial and legal services was $213, 854,000.[10] Approximately 1% of the total

[8] For example police budgets are available in county Comprehensive Annual Financial Reports. Summing these county numbers does not always produce identical results due to minor differences in definitions between county reports.
[9] The Hawai`i State Department of Public Safety participates with local and federal agencies in statewide drug enforcement and interdiction efforts.
[10] This includes state judiciary expenses, county prosecutors' offices, drug courts and the attorney general's office. Probation and investigation related to sentencing is also part of this budget. For 2001-2002 see: http://www.census.gov/govs/estimate/0212hisl_1.html

criminal cases heard were for marijuana possession.[11] Multiplying the 1% by the $213 million means a total of $2.1 million is used in various court-related possession activities.

Also of interest is the actual disposition of these misdemeanor drug cases in District Court. Approximately 65% are dismissed, not prosecuted, or stricken in any given year. A very small number is committed to Circuit Court for jury trial and a relatively small proportion, about 25%, results in conviction. In addition first offenses generally get probation.[12]

Table 2
Disposition of District Court Misdemeanor Drug Cases

Year	By Discharge/ Dismissal	By Nole Prosequi	Stricken	By Commitment to Circuit Court Jury Trial	By Conviction	Total
2000	300	31	3	39	150	523
2001	276	20	4	37	124	461
2002	310	36	2	42	127	517
2003	304	42	12	85	141	584

Source: The Judiciary State of Hawai`i Annual Report Statistical Supplement, Various Years, Table 17.

These statistics tend to confirm that the primary cost of the criminalization of marijuana criminalization is enforcement. Few are actually prosecuted under the law, fewer convicted, and virtually none serve jail time. Of those convicted, probation is the usual sentence for first time offenders. The burden in terms of enforcement costs fall on county level enforcement efforts.

Table 3, below, reports estimates of marijuana use from the National Survey on Drug Use and Health. Beginning in 1999 this survey was expanded so sample sizes were large enough to cover states. Combining samples into two-year averages is a means by

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[11] See The Judiciary State of Hawai`i "Annual Report Statistical Supplement." Various Years; misdemeanor drug cases which are identical to misdemeanor marijuana possession are reported. These numbers are divided by the total criminal cases heard in district and circuit court to arrive at the 1 percent figure.

[12] In addition some are offered deferred guilty pleas, where a defendant is released on good behavior, provided he or she does not re-offend. These outcomes will also be found in these statistics since those who do re-offend are found in the convictions category.

which trends can be measured. A change in the methodology of the survey greatly expanded it in 2003 and also greatly expanded reported marijuana use; therefore 2002-2003 is not directly comparable to previous time periods. The question on past year use was added in 2003. During 2002-2003 about 7% of the population over twelve used marijuana within the past 30 days, a measure indicating regular users. Almost 12% used it in the last year, indicative of infrequent users. Adjusting the number of arrests so they match the time periods of the survey, makes it possible to estimate the risk of arrest for regular marijuana users. This was 1.5% in 2002-2003. In terms of punishment it was effectively zero.

Table 3
Marijuana Use in Hawai`i, National Household Survey on Drug Abuse

Year	30 Days Use	Past Year Use	Percentage 30 Days	Percentage Year	Risk of Arrest
2003-2004	66,000	110,000	6.52%	10.80%	1.59%
2002-2003	69,000	115,000	6.95%	11.56%	1.54%
2000-2001	55,000	NA	5.82%	NA	2.09%
1999	57,000	NA	5.80%	NA	2.16%

Source: http://oas.samhsa.gov/nhsda, Substance Abuse & Mental Health Services Administration, Office of Applied Studies

Criminal justice resources used in the enforcement of the current marijuana law on possession in Hawai`i are about $6 million dollars. Given the usage levels, risk of arrest, and further risk of punishment it is questionable whether criminalization serves as a deterrent to use. This can be further analyzed by looking at research done nationally on use.

Table 4 below reports arrests for distribution and the costs associated with it. Those costs were approximately $1 million in 2002.

Table 4
Marijuana Distribution Arrests

Year	Marijuana-Sale/Manufacture	Marijuana-Sale/Manufacture	Cost of Manufacture Enforcement
1997	210	0.30%	$576,861
1998	166	0.26%	$545,697
1999	159	0.26%	$568,208
2000	167	0.26%	$574,859
2001	125	0.21%	NA
2002	240	0.38%	$969,749
2003	159	0.27%	NA
2004	110	0.18%	$495,576

Sources: Arrests from Hawai`i State Department of the Attorney General Uniform Crime Report, http://www.cpja.ag.state.hi.us/rs/cih/index.shtml. Police Budgets, U. S. Census Bureau, Federal State and Local Governments, State and Local Government Finances, http://www.census.gov/govs/www/state.html

Stronger enforcement efforts are directed at suppliers of marijuana. Assuming that all 240 distribution arrests were tried during fiscal year 2002, and that there were approximately 56,000 cases terminated that year by the judiciary which had a budget of approximately $214 million, then the court costs were approximately $850,000. According to the Department of Public Safety's Budget Office in 2005, each prisoner costs the state approximately $38,000 dollars per year to incarcerate. There were between 14 and 21 prisoners incarcerated for marijuana distribution over the past several years. These prisoners cost the state between approximately $582,000 and $800,000 in direct costs. [13] In addition to enforcement efforts directed towards finding dealers, there are special units directed at eradicating marijuana plants. The federal government funds these, in part, with additional funds provided at the local level. Matching three to one

[13] It should be noted that Hawai`i prisons suffer from severe overcrowding to the point that mandated court ordered relief has led to the export of prisoners to private prisons on the mainland. Overcrowding has other indirect costs including early release of prisoners and the potential return of these prisoners to criminal activity. See Ilyana Kuziemko and Steven Levitt, "An empirical analysis of imprisoning drug offenders, "Journal of Public Economics, 88, 2004. Discussed further below.

grants from the federal government fund various marijuana eradication programs. These total $360,900, so the one-third matching funds would be approximately $110,000.

The costs of enforcement of distribution laws appear to be approximately $3 million. Thus the total costs for enforcing all of the marijuana laws are in the $9 to $10 million range.[14]

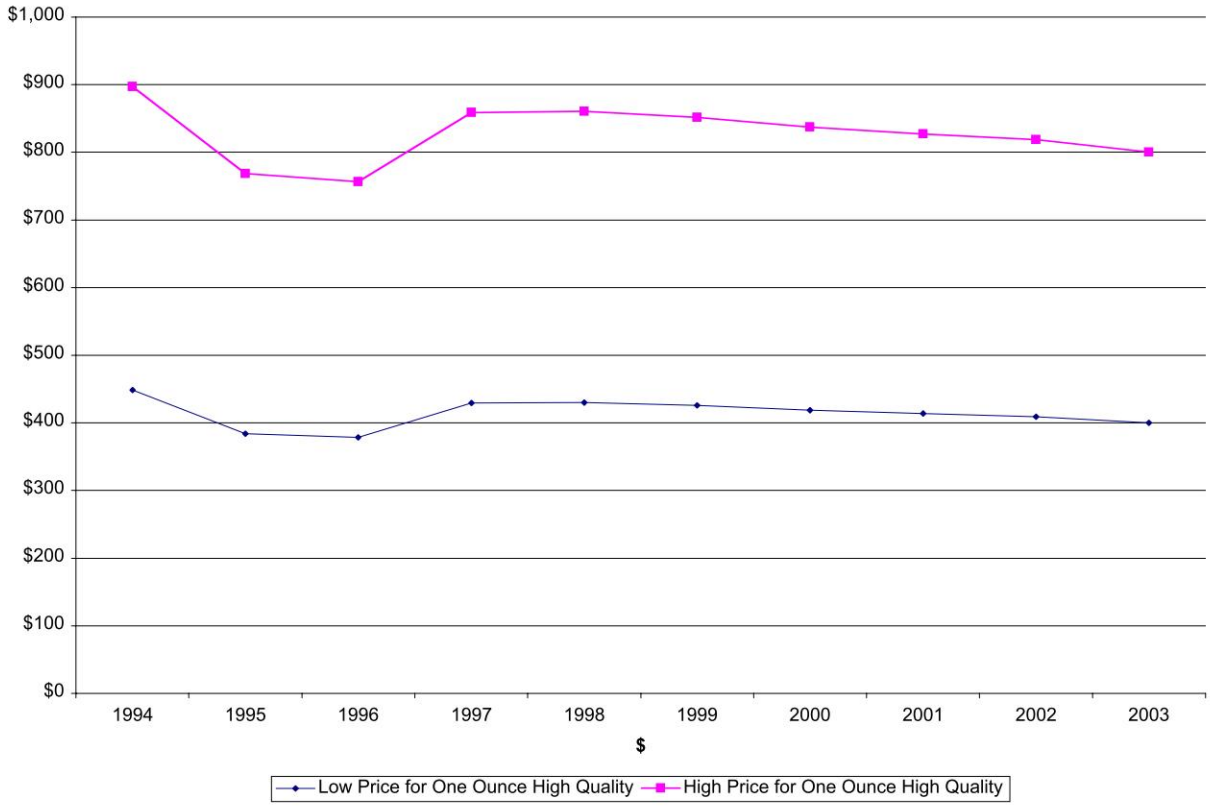
Enforcement efforts should restrict the supply of an illegal substance to such an extent that they affect the price of that product. Therefore it is useful to report prices for various amounts of marijuana, which is done in Table 5. Figure 1, plots the "real" price of marijuana in Honolulu, that is the price of marijuana net of inflation. The real price indicates what its cost is relative to the other prices of goods that consumers buy. The price series indicates a 12% drop in the real price of one ounce of high quality marijuana between 1994 and 2003. Given various estimates of the relationship between marijuana prices and consumption, this would suggest a 6% increase in marijuana consumption.

[14] A minimum of $8 million, plus other legal costs. Miron (2005) estimates that the total cost of marijuana prohibition in Hawai`i is $22 million. The differences between his estimates and these found here are first, I estimate police resources at $4 million while Miron estimates them at $2.7 million. The reason for this is that Miron reduces these arrests to stand alone arrests, a procedure I believe is flawed in Hawai`i for reasons outlined above. Second, Miron was unable to find data on the percentage of possession convictions for marijuana and assumes it was equal to the percentage of trafficking convictions. In turn he estimates trafficking convictions at 10.9 percent, which he then multiplies by the judicial budget for 2002. In this report it was possible to determine actual possession hearings. It was further assumed that all trafficking arrests were heard in the following year. The difference is substantial. Miron estimates judicial costs at $19.6 million, while using the actual numbers found in the Hawai`i State Judiciary Reports were in the $1 million range. In terms of incarceration, Miron estimates that 1 percent of the penal system's budget is used for incarcerating marijuana prisoners. His estimate is $1.96 million. In this report the actual number of prisoners are used and multiplied by per capita prisoner costs. The result is $910,000. Although the results are different from Miron's estimates, it should be noted that the difference lies in the fact that a large proportion of the court's resources are not used for marijuana enforcement.

Table 5 Honolulu Marijuana Prices				
Year	Joint	Gram	Ounce-High Quality	Pound
1994	$3-$5	NA	$400-$800	$6000-$9000
1995	$5	$25	$350-$700	$5000-$9000
1996	$5	$25	$350-$700	$5000-$9000
1997	$3-$10	NA	$400-$800	$6000-$9000
1998	$3-$10	NA	$400-$800	$6000-$9000
1999	$3-$10	NA	$400-$800	$6000-$9000
2000	$3-$10	NA	$400-$800	$6000-$9000
2001	$5-$20	$25	$400-$800	$6000-$9000
2002	$5-$20	NA	$400-$800	$6000-$9000
2003	$5-$20	$25	$400-$800	$6000-$9000
2004	$20-$40		$300-$550	$6000-$9000

Source: Hawai`i Community Epidemiology Working Group, National Institute of Health

Figure 1
Real Price of One Ounce of Marijuana in Honolulu Hawaii



Legalization can affect the price of marijuana in two ways. First, supply can increase and thereby prices will fall. In the Netherlands, where marijuana possession laws are laxly enforced, the price of marijuana is between 50% and 100% of U. S. prices. On

the other hand, taxes can raise the price of marijuana. Miron (2005) chooses two tax regimes; a relatively normal one and one that imposes "sin" taxes on marijuana that are equivalent to those charged for alcohol and tobacco. He then allocates a national number to each state based on either consumption or population, and divides that total between federal and state taxes. Miron's estimate for Hawai`i tax revenues is in the $4 million range. By contrast, tax revenues for tobacco in Hawai`i during 2003 were $77.5 million and for liquor were $41 million, with 462,000 adults consuming alcohol in the last 30 days and 221,000 consuming cigarettes.[15] This provides a range of annual per capita tax collections of $91.23 for alcohol and $350.59 for tobacco. There were approximately 58,000 adult marijuana users during that year. Assuming that they will pay a per capita amount of taxes similar to cigarette and alcohol users, then the range of marijuana tax collections would be between $5.3 million and $20.3 million.

The Implications of Decriminalization and Legalization on Use

Decriminalization:

Currently in Hawai`i, the chance of a marijuana user being arrested and convicted is approximately 0.4 percent. The apparent lower priority given by law enforcement and relatively mild penalties for marijuana offenses reflect policy decisions that make the probability of arrest and punishment of marijuana users insignificant and decreases the potential effects of decriminalization. Gary Becker suggests two efficient means of allocating enforcement resources. One would be to have lots of police, so law-breakers face a high risk of arrest but the punishments are somewhat mild. A second regime would be to have fewer police, reducing the risk of arrest but have severe or draconian, punishments for those who are caught. Either can function as a deterrent. Hawai`i, it can be said, meets neither. There is a low risk of arrest and a mild punishment. This means marijuana users in Hawai`i perceive the probability of arrest and punishment as insignificant.

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[15] Use from 2002-2003 National Surveys on Drug Use. Tax data from Hawai`i State Department of Taxation http://www.hawaii.gov/tax/

Research on the effects of marijuana decriminalization has tended to find either no relationship or a weak positive relationship between marijuana decriminalization and drug use. Johnston, O'Malley, and Bachman (1981) use data from Monitoring the Future, an annual survey of U. S. high school seniors, to see whether there were difference over time in marijuana use between states that decriminalized and those that did not. They found little difference. Thies and Register (1993) use data from the National Longitudinal Survey of Youth between 1984 and 1988 to analyze differences in use of alcohol, marijuana and cocaine among states who decriminalized and those that did not. They also find little evidence of any effect. In addition DiNardo and Lemieux (1992) find no effect of decriminalization on use.

Some studies have found a correlation between decriminalization and use. Model (1993) finds a statistically significant and positive result from decriminalization, but because he used hospital emergency room drug mentions these results are difficult to interpret. It might simply reflect attitudes on the part of the population in decriminalized states toward drug use, which could correlate with the establishment of decriminalization. Other studies that relied on cross-state variation in decriminalization status using recent data and showing a positive and statistically significant effect were Saffer and Chaloupka (1999); Chaloupka et al (1999); and Chaloupka, Grossman and Taurus (1999). Again these are difficult to interpret because they used a measure that assumed decriminalized state laws were identical and fundamentally different from criminalized states. The measure used could also reflect attitudes on the part of the population towards drug use.

Pacula, Chriqui and King (2003) found that attitudes on the part of the population towards drug use could play a role. They included actual legal dimensions such as penalties and found that these did not diminish the association between decriminalization and recent use. They conclude that their results tend to indicate that attitudes toward drug use simply tended to be more tolerant in decriminalized states leading to the positive association found in some studies between decriminalization and marijuana use. In other words, decriminalization did not cause increased drug use, but that it existed independently of the decriminalization statutes. They also demonstrate the extent to which non-decriminalized states have reduced penalties associated with possession of small amounts of marijuana as early as 1989, and call into question the interpretation of

studies evaluating this policy based on a simple cross sectional use of a variable denoting decriminalization.

Miron (2003) concludes, "The result that decriminalization has little impact on marijuana use might seem surprising since standard economic principles suggest that lowering the penalties for use should increase demand and therefore quantity consumed. The explanation for this counterintuitive result of little impact on use is that decriminalization frequently ratifies what has already taken place in the form of reduced enforcement of marijuana laws."[16] Given the limited prosecution and penalties associated with marijuana possession in Hawai`i it is doubtful that decriminalization would have much effect on marijuana use.

Legalization:

Regulation and legalization means governmental agencies enforce tax, and other laws, in a way that regulates the use of a product. The economics of substance use and abuse assumes that the substances in question share two properties. First, they are addictive in the sense that an increase in past consumption of the good leads to an increase in the current consumption. Second, their consumption harms the consumer and others. Because of these qualities there are both individual and social costs associated with their use.

Many social costs arise from outlawing the use of some goods, which creates black markets. Resulting social costs range from violence that affects innocent citizens as illegal gangs compete for markets, to a decline in respect for the law.[17] Often overlooked is that black market dealers can also lower costs of production in a number of ways. For example they do not obey labor laws, thereby reducing their costs of production.[18] Standard economic theory suggests that taxation can be used to offset some of these

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[16] Miron, "The effect of Marijuana Decriminalization the Budgets of Massachusetts Governments…" p. 8

[17] See Becker,G., Grossman, M., Murphy K., 2001. "The Simple Economics of the War on Drugs, Mimeo, University of Chicago Department of Economics.

[18] Levitt found almost all members of a drug gang in Chicago were paid less than the minimum wage forcing most gang members to live with their mothers.

social costs. As a result harmful activities can be reduced through both price effects and legal sanctions.[19]

In terms of economics, one could simply assume that addictive goods are "like" other goods and analyze the effects of prices and incomes on consumption. Or one could view addiction as "myopic" behavior: past consumption increases future consumption and there is no thought of future consequences. Becker and Murphy (1988) develop a model of addiction that suggests that addicts in some way also incorporate future consequences. Grossman suggests that despite its somewhat controversial nature, "Becker and Murphy's main contribution is to suggest that it is a mistake to assume addictive goods are not sensitive to price."[20]

On the other hand there is a growing concern about the efficacy of the war on drugs and the use of incarceration as a deterrent. Nationally, in 1980 there were 24,000 drug offenders in state prisons; in 2004 there were 400,000. There was virtually no increase in other types of offenders. While basic statistics on total marijuana production and consumption do not exist in any reasonable form, accurate estimates exist for drugs like heroin. As a result, studies related to these other drugs can inform our understanding of the consequences of legalization of marijuana.

For example, out of 700 metric tons of cocaine produced, world wide efforts, largely by United States authorities, interdict 300 tons. In addition there is the massive incarceration cited above. Despite these efforts the price of cocaine during this period fell by more than two-thirds and the consumption of cocaine grew by ten times. Of course the effects could have been worse without these efforts.

This is the question Kuziemko and Levitt (2004) take up. They analyzed the effect of incarcerating cocaine drug offenders on cocaine prices. Their results are the highest found for incarceration. They find that cocaine prices were 5% to 15% higher as a result of increases in drug punishment since 1985. There is a broad range of estimates related to the effect of the price of cocaine on use, so this price rise would have resulted in anywhere from a 5% to 20% drop in cocaine use. They also found that locking up drug offenders leads to a crowding out effect in that time served for other offenses dropped by

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[19] Provided that taxes are not set so high that they encourage a black market to develop.
[20] Grossman, "Individual Behavior," p. 15

7.6 months on average. Incarceration had about the same effects on violent and property crime as locking up other offenders, about 3%. [21] Their results are the most positive found for the effects of incarceration.

Their research, while demonstrating that massive incarceration of drug offenders can deter drug use, also demonstrates how costly such a policy is. They find that such levels of imprisonment are excessive. In order to justify the level of imprisonment, the individual and social costs of cocaine consumption would have to be $270 per gram. Estimates of the economic costs of alcohol and drug abuse in 1992 were approximately $30 billion. That is $12.1 billion in health care costs and $17.5 billion in lost productivity, with half of the lost productivity coming from jail time. For cocaine this added up to about $50 per gram. Thus the costs were more than five times greater than the benefits. Therefore even though jail time does affect use, it is an extremely expensive means of doing it. Further, suppliers have responded in a number of ways that reduce the cost of production such that the deterrent effect tends to be overwhelmed by these other effects.

Becker, Murphy and Grossman (2004) in a study of cigarette addiction find that in the short run a 10% increase in cigarette prices resulted in a 4% drop in consumption. In the long run, however, this increased to 7.5%. Grossman (2004) finds that the 70% rise in the real price of cigarettes, accounts for almost the entire 12 % drop in cigarette smoking between 1997 and 2003. Becker et al's results suggest that these effects will be magnified over time. Grossman also finds the 7% rise in the real price of beer between 1990 and 1992, as a result of federal excise tax hikes, "accounted for 90 percent of the 4 percentage point decline in binge drinking."[22] Even with illegal substances, such as marijuana, price swings account for 60 to 70% of the changes in consumption since 1975.[23]

Legalization would have the effect of probably increasing supply and thereby reducing the price. This in turn would probably increase consumption. This, however, could be offset by setting an appropriate tax level. A related question is the social and

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[21] It should be noted that Hawai`i and Missouri were excluded from their data due to poor reporting quality

[22] op cit, abstract

[23] Ibid, marijuana prices rose and fell dramatically over that period

individual costs related to marijuana use. Even so the evidence is fairly thin on what the actual social costs of marijuana are.

Conclusion

The cost savings from decriminalizing marijuana are approximately $4 million although this leaves out some additional costs related to legal defense, and some state programs like drug courts. These would bring the total to $5 million. The reason that these are so low is that Hawai`i appears to have a *de facto* policy of lax enforcement of this law. Legalization would save an additional $4 to $5 million. Taxes from legalization would bring in anywhere from $4 million to $23 million depending on tax rates. A large body of literature suggests that decriminalization would not lead to additional use. Legalization would increase the supply of marijuana and thereby reduce the price and increase use. Should the social costs, and thus public policy warrant it, this could be controlled through appropriate tax rates.

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AMERICAN CIVIL LIBERTIES UNION of HAWAI'I

Committee:	Committee on Finance
Hearing Date/Time:	Friday, February 22, 2013, 1:30 p.m.
Place:	Conference Room 308
Re:	*Testimony of the ACLU of Hawaii in Support of H.B. 668, HD1 Relating to Health*

Dear Chair Luke and Members of the Finance Committee:

The American Civil Liberties Union of Hawaii ("ACLU of Hawaii") writes in support of H.B. 668, HD1, Relating to Health, which transfers authority over Hawaii's medical cannabis program from the Department of Public Safety to the Department of Health.

In June of 2000, the Hawaii legislature made the unprecedented decision to legalize cannabis for medical reasons—the first state to do so without a voter initiative. By recognizing the value of medical cannabis and giving it a legal status, the state gave credence to the needs of pained and ailing patients and recognized the comprehensive research conducted by the Congressionally chartered Institute of Medicine (IOM) and the support and analysis of numerous professional and medical organizations.[1]

However, despite widespread recognition that cannabis has medicinal value and despite state recognition that qualifying individuals should have access to it, the current Hawaii medical cannabis program does not meet the needs of Hawaii's patients. As a member of the Medical Cannabis Working Group, the ACLU of Hawaii is aware of many problems that patients have with the medical cannabis program – including incidents such as the Department of Public Safety's release of patient names and addresses to a Hilo newspaper in June 2008. This incident compromised the safety and privacy of medical cannabis patients and is just one indication that a health-related program like Hawaii's medical cannabis program ought to be housed in the Department of Health, rather than the Department of Public Safety. As the Working Group reported:

> Hawai'i medical cannabis regulations are best handled through the Hawai'i State Department of Health ("DOH"), not [the Department of Public Safety's Narcotics Enforcement Division], to ensure the protection of qualified patients, caregivers, and dispensaries. General regulatory

[1] Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr. Marijuana and Medicine: Assessing the Science Base, Division of Neuroscience and Behavioral Research, Institute of Medicine (Washington DC: National Academy Press, 1990).

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oversight duties – including permitting, record maintenance and related protocols - should be the responsibility of DOH. Given the statutory mission and responsibilities of DOH, it is the natural choice and best-suited agency to address the regulation of any medical cannabis dispensing model. Law enforcement agencies are ill suited for handling such matters, having little or no expertise in horticultural, health and medical affairs.

The full report is available at http://www.acluhawaii.org/downloads/1002MCWG.pdf. The responsibility of regulating and monitoring Hawaii's medical cannabis program should be placed in the right hands and we urge you to support H.B. 688.

Thank you for this opportunity to testify.

Sincerely,
Laurie A. Temple
Staff Attorney and Legislative Program Director
ACLU of Hawaii

The ACLU has been the nation's guardian of liberty since 1925 and the ACLU of Hawaii since 1965. The ACLU works daily in the courts, legislatures and communities to defend and preserve the individual rights and liberties equally guaranteed to all by the Constitutions and laws of the United States and Hawaii. The ACLU works to ensure that the government does not violate our constitutional rights, including, but not limited to, freedom of speech, association and assembly, freedom of the press, freedom of religion, fair and equal treatment, and privacy. The ACLU network of volunteers and staff works throughout the islands to defend these rights, often advocating on behalf of minority groups that are the target of government discrimination. If the rights of society's most vulnerable members are denied, everyone's rights are imperiled.

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COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Dee Morikawa, Vice Chair

COMMITTEE ON PUBLIC SAFETY
Rep. Henry Aquino, Chair
Rep. Kaniela Ing, ViceChair

Friday, February 8, 2013
8:30 a.m.
Room 329

SUPPORT FOR HB 668 – TRANSFER OF MEDICAL CANNABIS PROGRAM TO DOH

Aloha Chairs Belatti & Aquino, Vice Chairs Morikawa& Ing and Members of the Committees!

My name is Kat Brady and I am the Coordinator of Community Alliance on Prisons, a community initiative promoting smart justice policies for more than a decade. This testimony is respectfully offered on behalf of the 5,800 Hawai`i individuals living behind bars, always mindful that approximately 1,500 individuals are serving their sentences abroad, thousands of miles away from their loved ones, their homes and, for the disproportionate number of incarcerated Native Hawaiians, far from their ancestral lands.

I am also the Vice President of the Drug Policy Forum of Hawai`i, the nonprofit that worked to educate legislators for many years that resulted in Hawai`i becoming the first state legislature to pass a medical cannabis law in 2000.

HB 668 transfers departmental jurisdiction of the medical marijuana laws from the Department of Public Safety (PSD) to the Department of Health and requires DPS to assist with the transfer. Effective July 1, 2013.

Community Alliance on Prisons is in support of this measure, as is the Director of the Department of Public Safety (PSD) who included this statement in remarks during his confirmation hearing before the Committee on Public Safety and Military Affairs yesterday.

The proper agency to handle health issues is the Department of Health. The medical cannabis program currently resides in the Narcotics Enforcement Division (NED) of PSD. This has presented a plethora of problems including (but certainly not limited to) the division's administrator releasing the confidential information about patients to the press, the continuing disregard of patients, the excessive overtime at NED (2500 hours in one year alone), the extreme intimidation of doctors who recommend medical cannabis to patients, and the extreme delay that patients experience obtaining their registration cards.

The Medical Cannabis program is a public health program; NED operates the program from an enforcement and control posture that is inconsistent with managing a health program. Therefore, placement in the NED is antithetical to the legislative intent of the measure and to the stated mission of the NED. The Medical Cannabis program is a public health program intended to serve the suffering and seriously ill people of Hawai`i.

The medical cannabis law was passed as compassionate legislation to address the needs and relieve the suffering of Hawai`i's residents. The NED has proven to be without compassion and, in fact, has proven their disdain for medical cannabis patients. This is a very sad statement for the Aloha State.

Of the 18 states, plus the District of Columbia, that have medical marijuana/cannabis programs, only Hawai'i and Vermont house them in a law enforcement agency. Most states have placed their program in a state health department.

The program's placement in NED is in part responsible for the reluctance of many physicians to recommend medical cannabis to their patients. Physicians are concerned that their program applications are reviewed by the same entity that deals with the Drug Enforcement Agency daily on issues of over-prescribing, "doctor shopping" and the like. This results in many patients being prescribed narcotics with many side effects, when medical cannabis has been shown to better relieve their suffering producing none of the awful side effect.

In the thirteen years since the inception of the medical cannabis program, the NED has done nothing to educate the public about the program or even how to access the application. The NED does not maintain a website on the program and has limited and hard to find information about the program on its current website. Such information is necessary for patients, caregivers, and physicians trying to stay within the law. In fact, the Drug Policy of Forum of Hawai`i issued a handbook for patients and doctors when NED failed to do so.

The law requires DOH to set up a protocol for adding new covered medical conditions for which research indicates that cannabis may be helpful, however, DOH has never done this. This is the only part of the medical marijuana law for which DOH is responsible.

If the entire program were housed in DOH, they would be more likely to activate this provision. Medical research has advanced in the past 13 years and there are many new conditions/ailments/diseases for which medical cannabis has been shown to be helpful.

Community Alliance on Prisons, therefore, supports the transfer of the Medical Cannabis program to DOH so it can be properly managed as the public health program the law intended.

Mahalo for this opportunity to testify.

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: Guy Archer, President, Americans for Democratic Action/Hawaii
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, Room 308, 1:30 pm
Position: Strong Support

Dr. Lester Grinspoon is an Associate Professor Emeritus of Psychiatry at Harvard Medical School. He graduated from Tufts University and Harvard Medical School. He was senior psychiatrist at the Massachusetts Mental Health Center in Boston for 40 years. Dr. Grinspoon is a fellow of the American Association for the Advancement of Science and the American Psychiatric Association. The following quote is from *Marihuana, the Forbidden Medicine,* co-authored by Dr. Grinspoon and published by Yale University Press in 1997, pages 256- 258 (footnotes omitted).

"The chief justification given by the federal government for not permitting medical use of marihuana is a lack of scientific studies demonstrating its efficacy. In denying the final plea for reclassification in 1992, Richard Bonner, then head of the Drug Enforcement Administration, offered the following suggestion: "Those who insist that marihuana has medical uses would serve society better by promoting or sponsoring more legitimate scientific research, rather than throwing their time, money, and rhetoric into lobbying, public relations campaigns, and perennial litigation."

Encouraged by this declaration, Donald Abrams, M.D., of the University of California at San Francisco, sought permission to conduct a privately financed pilot study comparing high, medium, and low doses of inhaled marihuana with dronabinol capsules in the treatment of weight loss associated with the AIDS wasting syndrome. Abrams' protocol was designed in consultation with the Food and Drug Administration and approved by the FDA, the University of California at San Francisco Institutional Review Board, the California Research Advisory Panel, and the Scientific Advisory Committee of the San Francisco Community Consortium, which sponsored the research.

The U. S. government would not allow Abrams to obtain a legal supply of marihuana. The Drug Enforcement Administration refused to permit him to import it from Hortapharm, a company licensed by the government of the Netherlands to cultivate cannabis for botanical and pharmaceutical research. The National Institute on Drug Abuse (NIDA), which controls the domestic supply of marihuana for clinical research, rejected Abrams' request in April 1995. The letter of rejection was sent nine months after the request was submitted – a delay described by Abrams and his colleagues as 'unacceptably long' and 'offensive not only to the investigators but to their patients.' Bonner's remark and the handling of Abram's protocol suggest that the government has responded to the increasingly persuasive therapeutic claims by urging others to

investigate its medical potential and then creating obstacles that make the research impossible to pursue."

Dr. Grinspoon concludes at page 283: "As we noted earlier, cannabis lost its medical status as an almost incidental effect of the Marihuana Tax Act of 1937, which was designed to prevent "recreational" use. The full potential of this remarkable substance, including its full medical potential, will be realized only when we end the regime of prohibition established two [now three] generations ago."

Advocates For Consumer Rights
Working for Hawaii's consumers since 1994
Scott Foster, Communications Director
808-988-0555 <afcr@hawaii.rr.com>

Testimony For Friday, February 22, 2013
Committee on Finance
SUPPORTING HB 668 HD1 "Relating to Health"
4:00 P.M.
Conference Room 308
State Capitol

Aloha Honorable Chair, Co-Chairs, and Committee Members;

My name is Scott Foster and I am the Communications Director of Hawai`i Advocates For Consumer Rights. Our 19-year old, statewide organization was co-founded by Mr. Ralph Nader and we continue to research and testify on public-policy issues such as Hawaii's Medical Marijuana (MMJ) program.

BACKGROUND

AFCR is proud to have been a part of the original coalition that came together in 1999 to pass Hawaii's MMJ law. *Very* controversial at the time, Hawai`i indeed broke new ground in 2000, when it became the first state to enact a law to remove criminal penalties for MMJ users *via a state legislature.*

Governor Ben Cayetano submitted the original bill and signed the final measure into law on June 14, 2000. Senate Bill 862 was passed by a vote of 32-18 in the House and 13-12 in the Senate, making Hawaii the sixth state in the nation to legalize medical marijuana. In 2012, Massachusetts became the 18th state to Legalize Medical Marijuana. The District of Columbia had joined the list in 2010.

A COMPROMISE WAS MADE

Governor Cayetano's original bill would have placed the program in the Department of Health (DOH). Unfortunately, the then Director of the DOH told advocates that unless we agreed to the program being housed at the Department of Public Safety (DPS), he would *not* support the legislation. Budgetary constraints were cited. Governor Cayetano left office and the Lingle administration refused to support the move to DOH. And so the issue has languished for the past 13 years.

With the benefits of MMJ now much better understood, it has also become clear that many Hawai`i patients who would otherwise participate in the program decline to do so simply because they fear giving their name and personal information to the DPS and must rely on the black market to obtain their MMJ – rather than legally grow their own supply or locate someone who could legally act as their surrogate. **For this reason, we strongly support the passage of HB 668, HD1.**

Mahalo for your time and kind consideration.

Scott Foster,
Communications Director
Hawai`i Advocates For Consumer Rights

the Drug Policy Forum of hawai'i

Dedicated to safe, responsible, humane and effective drug policies since 1993

February 22, 2013

To: Rep. Sylvia Luke, Chair
Rep. Scott Nishimoto, Vice Chair
Rep. Aaron Ling Johanson, Vice Chair and
Members of the Committee on Finance

From: Jeanne Y. Ohta, Executive Director

RE: HB 668 HD1 Relating to Health
Hearing: Friday, February 22, 2013, 1:30 p.m., Room 308

Position: Strong Support

Thank you for hearing this measure. I am Jeanne Ohta, Executive Director of the Drug Policy Forum of Hawai`i testifying in strong support of this measure which moves the Medical Use of Marijuana Program from the Department of Public Safety's Narcotics Enforcement Division to the Department of Health.

This is an important proposal, a request that patients and physicians have made for several years. The medical marijuana program should be in a department that has the experience of working with groups of patients and health programs. Easily accessible and easily understandable information on how the program works and outreach for the program are currently not available from the Department of Public Safety. This work would more likely be accomplished by a department with the experience and background of implementing other health programs.

Moving the administration of the program from the Department of Public Safety to the Department of Health was one of the top priorities recommended by the Medical Cannabis Working Group.

As a law enforcement agency, the Narcotics Enforcement Division has testified on numerous occasions that "marijuana has no medical use." Based on this belief, this agency should not have the responsibility of administering the program.

In my role as Executive Director, I receive many phone calls and emails about the medical marijuana program. The Drug Policy Forum has published a booklet with information about the program that includes answers to frequently asked questions. That same information is posted on our website. This information should be made available by the state, but is not. I have received inquiries from patients, families of patients, and from physicians.

Of the 18 states and the District of Columbia which have medical marijuana programs, only Hawaii and Vermont house them in a law enforcement agency. Other states have placed the program in a state health department.

Although other states provide web-based information, the NED has limited and hard to find information about the program on its current departmental website. Such information is necessary for patients, caregivers, and physicians who register because they want to be law-abiding citizens.

The NED requires physicians to obtain application forms from NED whereas other states (e.g. Oregon and Colorado) provide and accept forms from patients themselves and post the blank forms on their websites.

It is clear to me that by placing the program in the Department of Public Safety, a law enforcement approach rather than a public health approach is being used to administer the program. Current patients and physicians have expressed concern about dealing with a narcotics enforcement agency. The original intent of the law was to create a public health program out of concern for the seriously ill.

The department has needlessly taken an adversarial view of patient and physician participants in the program. Instead of assisting physicians and patients in maintaining their legal participation, both groups are viewed with suspicion.

There is also general concern about the records being kept in a law enforcement agency and it makes patients wonder who may also have access to them. In fact, in a serious breach of privacy, in June 2008, the Department of Public Safety released the entire list of the then 4,000 patients, their addresses, the location of their marijuana plants, license information, and the names of their physicians to Peter Sur, reporter for the *Hawaii Tribune-Herald*. In response to the release of their private information and to prevent any possibility of arrest by federal authorities, a few patients destroyed their marijuana plants. I believe patients would have more confidence in a health agency as they handle other sensitive information about patients.

Another good reason to move the program is that the Department of Health has the responsibility of considering new medical conditions that would qualify for the program. It seems reasonable that a single agency should be responsible for all aspects of the program.

Please pass this important measure. Thank you for the opportunity to testify.

HB668
Submitted on: 2/21/2013
Testimony for FIN on Feb 22, 2013 13:30PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Myron Berney	Natural Cancer Wellness Foundation	Support	Yes

Comments: Please add this to already submitted testimony as additional information in Support.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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HRS 329-11 of the Controlled Substances Act in Hawaii requires an extensive review and analysis in the Scheduling of Drugs.

HRS 329-11 (5) (d) provides a backdoor loop hole for NED to escape their DUE DILLEGENCE on Drug Scheduling.

The Mantra from the Law Enforcement Community is, “Follow the Federal Law; Follow the Federal Policy.” They go on saying, “Marijuana is illegal. Marijuana has no medical use. People using Medical Marijuana are violating the law and can not own a gun.”

Law Enforcement in Hawaii Deliberately Target Medical Marijuana Patients in violation of established Federal policy and guidelines.

The Law Enforcement Community has become entrenched in a unrealistic view not in all in harmony with any modern science, medical practice, or contemporary public health programs.

Marijuana doesn't have to be the safest drug, although Marijuana is one of the safest medicines
Marijuana doesn't have to be help otherwise incurable diseases, although Marijuana does.
Law Enforcement doesn't have to out of touch with reality, although they are.

It is impossible to wake them up, they have been lied to so long that they believe their own lies.

Somehow, Immediately, the Legislature has to move forward in One Giant Step for Mankind and get the Law Enforcement Community 100% out of Health Care, specifically, the Marijuana Laws must realistically be deleted.

DELETE MARIJUANA FROM HRS329-14 (20)
DELETE ALL CRIMINAL MARIJUANA LAWS

Time is Short.
May I suggest a joint public hearings with the Senate and House Committees on Judiciary, Health and Finance for informational briefing, questions and DM.

You just can't afford to flush over $70 Million in retail GETax down the underground market while selling off State Public Lands.

Any local kid knows probably 3 or 4 people he can obtain some herb. The only change in legalization is that the cops won't ruin people's lives anymore.
The Big change from legalization is Jobs, Economy and Revenue all from a reduction in crime.

The HRS 329-11, Controlled Substances Act, Review and Analysis for the Scheduling of Drugs in Hawaii

Table of Contents

Report 1(A)1 Medical Marijuana Information

MARIJUANA [National Institute of Health]
http://www.nlm.nih.gov/medlineplus/ency/article/001945.htm

Marijuana is also called "grass," "pot," "reefer," "joint," "hashish," "cannabis," "weed," and "Mary Jane."
About 2 in 5 Americans have used marijuana at least once in their life.
Marijuana comes from a plant called hemp (cannabis sativa). The main, active ingredient in marijuana is THC (short for delta-9-tetrahydrocannabinol). This and other ingredients, called cannabinoids, are found in the leaves and flowering parts of the marijuana plant. Hashish is a substance taken from the tops of female marijuana plants. It contains the highest amount of THC.
How fast you feel the effects of marijuana depend on how you use it:

- If you breathe in marijuana smoke (such as from a joint or pipe), you may feel the effects within seconds to several minutes.
- If you eat foods containing the drug (such as "hash brownies,") you may feel the effects with 30 -60 minutes.

Marijuana acts on your central nervous system. Low-to-moderate amounts of the drug may cause:

- Increased appetite ("the munchies")
- Feeling of joy (euphoria)
- Relaxed feeling
- Increased sensations of sight, hearing, and taste

MEDICAL MARIJUANA

It's active ingredient (THC) is legal.
THC has been approved by the U.S. Food and Drug Administration (FDA) for the following medical purposes:

- Relieving chronic pain and spasticity
- Stimulating appetite in patients with AIDS or who have undergone chemotherapy
- Treating glaucoma
- Treating nausea caused by chemotherapy in cancer patients

The medical use of marijuana is legal for medical purposes in at least 16 states also for the following medical purposes:

- Relieving chronic pain and spasticity
- Stimulating appetite in patients with AIDS or who have undergone chemotherapy
- Treating glaucoma
- Treating nausea caused by chemotherapy in cancer patients

Report 1(A)3 Current Recommended Medical Use

10 Major Health Benefits of Marijuana

The days of Reefer Madness are pretty far gone, but the American public is still vastly uninformed about marijuana, particularly concerning its myriad of amazing health benefits. Here are 10 (out of countless) health benefits that marijuana possesses. With that said, it's simply baffling that medical marijuana is not legal in most of the country, and still there retains such a negative reputation. So, if you have one of these conditions, now might be a good time to call up your cousin's dealer.

1. Cancer

There is a lot of unfounded rhetoric that states smoking pot can cause lung cancer because your inhaling smoke, like cigarettes. This simply isn't true. Cigarette smoke causes cancer because the tobacco is radiated whereas marijuana isn't. In fact, the American Association for Cancer Research has found the marijuana actually works to **slow down tumor growth** in the lungs, breasts, and brain considerably.

2. Seizures

Marijuana is a muscle relaxant and has "antispasmodic" qualities which have proven to be a very effective treatment of seizures. There are actually countless cases of people suffering from seizures that have only been able to function better through the use of marijuana.

3. Migraines

Since medicinal marijuana was legalized in California, doctors have reported that they have been able to treat **more than 300,000 cases of migraines** that conventional medicine couldn't through marijuana. And that's NOT just because it's easy to fake having migraines, right? RIGHT?!

4. Glaucoma

Marijuana's treatment of glaucoma has been one of the best documented. There isn't a single valid study that exists that disproves marijuana's very powerful and popular **effects on glaucoma patients**. Beat that, DEA!

5. Multiple Sclerosis

Marijuana's effects on multiple sclerosis patients became better documented when former talk-show host, Montel Williams began to use pot to treat his MS. Marijuana works to **stop the neurological effects and muscle spasms** that come from the fatal disease.

6. Tourette's and OCD

Just like marijuana can treat seizures and multiple sclerosis, marijuana's effects slow down the **tics in those suffering from Tourette's**, and the obsessive neurological symptoms in people with OCD.

7. ADD and ADHD

A well documented **USC study** done about a year ago showed that marijuana is not only a perfect alternative for Ritalin but treats the disorder without any of the negative side effects of the pharmaceutical.

8. IBS and Crohn's

Marijuana has shown that it can **help with symptoms of the chronic diseases** as it stops nausea, abdominal pain, and diarrhea.

9. Alzheimer's

Despite what you may have heard about marijuana's effects on the brain, the Scripps Institute, in 2006, proved that the **THC found in marijuana works to prevent Alzheimer's** by blocking the deposits in the brain that cause the disease.

10. Premenstrual Syndrome

Next time your girlfriend is complaining that you smoke too much weed, hand her a joint. Just like marijuana is used to treat IBS, it can be used to treat the **cramps and discomfort** that causes your girlfriend to lash out at you. Using marijuana for PMS actually goes all the way back to Queen Victoria. Put that in your pipe and smoke it. [Old King Cole was a Merry Old Soul...]

Medical Marijuana Uses & Treatments

http://www.cannabisdoctorsnetwork.com/medical-marijuana-uses.php

Medical marijuana is being prescribed by many different physicians for the treatment of a variety of different diseases, illnesses and chronic symptoms. While each state that has approved medical marijuana has its own definition of what medical marijuana can be used for legally in that state - you might be surprised at how many practical medicinal usages that marijuana offers.

Here is a list of diseases, illnesses or chronic symptoms that marijuana is currently being prescribed to patients to treat:

- Alzheimer's Disease is a severe neurological disorder that is still being studied, as the reasons for contracting this disease are widely unknown and still being researched. More than 4 million people have been diagnosed with this disease in the US, and there are few FDA approved medications. Numerous medical studies have suggested that cannabis therapy provides symptomatic relief and works to moderate the progression of this disease.
- Amyotrophic lateral sclerosis (ALS; Lou Gehrig's Disease) is a fatal neurodegenerative disorder that occurs from the depletion of the motor neurons. More than 30,000 Americans suffer from ALS. Recent clinical findings suggest that cannabis therapy aids in symptomatic relief as well is in moderating the progression of ALS.
- Chronic Pain is something that millions of Americans suffer from (about 1 in 5), yet over-the-counter pain killers are only semi-effective and prescribed painkillers are side effect ridden, addictive and expensive. Ongoing clinical trials that have been designed by the FDA have shown that inhaled cannabis can significantly reduce and alleviate neurological symptoms associated with chronic pain.
- Cancer/Gliomas have some of the highest mortality rates of any diseases in the US. Recent studies have concluded that THC induces apoptosis in glioma cells. Medical marijuana is also commonly prescribed to aid patients in dealing with the reactions and side effects associated with chemotherapy.
- Depression: Ongoing studies suggest that marijuana is beneficial in treating the symptoms of depression.
- Dystonia is a neurological disease similar to Parkinson's disease that affects more than 300,000 people in the US annually. Recent case studies have noted drastic improvements in subjective pain scores on patients immediately following cannabis therapy.
- Fibromyalgia is a neurological disorder that sends pain signals to all of the nerves in the body. Currently, between 3-6 millions Americans suffer from this chronic pain syndrome. Recent clinical trials have shown that patients who used cannabis therapy in place of painkillers noted significant and immediate improvements in reduction of pain and quality of life.
- Gastrointestinal (GI) Disorders affect 1 in 5 Americans. Non-clinical trials have suggested that cannabis therapy can effectively relieve many of the associated symptoms of GI.
- Hepatitis C affects nearly 4 million Americans annually and is characterized by pain and nausea. Recent studies demonstrated that patients using cannabis therapy had reduced pain and relieved nausea.

●Human Immunodeficiency Virus (HIV) currently affects half a million Americans. Cannabis therapy has been shown to aid patients in treating associated symptoms of this disease, such as lack of appetite, anxiety and nausea.

●Hypertension (high blood pressure) affects 1 in 4 adults in the US. Ongoing clinical studies suggest that cannabis therapy effectively treats hypertension by suppressing cardiac contractility and normalizing blood pressure.

●Incontinence (loss of bladder control) affects 1 in 10 Americans. Recent clinical trials indicate that cannabis therapy improves bladder control when compared to placebo.

●Methicillin-resistant Staphyloccus aureus (MRSA) is the resistance to antibiotics and or prescription drugs. Around 20,000 hospital deaths occur annually in the US as a result of MRSA. A 2008 clinical study concluded that all patients suffering from MRSA showed "potent antibacterial activity" and that cannabinoids were extremely effective at stopping the spread of MRSA.

●Multiple sclerosis (MS) is a degenerative disease that affects the central nervous system. Around 200 persons contract MS weekly in the US. Numerous clinical studies have concluded that cannabis therapy treats symptoms related to MS such as pain, spasticity, depression, fatigue, and incontinence.

●Muscle Relaxer: Marijuana has been shown to be a very effective muscle relaxer and can relieve spasms and pain.

●Osteoporosis is a skeletal disease where the bones rapidly deteriorate. Around 35 million Americans are considered high risk for contracting this disease, and more than 10 million are living with it currently. Recent studies have suggested that cannabis therapy aids in slowing the development of osteoporosis.

●Pruritus is a very common symptom that is associated with various different skin diseases. Ongoing clinical studies have concluded that cannabis therapy effectively treats pruritus.

●Rheumatoid Arthritis & Osteoarthritis is a severe inflammatory disease that can result in the loss of limb functions and includes symptoms such as stiffness, pain, swelling and numbness. Ongoing clinical studies have suggested that cannabis therapy effectively treats the pain, swelling and stiffness in patients.

●Sleep Apnea affects an estimated 4% of all Americans, a syndrome that is many times undiagnosed. Cannabinoids have been shown in recent studies to be an effective suppressant, respiratory stabilizer and serotonin-blocker for instances of serotonin-induced exacerbation.

●Tourette's Syndrome affects an estimated 100,000 people in the US annually and is characterized by vocal and physical tics that cannot be controlled. Uncontrolled and open clinical trials suggest that cannabis therapy is an effective treatment method for this syndrome.

Medical Marijuana is Appropriate Treatment for:
Below is a general list of ailments with symptoms and/or side effects that have been treated with medical marijuana. From https://www.marijuanadoctors.com/content/ailments/index

This text is for informative purposes only and is not intended as a substitute for medical advice from a doctor. Always consult your physician before making any decision on the treatment of a medical condition.

- Acquired Hypothyroidism (Learn more)
- Acute Gastritis (Learn more)
- Agoraphobia (Learn more)
- AIDS Related Illness (Learn more)
- Alcohol Abuse
- Alcoholism (Learn more)
- Alopecia Areata
- Alzheimer's Disease (Learn more)
- Amphetamine Dependency
- Amyloidosis
- Amyotrophic Lateral Sclerosis (ALS) (Learn more)
- Angina Pectoris
- Ankylosis
- Anorexia (Learn more)
- Anorexia Nervosa (Learn more)
- Anxiety Disorders (Learn more)
- Any chronic medical symptom that limits major life activities
- Any Chronic Medical Symptom that Limits Major Life Activities
- Arteriosclerotic Heart Disease (Learn more)
- Arthritis (Learn more)
- Arthritis (Rheumatoid) (Learn more)
- Arthropathy, gout (Learn more)
- Asthma (Learn more)
- Attention Deficit Hyperactivity Disorder (ADD/ADHD)
- Autism/Aspergers
- Autoimmune Disease (Learn more)
- Back Pain (Learn more)
- Back Sprain (Learn more)
- Bell's Palsy
- Bipolar Disorder (Learn more)
- Brain Tumor, Malignant (Learn more)
- Bruxism
- Bulimia (Learn more)
- Cachexia (Learn more)
- Cancer (Learn more)
- Cancer, Adrenal Cortical (Learn more)
- Cancer, Endometrial (Learn more)
- Cancer, Prostate (Learn more)
- Cancer, Testicular
- Cancer, Uterine (Learn more)
- Carpal Tunnel Syndrome (Learn more)
- Cerebral Palsy
- Cervical Disk Disease
- Cervicobrachial Syndrome
- Chemotherapy (Learn more)
- Chronic Fatigue Syndrome
- Chronic Pain (Learn more)
- Chronic renal failure
- Cocaine Dependence (Learn more)
- Colitis (Learn more)
- Conjunctivitis (Learn more)
- Constipation (Learn more)
- Crohn's Disease (Learn more)
- Cystic Fibrosis (Learn more)
- Damage to Spinal Cord Nervous Tissue
- Darier's Disease
- Degenerative Arthritis (Learn more)
- Degenerative Arthropathy (Learn more)
- Delirium Tremens (Learn more)

- Dermatomyositis
- Diabetes, Adult Onset (Learn more)
- Diabetes, Insulin Dependent
- Diabetic Neuropathy
- Diabetic Peripheral Vascular Disease
- Diarrhea
- Diverticulitis (Learn more)
- Dysthymic Disorder
- Eczema (Learn more)
- Emphysema (Learn more)
- Emphysema (Learn more)
- Endometriosis (Learn more)
- Epidermolysis Bullosa
- Epididymitis (Learn more)
- Epilepsy (Learn more)
- Felty's Syndrome
- Fibromyalgia (Learn more)
- Friedreich's Ataxia
- Gastritis (Learn more)
- Genital Herpes
- Glaucoma (Learn more)
- Glioblastoma Multiforme
- Graves Disease (Learn more)
- Headaches, Cluster (Learn more)
- Headaches, Migraine (Learn more)
- Headaches, Tension (Learn more)
- Hemophilia A (Learn more)
- Henoch-Schonlein Purpura
- Hepatitis C (Learn more)
- Hereditary Spinal Ataxia
- HIV/AIDS (Learn more)
- Hospice Patients
- Huntington's Disease (Learn more)
- Hypertension (Learn more)
- Hypertension
- Hyperventilation (Learn more)
- Hypoglycemia
- Impotence
- Inflammatory autoimmune-mediated arthritis
- Inflammatory Bowel Disease (IBD)
- Insomnia
- Intermittent Explosive Disorder (IED)
- Intractable Pain (Learn more)
- Intractable Vomitting
- Lipomatosis (Learn more)
- Lou Gehrig's Disease (Learn more)
- Lyme Disease
- Lymphoma (Learn more)
- Major Depression (Learn more)
- Malignant Melanoma
- Mania
- Melorheostosis (Learn more)
- Meniere's Disease
- Motion Sickness (Learn more)
- Mucopolysaccharidosis (MPS)
- Multiple Sclerosis (MS) (Learn more)
- Muscle Spasms
- Muscular Dystrophy (Learn more)
- Myeloid Leukemia
- Nail-Patella Syndrome
- Nightmares (Learn more)
- Obesity
- Obsessive Compulsive Disorder (Learn more)
- Opiate Dependence (Learn more)
- Osteoarthritis (Learn more)
- Panic Disorder (Learn more)
- Parkinson's Disease (Learn more)
- Peripheral Neuropathy (Learn more)
- Peritoneal Pain
- Persistent Insomnia (Learn more)

- Porphyria (Learn more)
- Post Polio Syndrome (PPS) (Learn more)
- Post-traumatic arthritis (Learn more)
- Post-Traumatic Stress Disorder (PTSD)(Learn more)
- Premenstrual Syndrome (PMS) (Learn more)
- Prostatitis (Learn more)
- Psoriasis
- Pulmonary Fibrosis (Learn more)
- Quadriplegia
- Radiation Therapy (Learn more)
- Raynaud's Disease
- Reiter's Syndrome (Learn more)
- Restless Legs Syndrome (RLS)
- Rheumatoid Arthritis (Learn more)
- Rheumatoid Arthritis
- Rheumatoid Arthritis (Learn more)
- Rosacea
- Schizoaffective Disorder
- Schizophrenia (Learn more)
- Scoliosis (Learn more)
- Sedative Dependence
- Seizures (Learn more)
- Senile Dementia
- Severe Nausea (Learn more)
- Shingles (Herpes Zoster)
- Sinusitis (Learn more)
- Skeletal Muscular Spasticity (Learn more)
- Sleep Apnea (Learn more)
- Sleep Disorders (Learn more)
- Spasticity (Learn more)
- Spinal Stenosis (Learn more)
- Sturge-Weber Syndrome (SWS)
- Stuttering (Learn more)
- Tardive Dyskinesia (TD) (Learn more)
- Temporomandibular joint disorder (TMJ)(Learn more)
- Tenosynovitis (Learn more)
- Terminal Illness (Learn more)
- Thyroiditis (Learn more)
- Tic Douloureux (Learn more)
- Tietze's Syndrome (Learn more)
- Tinnitus (Learn more)
- Tobacco Dependence (Learn more)
- Tourette's Syndrome (Learn more)
- Trichotillomania (Learn more)
- Viral Hepatitis (Learn more)
- Wasting Syndrome (Learn more)
- Whiplash (Learn more)
- Wittmaack-Ekbom's Syndrome (Learn more)
- Writers' Cramp (Learn more)

Report 2(A) Pharmacology of Cannabis

Elements of the endocannabinoid system (ECS) comprise

the cannabinoid receptors,
a family of nascent lipid ligands,
the 'endocannabinoids' and
the machinery for their biosynthesis and metabolism.
The function of the ECS is thus defined by modulation of these receptors, in particular, by two of the best-described ligands, 2-arachidonoyl glycerol and anandamide (arachidonylethanolamide).

The endocannabinoid system, ECS, is involved in

1. neuroprotection, [protecting nerves]
2. modulation of nociception, [pain]
3. regulation of motor activity,
4. neurogenesis, [growing new nerves]
5. synaptic plasticity and
6. the control of certain phases of memory processing.

In addition, the ECS acts to

1. modulate the immune and inflammatory responses and
2. to maintain a positive energy balance.

This theme issue aims to provide the reader with an overview of ECS pharmacology, followed by discussions on the pivotal role of this system in the modulation of neurogenesis in the developing and adult organism, memory processes and synaptic plasticity, as well as in pathological pain and brain ageing.

Skaper SD, Di Marzo V. **Endocannabinoids in nervous system health and disease: the big picture in a nutshell.** Philos Trans R Soc Lond B Biol Sci. 2012 Dec 5;367(1607):3193-200. doi: 10.1098/rstb.2012.0313.

Dipartimento di Scienze del Farmaco, Università degli Studi di Padova, , Largo 'Egidio Meneghetti' 2, 35131 Padova, Italy.

Abstract
The psychoactive component of the cannabis resin and flowers, delta9-tetrahydrocannabinol (THC), was first isolated in 1964, and at least 70 other structurally related 'phytocannabinoid' compounds have since been identified. The serendipitous identification of a G-protein-coupled cannabinoid receptor at which THC is active in the brain heralded an explosion in cannabinoid research. Elements of the endocannabinoid system (ECS) comprise the cannabinoid receptors, a family of nascent lipid ligands, the 'endocannabinoids' and the machinery for their biosynthesis and metabolism. The function of the ECS is thus defined by modulation of these receptors, in particular, by two of the best-described ligands, 2-arachidonoyl glycerol and anandamide (arachidonylethanolamide). Research on the ECS has recently aroused enormous interest not only for the physiological functions, but also for the promising therapeutic potentials of drugs interfering with the activity of cannabinoid receptors. Many of the former relate to stress-recovery systems and to the maintenance of homeostatic balance. Among other functions, the ECS is involved in neuroprotection, modulation of nociception, regulation of motor activity, neurogenesis, synaptic plasticity and the control of certain phases of memory processing. In addition, the ECS acts to modulate the immune and inflammatory responses and to maintain a positive energy balance. This theme issue aims to provide the reader with an overview of ECS pharmacology, followed by discussions on the pivotal role of this system in the modulation of neurogenesis in the developing and adult organism, memory processes and synaptic plasticity, as well as in pathological pain and brain ageing. The volume will conclude with discussions that address the proposed therapeutic applications of targeting the ECS for the treatment of neurodegeneration, pain and mental illness.

PMID:
23108539
[PubMed - in process]
PMCID:
PMC3481537
[Available on 2012/12/5]

Source

Report 2(B) Cannabis Toxicology [natural herb safer]

http://en.wikipedia.org/wiki/Tetrahydrocannabinol

There has never been a documented human fatality from overdosing on tetrahydrocannabinol or cannabis in its natural form,[22] though the synthetic THC pill "Marinol" was cited by the FDA as being responsible for 4 deaths between January 1, 1997 and June 30, 2005.[23]Information about THC's toxicity is primarily based on results from animal studies. The toxicity depends on the route of administration and the laboratory animal. Absorption is limited by serum lipids, which can become saturated with THC, mitigating toxicity.[24]

Marinol ® Does Not Drug Substitute for Medical Marijuana [Cannabis]
The herbal medicine is safer and has over 60 therapeutic ingredients. Marijuana contains more than 460 active chemicals and over 60 unique cannabinoids. This is in harmony with reports from Medical Marijuana Patients who consistently report that the God Given Herbal Medicine is more effective than Marinol.

The harmful effects of smoking can easily be mitigated through other established pharmaceutical delivery systems that are already developed. Vaporization, uses Aroma Therapy to deliver the healing oils by warming the herb up to but below the burning or smoking temperature [230 degrees C]. Studies have demonstrated that Tobacco smokers that also used Marijuana were less likely to get LUNG CANCER. Avoiding Cancer, Cancer protection, is Therapeutic not detrimental or abusive.

Seamon MJ, Fass JA, Maniscalco-Feichtl M, Abu-Shraie NA. **Medical marijuana and the developing role of the pharmacist.** Am J Health Syst Pharm. 2007 May 15;64(10):1037-44.

College of Pharmacy, Nova Southeastern University, Fort Lauderdale, FL 33328, USA. mseamon@nova.edu

S o u r c e

PURPOSE:
The pharmacology, therapeutic uses, safety, drug-drug interactions, and drug-disease interactions of medical marijuana are reviewed, and the legal issues related to its use and the implications of medical marijuana for the pharmacist are presented.

SUMMARY:
Marijuana contains more than 460 active chemicals and over 60 unique cannabinoids. The legal landscape surrounding marijuana is surprisingly complex and unsettled. In the United States, 11 states and several municipalities have legalized medical marijuana. Another state provides legislation that allows patients to claim a defense of medical necessity. Nevertheless, patients using medical marijuana may never interact with a pharmacist. Marijuana is a Schedule I controlled substance and its use is illegal under federal law. Marijuana has a number of purported therapeutic uses with a broad range of supporting evidence. There are five general indications for medical marijuana: (1) severe nausea and vomiting associated with cancer chemotherapy or other causes, (2) weight loss associated with debilitating illnesses, including HIV infection and cancer, (3) spasticity secondary to neurologic diseases, such as multiple sclerosis, (4) pain syndromes, and (5) other uses, such as for glaucoma. Marijuana is associated with adverse psychiatric, cardiovascular, respiratory, and immunologic events. Moreover, marijuana may interact with a number of prescription drugs * and concomitant disease states.

CONCLUSION:
Several states have legalized the use of marijuana for chronic and debilitating medication conditions. Pharmacists need to understand the complex legal framework surrounding this issue so that they can protect themselves and better serve their patients.

PMID: 17494903 [PubMed - indexed for MEDLINE]

* Cannabis is a mild MAOI inhibitor. Many psychiatric drugs and others medicines should not be taken with MAOI inhibitors.

Report (C) Risk to public health and particular susceptibility of segments of the population
Adverse Health Effects of Marijuana

Reviewing studies in Pub Med, the NIH Database,
we find a variety of studies on the adverse health effects of Cannabis.
Adverse Health effects, in order of perceived public health risk, may include:

1. Motor Vehicle Accidents
2. Cannabis dependency [easily managed]
3. respiratory disease [depends upon delivery methods]
4. cardiovascular disease [depends upon delivery methods]
5. low birth weight babies, small for gestational age due to growth restrictions in mid and late pregnancy, pre term labor and/or admissions to neonatal ICU [yes, no, maybe so, not advised]
6. adverse psychological effects may include:
7. Perhaps some subtle cognitive impairment
8. Possible adverse effects on adolescent psychosocial development and mental health.
9. Precipitation and exacerbation of schizophrenia in vulnerable individuals [no longer seem to elicit much interest]

Hollister LE. **Health aspects of cannabis: revisited.** Int J Neuropsychopharmacol. 1998 Jul;1(1):71-80. Harris County Psychiatric Center, University of Texas-Houston, Houston, TX, USA.

Source

Abstract

Literature pertaining to the effects of cannabis use and health which has been published during the past 11 years has been reviewed. Many older concerns about adverse effects on health (chromosomal damage *, 'cannabinol psychosis', endocrine abnormalities, cardiac events, impaired immunity) no longer seem to elicit much interest. Continuing concerns about the adverse cognitive effects of chronic use indicate that these can be demonstrated by proper testing; some studies suggest that they may be long-lasting. Although cannabis does not produce a specific psychosis, the possibility exists that it may exacerbate schizophrenia in persons predisposed to that disorder. However, evidence from retrospective surveys must always be questioned. Tolerance and dependence have occurred in man, confirming previous findings in many other species. Addiction tends to be mild and is probably less severe than with other social drugs. Driving under the influence of cannabis is impaired acutely; how long such impairments last is still unknown. More exacting tasks, such as flying an airplane, may be impaired for as long as 24 hours. While there is no doubt that marijuana smoke contains carcinogens, an increase in cancer among users has thus far been anecdotal. Because of the long latent period between cancer induction and initiation of cigarette smoking, the full story is yet to be told. Marijuana use during pregnancy is not advised although the consequences are usually not greater than those of smoking cigarettes, and far less than those from alcohol use. Whether smoked marijuana should become a therapeutic agent requires a cost-benefit analysis of the potential benefits versus the adverse effects of such use as we now know them.

* chromosomal damage came from USA spraying Mexican fields with herbacide Agent Orange and/or 2,4-D which contaminating the US Marijuana supply since it took up to 2 weeks for the herb to die. Hawaii Senate brought this problem to light and stopped the Federal aerial spraying on the Big Island of this toxic spray.

Seamon MJ, Fass JA, Maniscalco-Feichtl M, Abu-Shraie NA. **Medical marijuana and the developing role of the pharmacist.** Am J Health Syst Pharm. 2007 May 15;64(10):1037-44.

Source

College of Pharmacy, Nova Southeastern University, Fort Lauderdale, FL 33328, USA. mseamon@nova.edu

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PMID: 17494903

* Cannabis is a mild MAOI inhibitor. Many psychiatric drugs and others medicines should not be taken with MAOI inhibitors.

Taylor HG. Analysis of the medical use of marijuana and its societal implications. J Am Pharm Assoc (Wash). 1998 Mar-Apr;38(2):220-7.

Sparrow Hospital, Lansing, Michigan 48826, USA. hgtaylor@pilot.msu.edu

Source

OBJECTIVE:
To review the pharmacology, therapeutics, adverse effects, and societal implications of the medical use of marijuana.

DATA SYNTHESIS:
The most prominent effects of marijuana are mediated by receptors in the brain. Acute intoxication is characterized by euphoria, loss of short-term memory, stimulation of the senses, and impaired linear thinking. Depersonalization and panic attacks are adverse effects. Increased heart rate and reddened conjunctivae are common physical effects. Chronic, high doses may cause subtle impairment of cognitive abilities that are appear to be long-term, but of unknown duration. Marijuana may be a risk factor for individuals with underlying mental illness. It causes dependence, but compared with cocaine, alcohol, heroin, and nicotine, marijuana has little addictive power and produces only mild withdrawal symptoms. Marijuana shows clinical promise for glaucoma, nausea and vomiting, analgesia, spasticity, multiple sclerosis, and AIDS wasting syndrome.
CONCLUSION:
As a recreational drug, marijuana poses dangers, particularly to social and emotional development during adolescence and young adulthood. As a medical drug, marijuana should be available for patients who do not adequately respond to currently available therapies.
Comment in
- Medical marijuana: not the way the doctor would have ordered it. [J Am Pharm Assoc (Wash). 1998]

PMID: 9654850

Report 2(C)2 Public Health Drug Dependency not Abuse

§329-1 Definitions. As used in this chapter:
"Abuse" means the misuse of a substance or the use of a substance to an extent deemed deleterious or detrimental to the user, to others, or to society.

Drug dependence means that a person needs a drug to function normally. Abruptly stopping the drug leads to withdrawal symptoms.

Drug addiction is the compulsive use of a substance, despite its negative or dangerous effects.

A person may have a physical dependence on a substance without having an addiction. For example, certain blood pressure medications do not cause addiction but they can cause physical dependence. Other drugs, such as cocaine, cause addiction without leading to physical dependence.

Drug abuse is the use of illegal drugs, or the misuse of prescription or over-the-counter drugs for at least a year with negative consequences.

Why Distinguishing between Drug Dependence and Drug Addiction is Important

03/30/09 | by the professor | Categories: General, Nomenclature

The terms drug dependence and drug addiction are often used interchangeably, but this practice leads to confusion among professionals regarding the diagnostic implications of these terms and also contributes to misunderstanding the underlying causes of substance use. As described earlier, drug addiction refers to a behavioral syndrome where the procurement and use of a drug seem to dominate the individual's motivation and where the normal constraints on the individual's behavior seem largely ineffective. Inherent in this definition is the overwhelmingly powerful motivation to obtain and self-administer the drug. And as noted earlier,drug abuse simply means that the substance is used in a manner that does not conform to social norms; the motivation to use the substance may or may not be particularly strong compared with other motivators. The causes of drug abuse and drug addiction can be the same, but they are very often much different. Specifically, drug addiction involves the biological action of a drug on brain reward and motivation systems, while drug abuse often involves other psychosocial factors with only modest direct effects on brain reward systems.

Drug dependence, in contrast to the two terms described above, refers to a state where the individual is dependent upon the drug for normal physiological functioning. Abstinence from the drug produces withdrawal reactions which constitute the only evidence for dependence. Drug dependence can involve disturbances in general bodily (i.e., somatic) function such as vomiting, diarrhea, sweating, and the resulting symptoms indicate a physical dependence syndrome which is usually specific for a given class of drug. Drug dependence can also involve disturbances in psychological functioning, such as inability to concentrate, anxiety, depression, and the resulting symptoms indicate a psychological dependence syndrome which often shares common features with other abused drugs. It is important to note that psychological dependence has a physiological basis and thus it is preferable to use the term physical dependence to refer to disturbances in somatic function to avoid confusion.

A number of substances produce psychological and/or physical dependence without producing an addiction. The therapeutic uses of certain steroids, antidepressant medication of the SSRI class, and even some antihistamines all produce characteristic withdrawal syndromes when their use is abruptly discontinued. However, there is no strong motivation to continue the use of these substances for most patients; some patients even refuse to resume treatment with such drugs because of their adverse experience during unsupervised withdrawal.

Other substances can produce a notable psychological dependence without producing an exceptionally strong motivation to avoid abstinence. Caffeine has desirable stimulating effects that involve general arousal accompanied by a mild mood elevation for many daily coffee drinkers. And while the avid coffee drinker usually chooses not to miss their morning or afternoon ‘brew,’ many voluntarily abstain when the cost is too high ($8 for

a cup of coffee in NYC?) or access is difficult. The ensuing abstinence syndrome has both psychological (e.g., lethargy) and physical (e.g., mild headache) withdrawal signs, but the motivation to abate this condition is far below the level produced by highly addictive drugs such as cocaine and heroin.

Physical dependence often occurs without addiction (e.g., therapeutic use of steroids, SSRIs), and addiction can occur without appreciable physical dependence (e.g., cocaine). Similarly, psychological dependence can occur without addiction (e.g., morning coffee for millions of regular users), but it's not clear whether addiction ever occurs without psychological dependence. And of course drug abuse may or may not be accompanied by drug dependence and addiction.

The fact that notable signs of physical dependence occur with some of the more addictive drugs (e.g., heroin, barbiturates, alcohol) has lead many to mistakenly attribute the motivation for substance use to the avoidance of withdrawal discomfort. Other drugs, such as the psychomotor stimulants, do not produce these characteristic withdrawal reactions and have helped to debunk this common misconception. Of course there are other compelling lines of evidence that physical dependence is not the primary cause of drug addiction (see Bozarth, 1989, 1990, 2009; Bozarth & Wise, 1984; Wise & Bozarth, 1987) although it can contribute to the overall motivation for continued drug use (see Bozarth, 1994).

In summary, drug addiction describes the motivational strength of substance use;drug abuse describes the misuse of a substance without explicit reference to motivational strength; and drug dependence describes the necessity of using a substance to maintain normal psychological and/or somatic functioning without reference to the motivational strength of the substance use or to whether the substance use violates cultural norms. These three terms have distinctively different meanings although there are obvious and numerous cases where all three apply to the same drug-use situation (i.e., the individual may be dependent upon a drug which they abuse because they are addicted).

Report 2(C)3 Public Health Pregnancy

Although After adjustment for confounding, cannabis use was not associated with mean birth weight or gestational age or with low birth weight or preterm delivery, it is likely medically reasonable to avoid Cannabis during pregnancy.

van Gelder MM, Reefhuis J, Caton AR, Werler MM, Druschel CM, Roeleveld N; National Birth Defects Prevention Study. **Characteristics of pregnant illicit drug users and associations between cannabis use and perinatal outcome in a population-based study.** Drug Alcohol Depend. 2010 Jun 1;109(1-3):243-7. Epub 2010 Feb 18.

National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention, Mail-Stop E-86, 1600 Clifton Road, Atlanta, GA 30333, USA.

Source

Abstract

BACKGROUND:

According to the 2004 National Survey on Drug Use and Health, 4.6% of American women reported use of an illicit drug during pregnancy. Previous studies on illicit drug use during pregnancy and perinatal outcomes showed inconsistent results.

METHODS:

This population-based study included mothers who delivered live-born infants without birth defects between 1997 and 2004 and completed interviews for the National Birth Defects Prevention Study (response rate 69%; n=5871). Prevalence of self-reported illicit drug use (specifically cannabis, cocaine, and stimulants) during pregnancy and its associations with demographic and social factors were assessed. We used multivariable linear and logistic regression analyses to study the associations of cannabis use with birth weight and gestational age.

RESULTS:

The prevalence of reported illicit drug use during pregnancy was 3.6% (standard error 0.24). Pregnant users of cannabis, cocaine, and stimulants were younger, had a lower level of education and lower household income, and were less likely to have used folic acid in the periconceptional period than nonusers. Illicit drug users were also more likely to have used alcohol and tobacco. After adjustment for confounding, cannabis use was not associated with mean birth weight or gestational age or with low birth weight or preterm delivery.

CONCLUSION:

Women who report use of illicit drugs during pregnancy differ in demographic and socioeconomic background from nonusers. Reported cannabis use does not seem to be associated with low birth weight or preterm birth. Published by Elsevier Ireland Ltd.

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Drugs Contraindicated in Pregnancy

This chart represents information on select drugs that are contraindicated (Pregnancy category X) for women who are pregnant. This is not an inclusive list of products that carry that pregnancy category. Those drugs that are contraindicated at a certain phase of the pregnancy are listed next to the product name. For more information on specific drug monographs, see product entries or consult the manufacturer.

ALLERGIC DISORDERS

Vistaril (hydroxyzine) Early pregnancy

CARDIOVASCULAR SYSTEM

Advicor (niacin ext-rel/lovastatin)
Aggrenox (dipyridamole/aspirin) 3rd trimester
Altoprev (lovastatin)
Bayer (aspirin) 3rd trimester
Caduet (amlodipine/atorvastatin)
Coumadin (warfarin sodium)
Crestor (rosuvastatin)
Ecotrin (aspirin) 3rd trimester
Juvisync (sitagliptin/simvastatin)
Lescol (fluvastatin)
Lescol XL (fluvastatin)
Letairis (ambrisentan)
Lipitor (atorvastatin)
Livalo (pitavastatin)
Mevacor (lovastatin)
Multaq (dronedarone)
Pravachol (pravastatin)
Simcor (niacin ext-rel/simvastatin)
Tracleer (bosentan)
Vytorin (ezetimibe/simvastatin)
Zocor (simvastatin)

CENTRAL NERVOUS SYSTEM

Beyaz (drospirenone/ethinyl estradiol)
Doral (quazepam)
Estazolam
Flurazepam
Halcion (triazolam)
Restoril (temazepam)
Vistaril (hydroxyzine) Early pregnancy
Yaz (drospirenone/ethinyl estradiol)

DERMATOLOGICAL DISORDERS

Amnesteem (isotretinoin)
Avage (tazarotene)
Beyaz (drospirenone/ethinyl estradiol)
Carac (fluorouracil)
Claravis (isotretinoin)
Efudex (fluorouracil)
Estrostep Fe (norethindrone acetate/ethinyl estradiol)
Fluoroplex (fluorouracil)
Loryna (drospirenone/ethinyl estradiol)
Ortho Tri-Cyclen 28 (norgestimate/ethinyl estradiol)
Propecia (finasteride)
Silvadene (silver sulfadiazine) Late pregnancy
Solage (mequinol/tretinoin)
Solaraze (diclofenac sodium) 3rd trimester
Soriatane (acitretin)
Sotret (isotretinoin)
SSD (silver sulfadiazine) Late pregnancy
SSD AF (silver sulfadiazine) Late pregnancy
Tazorac (tazarotene)
Tilia Fe (norethindrone acetate/ethinyl estradiol)
Tri-Legest 21 (norethindrone acetate/ethinyl estradiol)
Tri-Legest Fe (norethindrone acetate/ethinyl estradiol)
Tri-previfem (norgestimate/ethinyl estradiol)
Tri-sprintec (norgestimate/ethinyl estradiol)
Yaz (drospirenone/ethinyl estradiol)

ENDOCRINE DISORDERS

Androderm (testosterone)
Androgel (testosterone)
Android (methyltestosterone)
Axiron (testosterone)
Delatestryl (testosterone enanthate)
Depo-testosterone (testosterone cypionate)
Egrifta (tesamorelin)
Fluoxymesterone
Fortesta (testosterone)
Juvisync (sitagliptin/simvastatin)
Lupron (leuprolide acetate)
Methitest (methyltestosterone)
Oxandrin (oxandrolone)
Striant (testosterone)
Supprelin LA (histrelin acetate)
Synarel (nafarelin)
Testim (testosterone)
Testred (methyltestosterone)
Virilon (methyltestosterone)

GASTROINTESTINAL TRACT

Bellergal-S (phenobarbital/ergotamine tartrate) Cytotec (misoprostol)

INFECTIONS & INFESTATIONS

Bactrim (sulfamethoxazole/trimethoprim) 3rd trimester
Copegus (ribavirin)
Flagyl (metronidazole) 1st trimester for trichomoniasis
Furadantin (nitrofurantoin) Pregnancy at term
Gantrisin (sulfisoxazole) 3rd trimester
Grifulvin V (griseofulvin)
Gris-Peg (griseofulvin)
Macrobid (nitrofurantoin as macrocrystals and monohydrate) Pregnancy at term
Macrodantin (nitrofurantoin macrocrystals) Pregnancy at term
Rebetol (ribavirin)
Rebetron (ribavirin/interferon alfa -2b)
Septra (sulfamethoxazole/trimethoprim) 3rd trimester
Sulfadiazine Pregnancy at term
Tindamax (tinidazole) 1st trimester
Urobiotic-250 (oxytetracycline HCl/sulfamethizole/phenazopyridine) Late pregnancy
Virazole (ribavirin)

METABOLIC DISORDERS

Zavesca (miglustat)

MUSCULOSKELETAL DISORDERS

Advil (ibuprofen) 3rd trimester
Aleve (naproxen sodium) 3rd trimester
Ansaid (flurbiprofen) Late pregnancy
Arava (leflunomide)
Arthrotec (diclofenac sodium/ misoprostol)
Bayer (aspirin) 3rd trimester
BC Arthritis Strength (aspirin/caffeine/salicylamide) 3rd trimester
Cataflam (diclofenac potassium) Late pregnancy
Celebrex (celecoxib) 3rd trimester
Choline magnesium trisalicylate Pregnancy at term
Dantrium (dantrolene)
Daypro (oxaprozin) 3rd trimester
Diclofenac sodium Late pregnancy
Diflunisal 3rd trimester
Duexis (ibuprofen/famotidine) Late pregnancy (≥30 wks)
Ecotrin (aspirin) 3rd trimester
Etodolac Late pregnancy
Evista (raloxifene HCl)
Feldene (piroxicam) Late pregnancy
Ketoprofen Late pregnancy
Mobic (meloxicam) 3rd trimester
Motrin (ibuprofen) 3rd trimester
Nabumetone 3rd trimester
Nalfon (fenoprofen calcium) 3rd trimester
Naprelan (naproxen) 3rd trimester
Prevacid Naprapac (lansoprazole/naproxen) 3rd trimester
Probenecid + Colchicine
Prolia (denosumab)
Rheumatrex (methotrexate sodium)
Salsalate 3rd trimester
Soma Compound w. Codeine(carisoprodol/aspirin/codeine) 3rd trimester
Vimovo (naproxen/esomeprazole) Late pregnancy (≥ 30 wks)
Zipsor (diclofenac potassium) Late pregnancy

NEOPLASMS

Bexxar (tositumomab)
Casodex (bicalutamide)
Delestrogen (estradiol valerate)
Efudex (fluorouracil)
Eligard (leuprolide acetate)
Estrace (estradiol)
Evista (raloxifene HCl)
Firmagon (degarelix)
Fluoxymesterone
Menest (esterified estrogens)
Revlimid (lenalidomide)
Targretin (bexarotene)
Thalomid (thalidomide)
Trelstar (triptorelan pamoate)
Trexall (methotrexate)
Vantas (histrelin acetate)
Zytiga (abiraterone acetate)

NUTRITION

Didrex (benzphetamine)
Fosteum (genistein/citrated zinc/cholecalciferol)
Megace ES (megestrol acetate)
Megace Suspension (megestrol acetate)
Xenical (orlistat)

OB/GYN	
ALL ORAL CONTRACEPTIVES	Luveris (lutropin alfa)
ALL HORMONE REPLACEMENT THERAPY	Menopur (menoptropins)
Advil (ibuprofen) 3rd trimester	Methergine (methylergonovine)
Aleve (naproxen sodium) 3rd trimester	Midol cramp (ibuprofen) 3rd trimester
Aygestin (norethindrone acetate)	Midol menstrual (acetaminophen/caffeine/pyrilamine)3rd trimester
Betadine douche (povidone-iodine)	Midol PMS (acetaminophen/ pamabrom/pyrilamine) 3rd trimester
Bravelle (urofollitropin)	Midol teen (acetaminophen/ pamabrom) 3rd trimester
Cataflam (diclofenac potassium) Late pregnancy	Mifeprex (mifepristone)
Celebrex (celecoxib) 3rd trimester	Motrin (ibuprofen) 3rd trimester
Cetrotide (cetrorelix)	Naprelan (naproxen) 3rd trimester
Clomid (clomiphene citrate)	Ovidrel (choriogonadotropin alfa)
Depo-subQ provera (medroxyprogesterone acetate)	Ponstel (mefenamic acid) Late pregnancy
Endometrin (micronized progesterone) Ectopic pregnancy	Repronex 75 IU (follicle-stimulating hormone/luteinizing hormone)
Flagyl (metronidazole) 1st trimester for trichomoniasis	Repronex 150 IU (follicle-stimulating hormone/luteinizing hormone)
Follistim (follitropin beta)	Serophene (clomiphene citrate)
Ganirelix acetate	Synarel (nafarelin acetate)
Gonal-F (follitropin alfa)	Tindamax (tinidazole) 1st trimester
Lupron Depot (leuprolide acetate)	Zoladex (goserelin)

Some Medications and Driving Don't Mix

http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm107894.htm

If you are taking a medication, is it OK to drive?

Most likely, yes. But the Food and Drug Administration (FDA) advises that it's best to be absolutely sure before you get behind the wheel.

While most medications don't affect driving ability, some prescription and over-the-counter (OTC) medicines can cause reactions that may make it unsafe to drive.

These reactions may include

- sleepiness/drowsiness
- blurred vision
- dizziness
- slowed movement
- fainting
- inability to focus or pay attention
- nausea
- excitability

Driving while on medications can also be a legal issue. State laws differ, but being found driving under the influence of certain medications (prescription and OTC products) could get you in the same kind of trouble as people caught driving under the influence of alcohol.

Products That Require Caution

Knowing how your medications—or any combination of them—affect your ability to drive is clearly a safety measure involving you, your passengers, and others on the road.

Products that could make it dangerous to drive include

- prescription drugs for anxiety
- some antidepressants
- products containing codeine
- some cold remedies and allergy products
- tranquilizers
- sleeping pills
- pain relievers
- diet pills, "stay awake" drugs, and other medications with stimulants (e.g. caffeine, ephedrine, pseudoephedrine)

Products that contain stimulants may cause excitability or drowsiness. Also, never combine medication and alcohol while driving.

This article appears on FDA's Consumer Updates page, which features the latest on all FDA-regulated products.

Date Posted: December 11, 2008

Driving when you are taking medications.

http://www.nhtsa.gov/people/injury/olddrive/medications/index.htm

For most people, driving represents freedom, control and independence. Driving enables most people to get to the places they want or need to go. For many people, driving is important economically – some drive as part of their job or to get to and from work.

Driving is a complex skill. Our ability to drive safely can be affected by changes in our physical, emotional and mental condition. The goal of this brochure is to help you and your health care professional talk about how your medications may affect your ability to drive safely.

How can medications affect my driving?

People take medications for a variety of reasons. Those can include:

- allergies
- anxiety
- cold
- depression
- diabetes
- heart and cholesterol conditions
- high blood pressure
- muscle spasms
- pain
- Parkinson's disease
- schizophrenia

Medicines include medications that your doctor prescribes and over-the-counter medications that you buy without a doctor's prescription. Many individuals also take herbal supplements. Some of these medications and supplements may cause a variety of reactions that may make it more difficult for you to drive a car safely. These reactions may include:

- sleepiness
- blurred vision
- dizziness
- slowed movement
- fainting
- inability to focus or pay attention
- nausea

Often people take more than one medication at a time. The combination of different medications can cause problems for some people. This is especially true for older adults because they take more medications than any other age group. Due to changes in the body as people age, older adults are more prone to medication related problems. The more medications you take, the greater your risk that your medicines will affect your ability to drive safely. To help avoid problems, it is important that at least once a year you talk to your doctor or pharmacist about all the medications – both prescription and over-the-counter – you are taking. Also let your professional know what herbal supplements, if any, you are taking. Do this even if your medications and supplements are not currently causing you a problem.

Can I still drive safely if I am taking medications?

Yes, most people can drive safely if they are taking medications. It depends on the effect those medications – both prescription and over-the-counter – have on your driving. In some cases you may not be aware of the effects. But, in many instances, your doctor can help to minimize the negative impact of your medications on your driving in several ways. Your doctor may be able to:

- adjust the dose;
- adjust the timing of doses or when you take the medication;
- add an exercise or nutrition program to lessen the need for medication; and
- change medication to one that causes less drowsiness.

What can I do if I am taking medications?

Talk to your doctor honestly.

When your doctor prescribes a medicine for you, ask about side effects. How should you expect the medicine to affect your ability to drive? Remind your doctor of other medications – both prescription and over-the-counter – and herbal supplements you are taking, especially if you see more than one doctor. Talking honestly with your doctor also means telling the doctor if you are not taking all or any of the prescribed medication. Do not stop taking your medication unless your doctor tells you to.

Ask your doctor if you should drive — especially when you first take a medication.

Taking a new medication can cause you to react in a number of ways. It is recommended that you do not drive when you first start taking a new medication until you know how that drug affects you. You also need to be aware that some over-the-counter medicines and herbal supplements can make it difficult for you to drive safely.

Talk to your pharmacist.

Get to know your pharmacist. Ask the pharmacist to go over your medications with you and to remind you of effects they may have on your ability to drive safely. Be sure to request printed information about the side effects of any new medication. Remind your pharmacist of other medicines and herbal supplements you are taking. Pharmacists are available to answer questions wherever you get your medications. Many people buy medicines by mail. Mail-order pharmacies have a toll-free number you can call and a pharmacist available to answer your questions about medications.

Monitor yourself.

Learn to know how your body reacts to the medications and supplements. Keep track of how you feel after you take the medication. For example, do you feel sleepy? Is your vision blurry? Do you feel weak and slow? When do these things happen?

Let your doctor and pharmacist know what is happening.

No matter what your reaction is to taking a medicine – good or bad – tell your doctor and pharmacist. Both prescription and over-the-counter medications are powerful—that's why they work. Each person is unique. Two people may respond differently to the same medicine. If you are experiencing side effects, the doctor needs to know that in order to adjust your medication. Your doctor can help you find medications that work best for you.

What if I have to cut back or give up driving?

You can keep your independence even if you have to cut back or give up on your driving due to your need to take medications. It may take planning ahead on your part, but it will get you to the places you want to go and the people you want to see. Consider:

- rides with family and friends;
- taxi cabs;
- shuttle buses or vans;
- public buses, trains and subways; and
- walking.

Also, senior centers and religious and other local service groups often offer transportation services for older adults in the community.

Who can I call for help with transportation?

Call the ElderCare Locator at 1-800-677-1116 and ask for the phone number of your local Office on Aging, or go to their website at www.eldercare.gov.

Contact your regional transit authority to find out which bus or train to take.

Call Easter Seals Project ACTION (Accessible Community Transportation In Our Nation) at 1-800-659-6428 or go to their website atwww.easterseals.com/transportation.

Where do I find out more about medications?

Your first step is to talk with your health care professional. You also can contact the:

- American Pharmacists Association
  www.pharmacyandyou.org
- National Association of Chain Drug Stores
  www.nacds.org

You also can get a copy of the “Age Page On Older Drivers” from the National Institute on Aging by calling 1-800-222-2225, or by going to their website atwww.niapublications.org/engagepages/drivers.asp.

Wear your safety belt

Always wear your safety belt when you are driving or riding in a car. Make sure that every person who is riding with you also is buckled up. Wear your safety belt even if your car has air bags.

Report 2 (D) Existence of therapeutic alternatives for substances that are or may be used for medical purposes

Marinol ® Does Not Drug Substitute for Medical Marijuana [Cannabis]
The herbal medicine is safer and has over 60 therapeutic ingredients. Marijuana contains more than 460 active chemicals and over 60 unique cannabinoids. This is in harmony with reports from Medical Marijuana Patients who consistently report that the God Given Herbal Medicine is more effective than Marinol.

Cannabis Toxicology

http://en.wikipedia.org/wiki/Tetrahydrocannabinol
There has never been a documented human fatality from overdosing on tetrahydrocannabinol or cannabis in its natural form,[22] though the synthetic THC pill "Marinol" was cited by the FDA as being responsible for 4 deaths between January 1, 1997 and June 30, 2005.[23]Information about THC's toxicity is primarily based on results from animal studies. The toxicity depends on the route of administration and the laboratory animal. Absorption is limited by serum lipids, which can become saturated with THC, mitigating toxicity.[24]

The Natural God Given Herb is safer, no deaths, no overdose and more effective, more active natural medical compounds.

Marijuana Safer and More Effective than Cymbalta
Both medicines treat pain, anxiety
Note: All SSRI cause drug dependency and can not be stopped abruptly.

Cymbalta isn't regulated by the Controlled Substance Act although it is a prescription drug, rather than an over-the-counter drug. This means that it can only be dispensed upon request by a licensed medical practitioner. In that sense, Cymbalta is a controlled substance. Cymbalta is a particular type of drug used to treat depression that is known as a serotonin-norepinephrine reuptake inhibitor (SNRI). Since Cymbalta is not a drug that runs the risk of dependency or abuse, it is not considered a scheduled drug under the Controlled Substance Act. Scheduled drugs under the Controlled Substance Act are subject to much greater regulation and abuse of these substances can lead to criminal charges. Cymbalta is not controlled in this manner. WRONG: All SSRI cause drug dependency and can not be stopped abruptly. If you suddenly stop taking duloxetine, you may experience **withdrawal symptoms** such as nausea; vomiting; diarrhea; anxiety; dizziness; tiredness; headache; pain, burning, numbness, or tingling in the hands or feet; irritability; difficulty falling asleep or staying asleep; sweating; and nightmares. Tell your doctor if you experience any of these symptoms when your dose of duloxetine is decreased.

FDA Warnings: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000274/
A small number of children, teenagers, and young adults (up to 24 years of age) who took antidepressants ("mood elevators") such as duloxetine during clinical studies became suicidal (thinking about harming or killing oneself or planning or trying to do so). Children, teenagers, and young adults who take antidepressants to treat depression or other mental illnesses may be more likely to become suicidal than children, teenagers, and young adults who do not take antidepressants to treat these conditions. However, experts are not sure about how great

this risk is and how much it should be considered in deciding whether a child or teenager should take an antidepressant. Children younger than 18 years of age should not normally take duloxetine, but in some cases, a doctor may decide that duloxetine is the best medication to treat a child's condition.

You should know that your mental health may change in unexpected ways when you take duloxetine or other antidepressants even if you are an adult over 24 years of age. These changes may occur even if you do not have a mental illness and you are taking duloxetine to treat a different type of condition. You may become suicidal, especially at the beginning of your treatment and any time that your dose is increased or decreased. You, your family, or caregiver should call your doctor right away if you experience any of the following symptoms: new or worsening depression; thinking about harming or killing yourself, or planning or trying to do so; extreme worry; agitation; panic attacks; difficulty falling asleep or staying asleep; aggressive or hostile behavior; irritability; acting without thinking; severe restlessness; frenzied abnormal excitement; or any other unusual changes in behavior. Be sure that your family or caregiver checks on you daily and knows which symptoms may be serious so they can call the doctor if you are unable to seek treatment on your own.

Your healthcare provider will want to see you often while you are taking duloxetine, especially at the beginning of your treatment. Be sure to keep all appointments for office visits with your doctor.

The doctor or pharmacist will give you the manufacturer's patient information sheet (Medication Guide) when you begin treatment with duloxetine. Read the information carefully and ask your doctor or pharmacist if you have any questions. You also can obtain the Medication Guide from the FDA website:http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/UCM096273.
No matter your age, before you take an antidepressant, you, your parent, or your caregiver should talk to your doctor about the risks and benefits of treating your condition with an antidepressant or with other treatments. You should also talk about the risks and benefits of not treating your condition. You should know that having depression or another mental illness greatly increases the risk that you will become suicidal. This risk is higher if you or anyone in your family has or has ever had bipolar disorder (mood that changes from depressed to abnormally excited) or mania (frenzied, abnormally excited mood), depression, or has thought about or attempted suicide. Talk to your doctor about your condition, symptoms, and personal and family medical history. You and your doctor will decide what type of treatment is right for you.

Duloxetine is used to treat depression and generalized anxiety disorder (GAD; excessive worry and tension that disrupts daily life and lasts for 6 months or longer). Duloxetine is also used to treat pain and tingling caused by diabetic neuropathy (damage to nerves that can develop in people who have diabetes) and fibromyalgia (a long-lasting condition that may cause pain, muscle stiffness and tenderness, tiredness, and difficulty falling asleep or staying asleep). Duloxetine is also used to treat ongoing bone or muscle pain such as lower back pain or osteoarthritis (joint pain or stiffness that may worsen over time). Duloxetine is in a class of medications called selective serotonin and norepinephrine reuptake inhibitors (SNRIs). It works by increasing the amounts of serotonin and norepinephrine, natural substances in the brain that help maintain mental balance and stop the movement of pain signals in the brain. [increases transmitter in the synapse but decreases serotonin and norepi pools]

Duloxetine may help control your symptoms but will not cure your condition. It may take 1 to 4 weeks or longer before you feel the full benefit of duloxetine. Continue to take duloxetine even if you feel well. Do not stop taking duloxetine without talking to your doctor. Your doctor will probably decrease your dose gradually. If you suddenly stop taking duloxetine, you may experience **withdrawal symptoms** such as nausea; vomiting; diarrhea; anxiety;

dizziness; tiredness; headache; pain, burning, numbness, or tingling in the hands or feet; irritability; difficulty falling asleep or staying asleep; sweating; and nightmares. Tell your doctor if you experience any of these symptoms when your dose of duloxetine is decreased.

What side effects can this medication cause?

Duloxetine may cause side effects. Tell your doctor if any of these symptoms are severe or do not go away:

- nausea
- vomiting
- constipation
- diarrhea
- heartburn
- stomach pain
- decreased appetite
- dry mouth
- increased urination
- difficulty urinating
- sweating or night sweats
- dizziness
- headache
- tiredness
- weakness
- drowsiness
- muscle pain or cramps
- changes in sexual desire or ability
- uncontrollable shaking of a part of the body

Some side effects can be serious. If you experience any of the following side effects, or those mentioned in the IMPORTANT WARNING section, call your doctor immediately:

- unusual bruising or bleeding
- pain in the upper right part of the stomach
- swelling of the abdomen
- itching
- yellowing of the skin or eyes
- dark colored urine
- loss of appetite
- extreme tiredness or weakness
- confusion
- flu-like symptoms
- fever, sweating, confusion, fast or irregular heartbeat, and severe muscle stiffness
- blurred vision
- fever
- blisters or peeling skin
- rash
- hives
- difficulty breathing or swallowing
- swelling of the face, throat, tongue, lips, eyes, hands, feet, ankles, or lower legs
- hoarseness

Duloxetine may cause other side effects. Call your doctor if you have any unusual problems while taking this medication.

If you experience a serious side effect, you or your doctor may send a report to the Food and Drug Administration's (FDA) MedWatch Adverse Event Reporting program online [at http://www.fda.gov/Safety/MedWatch] or by phone 1-800-332-1088].

In case of overdose, call your local poison control center at 1-800-222-1222. If the victim has collapsed or is not breathing, call local emergency services at 911.

Symptoms of overdose may include the following:

- agitation
- hallucinating (seeing things or hearing voices that do not exist)
- fast heartbeat
- fever
- loss of coordination
- nausea
- vomiting
- diarrhea
- drowsiness
- seizures
- dizziness
- lightheadedness
- fainting
- unresponsiveness

FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 21, 2013 11:27 AM
To: FINTestimony
Cc: shannonkona@gmail.com
Subject: *Submitted testimony for HB668 on Feb 22, 2013 13:30PM*

HB668
Submitted on: 2/21/2013
Testimony for FIN on Feb 22, 2013 13:30PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Shannon Rudolph	Individual	Support	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing , improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov

FINTestimony

From: Douglas Campbell [dcamp42@aol.com]
Sent: Thursday, February 21, 2013 11:58 AM
To: FINTestimony
Subject: Bill 668 HD1

I want to express my feelings about this bill and its importance to me. Medical Marijuana has changed my quality of life to being a productive person again,allowing me to take less pain medications and being able to have an appetite.My general health both mentally and psychically has improved.Any improvements to the medical marijuana program can only assist me in furthering my recovery.Mahalo, D Campbell (808)779-4471

FINTestimony

From: Ken [Boilrweldr@hawaii.rr.com]
Sent: Wednesday, February 20, 2013 4:14 PM
To: FINTestimony
Subject: HB 668, HD 1 – Relating to Health

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: Kenneth L. Ketcherside, 1876 Launiupoko Pll, Wailuku, Hi 96793 808-243-0069
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support

Dear Honorable Representatives:

The transfer to the Department of Health is worth the money/appropriation to ensure medical cannabis patients, caregivers, and physicians receive the care and attention that they deserve:

- The transfer to the Department of Health will allow my wife, Michelle Yi, her Doctor at Kaiser, and I, her caregiver and MMJ grower/provider to have access to information about the program that will help all of us to stay within the law.
- The Department of Health is better equipped to handle a medical program and address the needs of the medical community.
- The Department of Health is committed to the well being of the medical cannabis patients, caregivers and physicians whereas the police and prosecutors are not at all concerned with our health and only want to justify their jobs with many arrests and prosecutions.
- By putting the right money towards the transfer to the Department of Health, Hawaii's medical cannabis program will be comparable to other states with medical cannabis program and no longer behind the times.

Over the past 13 years, the NED has not shown that it is qualified to manage a public health program:

- The NED does not maintain a website on the program and has limited and hard to find information about the program on its current website. Such Information is necessary for patients, caregivers, and physicians trying to stay within the law.
- The NED does no public health outreach to inform qualifying patients of the existence of the program. Instead it works from an enforcement and control posture that is inconsistent with managing a health program.
- The NED requires physicians to obtain application forms for patients whereas other states (e.g. Oregon and Colorado) provide and accept forms from patients themselves and post the blank forms on their websites.

- In the past, the NED has violated patient confidentiality and put Hawaii's sick people at risk by releasing the names and addresses of the registered patients, caregivers and physicians to the media. And that is a carte-blanche violation of patient's rights of privacy.

Hawaii's Medical Cannabis program is a health program, not a narcotics enforcement program:

- The medical cannabis program is a public health program conceived out of concern for the health of the seriously ill. It belongs in Hawaii's Department of Health.
- Of the 18 states plus District of Columbia which have medical marijuana programs, only Hawai'i and Vermont house them in a law enforcement agency. Other states have placed the program in a state health department.
- Placement in the NED is antithetical to the legislative intent of the measure and to the stated mission of the NED; it is a public health program intended to serve the seriously ill.
- Many patients, caregivers, and physicians are intimidated by dealing with a narcotics enforcement agency; they therefore do not register and face the threat of arrest by state or local authorities.
- The program's placement in NED is in part responsible for the reluctance of many physicians to certify patients. Physicians are concerned that their program applications are reviewed by the same entity that deals with the Drug Enforcement Agency daily on issues of over-prescribing, "doctor shopping" and the like.
- The law requires DOH to set up a protocol for adding new covered medical conditions for which research indicates that cannabis may be helpful. *This provision is in current law, but has never been implemented. This is the only part of the medical marijuana law for which DOH is responsible*. If the entire program were housed in DOH, it would be more likely to activate this provision. Medical research has advanced in the past 13 years and there are many new conditions/ailments/diseases for which medical cannabis has been shown to be helpful.

Please, please, I pray, you consider this personal email to help guide you in your consideration of this badly need change in the current law.

Aloha
Ken Ketcherside

FINTestimony

From: Matt Binder [mattbinder@earthlink.net]
Sent: Thursday, February 21, 2013 6:51 AM
To: FINTestimony
Subject: HB 668, HD 1 testimony

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: Matt Binder
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support

HRS Section 329-121is entitled "Medical Use of Marijuana" and I think it is clear that oversight and enforcement of the law by the DOH would be far superior to the current oversight by DPS. This is made even more clear when you look at the other 18 states with medical marijuana programs, only one other has its program under law enforcement jurisdiction.

The DOH is much better equipped to handle the kinds of medical issues involved in the law as well as the physician and patient record-keeping and certification processes. The Narcotics Enforcement Division (NED) has proven to be particularly unable to handle the privacy and public health aspects of the law.

I urge you to pass HB 668 and transfer jurisdiction of the Medical Marijuana law to the Department of Health where it belongs.

Thank you,

Matt Binder
Kealakekua

FINTestimony

From: zak [zako811@gmail.com]
Sent: Wednesday, February 20, 2013 7:46 PM
To: FINTestimony
Subject: HB668

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: Zachary Lee
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support

The transfer to the Department of Health is worth the money/appropriation to ensure medical cannabis patients, caregivers, and physicians receive the care and attention that they deserve:

- The transfer to the Department of Health will allow patients/caregivers/physicians to have access to information about the program that will help me stay within the law.
- The Department of Health is better equipped to handle a medical program and address the needs of the medical community.
- The Department of Health is committed to the well being of the medical cannabis patients, caregivers and physicians.
- By putting the right money towards the transfer to the Department of Health, Hawaii's medical cannabis program will be comparable to other states with medical cannabis program and no longer behind the times.

Over the past 13 years, the NED has not shown that it is qualified to manage a public health program:

- The NED does not maintain a website on the program and has limited and hard to find information about the program on its current website. Such Information is necessary for patients, caregivers, and physicians trying to stay within the law.
- The NED does no public health outreach to inform qualifying patients of the existence of the program. Instead it works from an enforcement and control posture that is inconsistent with managing a health program.
- The NED requires physicians to obtain application forms for patients whereas other states (e.g. Oregon and Colorado) provide and accept forms from patients themselves and post the blank forms on their websites.
- In the past, the NED has violated patient confidentiality and put Hawaii's sick people at risk by releasing the names and addresses of the registered patients, caregivers and physicians to the media.

Hawaii's Medical Cannabis program is a health program, not a narcotics enforcement program:

- The medical cannabis program is a public health program conceived out of concern for the health of the seriously ill. It belongs in Hawaii's Department of Health.
- Of the 18 states plus District of Columbia which have medical marijuana programs, only Hawai'i and Vermont house them in a law enforcement agency. Other states have placed the program in a state health department.

- Placement in the NED is antithetical to the legislative intent of the measure and to the stated mission of the NED; it is a public health program intended to serve the seriously ill.
- Many patients, caregivers, and physicians are intimidated by dealing with a narcotics enforcement agency; they therefore do not register and face the threat of arrest by state or local authorities.

The program's placement in NED is in part responsible for the reluctance of many physicians to certify patients. Physicians are concerned that their program applications are reviewed by the same entity that deals with the Drug Enforcement Agency daily on issues of over-pres

FINTestimony

From: Scott Temple [patempl@yahoo.com]
Sent: Thursday, February 21, 2013 10:12 AM
To: FINTestimony
Subject: HB668.HD1

/HEARING_FIN_02-22-13_2_.HTM

Representative Sylvia Luke, Committee Chair Representative Scott Nishimoto, Committee Vice-Chair Representative Aaron Ling Johanson, Committee Vice-Chair

From: Scott Temple
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support

Esteemed Representatives...

I support HB 668, because as a medical marijuana patient, I am a sick person, not a drug dealer. I am ill with seizures and Hep C and cirrhosis, and I am trying to stay alive. I am caregiver for my son with fibromyalgia, and he is not a druggie, he is a sick person trying to survive.

We are the same as my wife, who is a diabetes patient. She does not use medical marijuana, altho she would definitely benefit from it if allowed by the state. She is a sick person trying to survive with legal pharma drugs. My son and I are sick persons trying to stay alive with legal medical marijuana, in addition to pharma drugs from our doctors.

None of us are druggies or dealers of drugs. This medical marijuana program should be placed in the Dept. of Public Health, because this issue is about our health and survival. I would like health professionals making decisions about our public health, not law enforcement officials. We are not criminals!

Please pass HB 668.

Thank you and aloha,
Scott Temple

FINTestimony

From: Subhadra Corcoran [peacesubhadra@gmail.com]
Sent: Thursday, February 21, 2013 9:04 AM
To: FINTestimony
Subject: hb688 hd1

I support this bill. Medical defines the subject. It is medical before marijuana, a health issue. Thank you, Mrs. Corcoran

FINTestimony

From: david ostler [dostler007@gmail.com]
Sent: Wednesday, February 20, 2013 5:24 PM
To: FINTestimony
Subject: House Finance Committee to hear HB 668, HD 1, Transferring the Medical Cannabis Program to the Department of Health

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: David Ostler
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support

Medical cannabis is a health issue not a narcotics issue. Most of the other states with medical cannabis, the program is maintained under the Health Departments.

- The medical cannabis program is a public health program conceived out of concern for the health of the seriously ill. It belongs in Hawaii's Department of Health.
- Of the 18 states plus District of Columbia which have medical marijuana programs, only Hawai'i and Vermont house them in a law enforcement agency. Other states have placed the program in a state health department.
- Placement in the NED is antithetical to the legislative intent of the measure and to the stated mission of the NED; it is a public health program intended to serve the seriously ill.
- Many patients, caregivers, and physicians are intimidated by dealing with a narcotics enforcement agency; they therefore do not register and face the threat of arrest by state or local authorities.
- The program's placement in NED is in part responsible for the reluctance of many physicians to certify patients. Physicians are concerned that their program applications are reviewed by the same entity that deals with the Drug Enforcement Agency daily on issues of over-prescribing, "doctor shopping" and the like.
- The law requires DOH to set up a protocol for adding new covered medical conditions for which research indicates that cannabis may be helpful. *This provision is in current law, but has never been implemented. This is the only part of the medical marijuana law for which DOH is responsible*. If the entire program were housed in DOH, it would be more likely to activate this provision. Medical research has advanced in the past 13 years and there are many new conditions/ailments/diseases for which medical cannabis has been shown to be helpful.

FINTestimony

From: Ren Walker [renwalker@hawaii.rr.com]
Sent: Thursday, February 21, 2013 9:16 AM
To: FINTestimony
Subject: RE HB 668

i have had 14 operations on my legs, and 8 on my right ankle alone
the damn thing hurts every step i take, and i have been allergic to
morphine and its derivatives since the days of fall out shelters
and id bracelets, proclaiming my morphine allergy. i have been to all kinds to
orthopedic guys who tell me try to keep walking on it , or the last 5 degrees
of vertical morion in R ankle will go, as the ankle will freeze up permanently
from alla arthritis in the ankle...so i walk, and it hurts, and i take Advil
and smoke marijuana. the pot doesn't take away the pain, but it makes me
more preoccupied with other tasks at hand, eg golf, or gardening.

to have the medical program supervised by the narco squad
who is known from dozens of cases to later steal and use or sell
the confiscated drugs, is much like having the wolf guard the
lunch room, ... i mean hen house

please organize along the lines of what MUM is intended for
and quit burying your heads in the sand, hoping the drug lobbies
and the old police state is going to keep the old status quo around
forever, to keep their little fiefdoms and budgets

continued waste of tax payer $$$ in time when need to be realistic.
please note other reasons cited by many why NED should n o t be trusted

mahalo for your time and thought

ren walker

FINTestimony

From: Tiffany Edwards [newswoman@me.com]
Sent: Thursday, February 21, 2013 4:45 AM
To: FINTestimony
Subject: Strong Support for HB 668, HD 1

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: Tiffany Edwards Hunt
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm

Position: Strong Support

My family and I are in full support of the bill proposing to relocate the medical marijuana program to the Department of Health. We believe this would be a very sensible move. Please vote yes to House Bill 668. Thank you for the opportunity to weigh in on your decision.

Tiffany Edwards Hunt

Tiffany Edwards Hunt
(808) 938-8592
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(808)965-2322.

FINTestimony

From: Kim Barnes [kimsisland@yahoo.com]
Sent: Thursday, February 21, 2013 8:04 AM
To: FINTestimony
Subject: submit testimony HB 668, HD 1 – Relating to Health

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: (Your Name)
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support

I fell stongly about moving the Medical Cannabis program from the Department of Public Safety to the Department of Health. It is always a good idea to use your personal experiences and stories. You may also use two or three of the talking points I've provided below. Try to address the details in the bill you are testifying on since there may be some parts you like more than others.

The transfer to the Department of Health is worth the money/appropriation to ensure medical cannabis patients, caregivers, and physicians receive the care and attention that they deserve:

- The transfer to the Department of Health will allow patients/caregivers/physicians to have access to information about the program that will help me stay within the law.
- The Department of Health is better equipped to handle a medical program and address the needs of the medical community.
- The Department of Health is committed to the well being of the medical cannabis patients, caregivers and physicians.
- By putting the right money towards the transfer to the Department of Health, Hawaii's medical cannabis program will be comparable to other states with medical cannabis program and no longer behind the times.

Over the past 13 years, the NED has not shown that it is qualified to manage a public health program:

- The NED does not maintain a website on the program and has limited and hard to find information about the program on its current website. Such Information is necessary for patients, caregivers, and physicians trying to stay within the law.
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- In the past, the NED has violated patient confidentiality and put Hawaii's sick people at risk by releasing the names and addresses of the registered patients, caregivers and physicians to the media.

Hawaii's Medical Cannabis program is a health program, not a narcotics enforcement program:

- The medical cannabis program is a public health program conceived out of concern for the health of the seriously ill. It belongs in Hawaii's Department of Health.

- Of the 18 states plus District of Columbia which have medical marijuana programs, only Hawaii and Vermont house them in a law enforcement agency. Other states have placed the program in a state health department.
- Placement in the NED is antithetical to the legislative intent of the measure and to the stated mission of the NED; it is a public health program intended to serve the seriously ill.
- Many patients, caregivers, and physicians are intimidated by dealing with a narcotics enforcement agency; they therefore do not register and face the threat of arrest by state or local authorities.
- The program's placement in NED is in part responsible for the reluctance of many physicians to certify patients. Physicians are concerned that their program applications are reviewed by the same entity that deals with the Drug Enforcement Agency daily on issues of over-prescribing, "doctor shopping" and the like.
- The law requires DOH to set up a protocol for adding new covered medical conditions for which research indicates that cannabis may be helpful. This provision is in current law, but has never been implemented. This is the only part of the medical marijuana law for which DOH is responsible. If the entire program were housed in DOH, it would be more likely to activate thi s provision. Medical research has advanced in the past 13 years and there are many new conditions/ailments/diseases for which medical cannabis has been shown to be helpful.

Kim Harrison
(808)398-0076

FINTestimony

From: R Temple [rtemple@hotmail.com]
Sent: Thursday, February 21, 2013 10:57 AM
To: FINTestimony
Subject: HB 668

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair

From: Robin Temple

RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm

Position: Strong Support

Dear Representatives;

Please pass HB 668. I think it only makes sense to have the Department of Health oversee the medical cannabis program, since this is a health issue and not a law enforcement issue.

Thank you.

Robing Temple

FINTestimony

From: Bobich, Joseph [j.bobich@tcu.edu]
Sent: Wednesday, February 20, 2013 4:12 PM
To: FINTestimony
Subject: HB 668, HD 1

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: Joseph A. Bobich, Ph. D.
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support
To Whom It May Concern:

Writing as both a brain chemistry researcher my entire 40-year-long career and as the holder of a blue card, this is a step, albeit a small one, in the right direction.

Sincerely,

Joseph A. Bobich, Ph. D.
Professor of Chemistry, Emeritus

FINTestimony

From: Edy Hall [edygoeshawaiian@yahoo.com]
Sent: Thursday, February 21, 2013 8:39 AM
To: FINTestimony
Subject: HB 668, HD 1 - Relating to Health

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: Edith R Hall
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: **Strong Support**

My family and I are in full support of the bill proposing to relocate the medical marijuana program to the Department of Health.

We believe this would be a very sensible move. Please vote yes to House Bill 668.

Thank you for the opportunity to weigh in on your decision.

Edith R Hall

po box 387
Pahoa, HI 96778 *edygoeshawaiian@yahoo.com* *home: 808-965-0534*

FINTestimony

From: Lee Eisenstein [lionel@cruzio.com]
Sent: Thursday, February 21, 2013 12:29 PM
To: FINTestimony
Subject: RE: HB 668, HD 1 – Relating to Health

To: Representative Sylvia Luke, Committee Chair Representative Scott Nishimoto, Committee Vice-Chair Representative Aaron Ling Johanson, Committee Vice-Chair
From: Lee Eisenstein
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support

Aloha,

The transfer to the Department of Health is worth the money/appropriation to ensure medical cannabis patients, caregivers, and physicians receive the care and attention that they deserve:

The transfer to the Department of Health will allow patients/caregivers/physicians to have access to information about the program that will help me stay within the law.
The Department of Health is better equipped to handle a medical program and address the needs of the medical community.
The Department of Health is committed to the well being of the medical cannabis patients, caregivers and physicians.
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The NED requires physicians to obtain application forms for patients whereas other states (e.g. Oregon and Colorado) provide and accept forms from patients themselves and post the blank forms on their websites.
In the past, the NED has violated patient confidentiality and put Hawaii's sick people at risk by releasing the names and addresses of the registered patients, caregivers and physicians to the media.

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Placement in the NED is antithetical to the legislative intent of the measure and to the stated mission of the NED; it is a public health program intended to serve the seriously ill.

Many patients, caregivers, and physicians are intimidated by dealing with a narcotics enforcement agency; they therefore do not register and face the threat of arrest by state or local authorities.

The program's placement in NED is in part responsible for the reluctance of many physicians to certify patients. Physicians are concerned that their program applications are reviewed by the same entity that deals with the Drug Enforcement Agency daily on issues of over-prescribing, "doctor shopping" and the like.

The law requires DOH to set up a protocol for adding new covered medical conditions for which research indicates that cannabis may be helpful. This provision is in current law, but has never been implemented. This is the only part of the medical marijuana law for which DOH is responsible. If the entire program were housed in DOH, it would be more likely to activate this provision. Medical research has advanced in the past 13 years and there are many new conditions/ailments/diseases for which medical cannabis has been shown to be helpful.

Aloha,
Lee
<http://members.cruzio.com/~lionel/dreamerdemo.htm>

P.S. Effectively and safely treating serious, infectious diseases, like drug resistant staph, "MERSA", (which is the bane of US hospitals), should not be a crime. Marijuana excels at this. Especially using raw, fresh and therefore, non-psychoactive, (no high) marijuana, either juiced or in a smoothie.

In order for Hawaii's people to effectively and safely protect themselves from infectious diseases such as MERSA, larger amounts of marijuana are required. A large handful of flowers and leaves in a smoothie, taken daily does this!

Denying the lawful ability of Hawaii's people to do this, is inhumane in the extreme. Denying people the right to safely treat themselves from potentially life threatening conditions may be considered a human rights crime, by any reasonable standard.

Clinical studies also show life extension properties, from marijuana consumption. Extending one's lifespan with a non-toxic, herb, should not be a crime. Marijuana is shown to possess strong, anti-bacterial properties. Safely protecting oneself from bacterial infections, should not be a crime.

In view of these facts, can you see how the current, harshly limited and inadequate medical marijuana law appears? So can I.

FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 21, 2013 2:59 PM
To: FINTestimony
Cc: buzzzed@msn.com
Subject: *Submitted testimony for HB668 on Feb 22, 2013 13:30PM*

HB668
Submitted on: 2/21/2013
Testimony for FIN on Feb 22, 2013 13:30PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Sandy Webb	Individual	Support	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing , improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 21, 2013 1:13 PM
To: FINTestimony
Cc: vince.callagher@gmail.com
Subject: Submitted testimony for HB668 on Feb 22, 2013 13:30PM

HB668
Submitted on: 2/21/2013
Testimony for FIN on Feb 22, 2013 13:30PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
vincent callagher	Individual	Support	No

Comments: This is concerning HB 668. I strongly support HB 668, transfering licensing of Medical marijuana patients from, (NED) dept. of Saftey to, the Dept. of Health. As a medical Marijuana patient I have had delayed mailing of licencses as well as private medical information made available to improper parties. Please support changing this process from NED to the health Dept.

Please note that testimony submitted less than 24 hours prior to the hearing , improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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Robert Slavin

Supporting a transfer of jurisdiction over the medical marijuana laws from the Department of Public Safety to the Department of Health.

There have been many problems resulting from the Department of Public Safety being in control of the marijuana as a narcotics issue rather than a medical one. N.E.D. released supposedly private records to the public, and consistently lobbies against the very medical marijuana laws that they are entrusted to assist.

I am a 70 year old retired teacher; I rarely use alcohol and quit smoking cigarettes in 1979. I am educated, have always been a hard-working and useful member of society, and I have found relief from a moderate use of cannabis - so much less impairing than the narcotics that my doctors prescribe. I suffer from an array of neuropathies & paresthesias related to cervical radiculopathy. I had a subtotal meniscectomy in 1996, a knee replacement in 2012, and suffer from ongoing knee and iliotibial band pain. Degenerative changes are occuring in my knees, neck, ankles and probably more - arthritic spurs (osteophytes). My condition is eased by this natural substance.
Please help stop the uneven enforcement of antiquated marijuana laws. Let's have professionals skilled in managing health related programs be charged with running this medical program.

FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 21, 2013 11:17 AM
To: FINTestimony
Cc: theede@hawaii.rr.com
Subject: Submitted testimony for HB668 on Feb 22, 2013 13:30PM

HB668
Submitted on: 2/21/2013
Testimony for FIN on Feb 22, 2013 13:30PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Teri Heede	Individual	Support	Yes

Comments: To: Representative Sylvia Luke, Committee Chair Representative Scott Nishimoto, Committee Vice-Chair Representative Aaron Ling Johanson, Committee Vice-Chair From: Teri Heede RE: HB 668, HD 1 – Relating to Health Hearing: Friday, February 22, 2013, room 308, 1:30 pm Position: Strong Support Aloha Chair Luke, Vice Chairs Nishimoto & Johanson & Committee Members! I am writing in strong support of HB 668, HD1 which transfers the medical marijuana program to the Department of Health. It is not logical to have Public Safety administer the program. They are highly qualified as law enforcement experts and dealing with criminals but they have not exhibited the proper expertise in dealing with patient issues. As a patient working on the Medical Cannabis Working group, we achieved patient consensus when we identified it as a top priority to move the administration of the program from the Department of Public Safety to the Department of Health. I personally can attest to having my patient information compromised, my doctors were harassed and intimidated, and I suffered unacceptable delays in processing required paperwork. In Kona, I was surprised to find out that the police had been using my picture during Rotary Club meetings, complaining that “This woman testifies at the legislature all the time”. (Recently the media played right along with that. After busting a cop for growing marijuana plants, they were unable to get a good picture of him running away from their cameras so, they just flashed a picture of me from some stock footage, smoking from a bong. SHEESH!!) I have suffered enormous stress in being treated like a criminal instead of a sick person. I have Multiple Sclerosis, Arthritis, Barrett’s Esophagus Syndrome, GERD, and Chondromalacia in both knees. I have tried hundreds of prescriptions and marijuana works best for me. I, and many more like me, need to be treated like a patient, not a criminal. Before I became too ill to work, I was a Computer Engineer. I have done extensive work for the Department of Defense (DOD) as a Computer Systems Analyst and even served on a Senate Subcommittee making recommendations for computer systems used by DOD. In my opinion, it would be extremely beneficial and cost effective to move the administration completely to Department of Health. It is not difficult to maintain an automated, 24/7 database system, which would be accessible by law enforcement personnel. There is no logical reason to maintain the administration of this program in two departments given the availability of secure database technology. Perhaps the overriding g reason to move the program to the Department of Health is because they will be considering new medical conditions that would qualify for the program. For example, recently the Veteran’s Administration began a taking a different approach to veterans using medical marijuana who suffer from PTSD. They are accepting the anecdotal evidence coupled with the empirical evidence presented by patients that currently use medical marijuana and view it as beneficial. As one doctor explained to me, the influx of service men and women with emotional and physical problems coming back from combat can’t be treated solely with psychotropic drugs and

painkillers. They don't necessarily have a medical condition or something that can be treated solely with pharmaceuticals. These compassionate medical personnel want every available option. The Department of Health will be deciding which conditions can be added to the list and should completely have this program. Mahalo for your time and consideration regarding this important issue. Teri Heede 92-994 Kanehoa Loop Kapolei, HI 96707 Home phone: (808) 672-6312

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FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 21, 2013 11:09 AM
To: FINTestimony
Cc: bacher.robert@gmail.com
Subject: Submitted testimony for HB668 on Feb 22, 2013 13:30PM

HB668
Submitted on: 2/21/2013
Testimony for FIN on Feb 22, 2013 13:30PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Robert Bacher	Individual	Support	No

Comments: Over the past 13 years, the NED has not shown that it is qualified to manage a public health program: The NED does not maintain a website on the program and has limited and hard to find information about the program on its current website. Such Information is necessary for patients, caregivers, and physicians trying to stay within the law. The NED does no public health outreach to inform qualifying patients of the existence of the program. Instead it works from an enforcement and control posture that is inconsistent with managing a health program. The NED requires physicians to obtain application forms for patients whereas other states (e.g. Oregon and Colorado) provide and accept forms from patients themselves and post the blank forms on their websites. In the past, the NED has violated patient confidentiality and put Hawaii's sick people at risk by releasing the names and addresses of the registered patients, caregivers and physicians to the media. Hawaii's Medical Cannabis program is a health program, not a narcotics enforcement program.

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Re: HB668D1

To: Committee on Finance

Hearing Date: February 22, 2013
Time: 1:30 pm
Room: 308

Dear Honorable Representatives,

This testimony is in support of HB668HD1 to allow medical cannabis to be used for severe pain. My name is Gene Thomas. I am a retired pharmacist and use a variety of cannabis that is non-psychotropic; high in cannabidiol and low in tetrahydrocannabinol (THC, the psychotropic/euphoria agent in marijuana) for severe leg cramps and back pain. As a retired pharmacist, I am all too familiar with the dangerous side effects of pharmaceutical drugs, not to mention how horribly overpriced they are!

This measure would also help the state save money on prescription Marinol which is synthetic THC and does not work as well as cannabis. The average cost of Marinol for a 90 day supply is $2036.00! Check this link: http://medicalmarijuana.procon.org/view.answers.php?questionID=000091 for verification.

Cannabis allows me to sleep through most of night without taking addictive pain medication and muscle relaxants. Recently, there have been many positive new developments in medical cannabis research. If you would like more information or consultation on medical cannabis, use please don't hesitate to call me at (808) 443-4188.

Thank you for your consideration. Why not let us grow our own medicine and take charge of our own health? Please, make the right decision and support HB 668 HD 1.

Sincerely,

Gene Thomas, Pharmacist (retired)

To: Representative Sylvia Luke, Committee Chair Representative Scott Nishimoto, Committee Vice-Chair Representative Aaron Ling Johanson, Committee Vice-Chair From: Mary Marvin Porter RE: HB 668, HD 1 – Relating to Health Hearing: Friday, February 22, 2013, room 308, 1:30 pm Position: Strong Support

Aloha,

I strongly support the transferring of the medical use of marijuana program from the Department of Public Safety to the Department of Health. The medical cannabis program is a public health program and belongs in Hawaii's Department of Health. Many patients and physicians are intimidated by dealing with a narcotics enforcement agency. Of the 18 states having medical marijuana programs, only Hawaii and Vermont house them in a law enforcement agency. NED has not done a good job managing this public health program and has violated patient confidentiality. Please support HB 668, HD 1.

Mahalo,

Mary Marvin Porter,

Island Eyes Video, Keaau, Hawaii

FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 21, 2013 10:35 AM
To: FINTestimony
Cc: nihipalim001@hawaii.rr.com
Subject: Submitted testimony for HB668 on Feb 22, 2013 13:30PM

HB668
Submitted on: 2/21/2013
Testimony for FIN on Feb 22, 2013 13:30PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Michele Nihipali	Individual	Support	No

Comments: Medical Marijuana is a matter of Health, not public safety. Professionals skilled in managing health related programs should be in charge not the NEC. This is totally against what the NEC stands for. Please put medical marijuana under healthcare programs.

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To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair

From: Rev. Dennis Shields
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support

Aloha Chair Luke, & Vice-Chairs Nishimoto, Johanson

I having obtained, if not the first then one of the very first blue cards 12 years ago, I strongly urge the committees to move the program from the control of the Narcotics enforcement Division to the Health Department as having law enforcement control this program is truly the fox guarding the hen house

Our names have been disclosed to the media without our permission and were it not for the honor of journalist my name and the location at which I am registered to grow my medicine would have been broadly dispersed to anyone

Excessive delays in renewal of our registration papers has been experienced yearly and for several years the condition mandated in the current law to issue letters of receipt once a patients had filed their paperwork with the department was totally ignored

Complaints of not enough funding were made by the department while reports of registration fees being utilized by the department head to lobby against the medicinal use of cannabis were well known

The unnecessary red tape in being qualified; the lack of full information by the NED has intimidated many patients in pain who should have by now, after a dozen years of the program being in effect [the first patient registered ME was not until Jan of 2001], have a more streamlined and efficient process

The Health department is tasked with approving additional disorders and illnesses cannot and is not able to so function with the program being controlled by NED

Please right this wrong and move the program where it was originally intended to reside with the Health Department

Mahalo for considering this bill

Aloha

Rev. Dennis Shields

FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 21, 2013 9:40 AM
To: FINTestimony
Cc: forecharlee@msn.com
Subject: Submitted testimony for HB668 on Feb 22, 2013 13:30PM

HB668
Submitted on: 2/21/2013
Testimony for FIN on Feb 22, 2013 13:30PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Charles Webb, MD	Individual	Support	No

Comments: Health care should be overseen by health care workers.

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To: Representative Sylvia Luke, Committee Chair, House Finance Committee
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: Clifton Otto, MD
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support

Hawaii's Medical Marijuana Program is broken. One of the main reasons: the fact that a law enforcement agency that recognizes Marijuana only as an illegal controlled substance is in charge of treating it like a medicine, which opposes the agency's mission.

The answer: treat Marijuana (Cannabis) as medicine, which means making its medical use safe and available for a well-defined and closely regulated segment of the population.

Hawaii's Medical Marijuana Program was created because States hold the authority to decide the medical use of controlled substances. The fact is that the State of Hawaii has already accepted the Medical Use of Marijuana. The problem is that the State has yet to properly notify the Federal Government that this change in Accepted Medical Use has occurred.

In order for Hawaii's Medical Marijuana Program to be successful, meaning that patients are able to receive the relief that they legitimately require, Marijuana, in this very specific state-protected case, must be treated as medicine, which logically requires placement of the program within the Department of Health. If patients are following the rules of the program, then the use of Cannabis remains a health issue, which the Department of Health can appropriately administer. If patients willfully disobey the rules with a clear intent to commercially distribute, then possession becomes a narcotics enforcement issue, which would require involvement of the Department of Public Safety. Rules that are patient-centered to allow appropriate access would make it easy to distinguish the two.

The term "Marijuana" has no place within a discussion of the Medical Use of Cannabis. "Marijuana" is a slang term adopted by prohibitionists to propagate negative connotations about the plant and its use. Therefore, when Hawaii's Medical Marijuana Program is transferred to the Department of Health, the name of the program should be changed to "Hawaii's Medical Cannabis Program".

Clifton Otto, MD
Honolulu, HI

FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 21, 2013 5:58 AM
To: FINTestimony
Cc: mattrifkin28@gmail.com
Subject: Submitted testimony for HB668 on Feb 22, 2013 13:30PM

HB668
Submitted on: 2/21/2013
Testimony for FIN on Feb 22, 2013 13:30PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Matthew Rifkin	Individual	Support	No

Comments: I was a resident in Hawaii for almost 10 years, and a medical cannabis patient and advocate for more than 6. In 2010 I served on the Medical Cannabis Working Group, which came up with recommendations on ways to improve the medical cannabis program. Moving the program to the department of health is one of the most basic and simple things to be done, and yet it still has not happened. The Dept of Health needs to create the appropriate panel of doctors to consider new qualifying conditions for the program (such as PTSD), as well as be more sympathictc and responsive to the needs of patients. The Governor says he supports the medical cannabis program, and it is time for the public safety and health departments to uphold his policies.

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FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 21, 2013 1:52 AM
To: FINTestimony
Cc: primojr99@gmail.com
Subject: Submitted testimony for HB668 on Feb 22, 2013 13:30PM

HB668
Submitted on: 2/21/2013
Testimony for FIN on Feb 22, 2013 13:30PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Philip Valentine Jr.	Individual	Support	No

Comments: Rep. Sylvia Luke, Chair Rep. Scott Y. Nishimoto, Vice Chair Rep. Aaron Ling Johanson, Vice Chair From: (Your Name) RE: HB 668 – Relating to Health Hearing: Friday, February 22, 2013, room 308, 1:30 pm Position: Strong Support I am a registered medicinal marijuana patient. I firmly believe like many others that this could be a pinnacle year for canabis and everything connected to it. Although I am very sick and disabled I just wanted to share some personal testimony so that you know the REAL truth about medicinal marijuana. It is crucial that the elected officials calling the shots understand that we are not just stoners we are ill, and this all about medicinal use for relief from pain. I am in strong support of HB 668 (Relating to Health). The Medical Cannabis Program should be moved from the Dept. of Public Safety to the Dept. of Health. In the past 13 years the program has very little information (which is also hard to find), and this causes a lot of confusion for patients, caregivers, doctors, who are just trying to stay within the law. There are no public health outreach phone numbers, web sites, to get the information out to existing or future qualifying patients so they can get the help they need. It currently works from a control and enforcement posture which is not consistant with a health program. I am also concerned about possible occurances of patient confidentiality violations that has already happened in the past when the names and addresses of patients, caregivers, doctors, were released to the media by the NED. Because of this posture patients, caregivers, doctors, are intimidated to not register with a narcotics enforcement agency which forces them to have to break the law to recieve or provide relief.This is also directly why doctors are reluctant to certify their patients. Mahalo Philip Valentine Jr

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To: Representative Sylvia Luke, Committee Chair; Representative Scott Nishimoto, Committee Vice-Chair; Representative Aaron Ling Johanson, Committee Vice-Chair

From: Kanoa Meriwether MA

RE: HB 668, HD 1 – Relating to Health

Hearing: Friday, February 22, 2013, room 308, 1:30 pm

Position: Strong Support

I am writing in strong support of HB 668. I have a Bachelor's degree from the University of Hawaii and a Master's degree in clinical psychology with a specialization in addiction from the University of Nebraska-Lincoln. I have taught and worked in the addictions field for over 15 years here in Hawaii. Currently I am at the University of Hawaii-West Oahu where I serve as the head of our certificate in substance abuse studies and teach courses in addiction counseling (courses include Psy 406 assessment and treatment of addiction, Psy 405 Biological correlates of addiction and substance abuse, and Psy 403 Causation and prevention of substance abuse). As a counselor and teacher I have had the chance to interact with a wide variety of professionals in the field and individuals in recovery. I am in support of HB 668 for the following reasons:

1. The medical cannabis program is a public health program conceived out of concern for the health of the seriously ill. It belongs in Hawaii's Department of Health.
2. The Narcotics Enforcement Division (NED) does a poor job of managing this health-related program. The NED works from an enforcement and control posture that is inconsistent with managing a health program. The NED does no outreach, has no website, and provides limited information regarding the program (compare to Colorado's Dept. of Public Health website, for example).
3. In my interactions with patients, caregivers, and physicians, I have learned that many are intimidated by dealing with a narcotics enforcement agency; they therefore do not register and face the threat of arrest by state or local authorities. This is in opposition to the spirit of the MMJ program.
4. All other MMJ states (beside Hawaii and Vermont)have placed their MMJ program in health departments.
5. The law requires DOH to set up a protocol for adding new covered medical conditions for which research indicates that cannabis may be helpful. This provision is in current law, but has never been implemented. This is the only part of the medical marijuana law for which DOH is responsible. If the entire program were housed in DOH, it would be more likely to activate this provision. Medical research has advanced in the past 13 years and there are many new ailments and diseases for which medical cannabis has been shown to be helpful.

Thank you for the opportunity to provide testimony on this important bill.

FIN 308 Feb 22, 2013 1:30 PM

RE: HB 668 HD1 Relating to Health

Position: SUPPORT

Rep. Sylvia Luke, Chair, Rep. Scott Nishimoto, Vice Chair

Rep. Aaron Ling Johanson, Vice Chair and the Members of the Committee on Finance

As a medical patient with advanced arthritis I am not able to leave my disease at home, yet I find I am stigmatized and criminalized for a medical determination made with my primary care physician. I have to buy a license and disclose personal medical information and be subject to harassment and or arrest if I take or use the medicine Dr. Earnest Bade has determined is the best treatment for my particular medical circumstances, I find this offensive, intrusive, and oppressive.

The DPS has no business taxing me for a license and interfering with the treatment of my disease.

Moving the administration of the program from the Department of Public Safety to the Department of Health is necessary as health decisions should be made by people qualified to make those determinations.

Currently the program is confusing and misleading putting patients at risk of arrest. These decisions need to be made by those experienced with health programs not criminal ones. We are not criminals quite treating us like we are.

Taking a law enforcement approach to a public health problem is counterproductive and waste resources. Dealing with the NEA has been frustrating and intimidating, we should not living in fear and looked at as criminals.

This law was to created for patients with serious or chronic illnesses, but has morphed into an abusive investigative process that is dehumanizing to people made to fee guilty for seeking what to many is the safest treatment for our illnesses..

Records including our addresses are being kept by a LEA who may have or share access to them. My personal health records are private, it is insulting and invasive for that information to be in the hands of people not qualified to understand or safeguard it.

As an example of the abusive lack of discretion or concern for our privacy and safety in June 2008, the DPS released the entire patients database including, addresses, the location of their marijuana plants, license information, and the names of their physicians to Peter Sur, reporter for the Hawaii

Tribune-Herald. We do not know who else has been given this information.

The Department of Health is task and rightly so with considering new medical conditions qualify for the program. No other medication including many far more dangerous are restricted to the DPS, nor are doctor patient relationships subject to licening, random investigation, or records being kepy by law enforcement agencies. After more than a decade with many models around the country their really is no need to continue to treat people like me who are 57 years old and disabled like criminals because of medical decisions that are non of the governments preview.

Robert Petricci

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: Cara Rand
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support

I write in strong support of the transfer of the medical use of marijuana program as a public health program. Section 1 of the bill states "The status of the medical use of marijuana program as a public health program is more in keeping with the mission and expertise of the department of health. The department of health is experienced in working with patients and health programs, including such important tasks as public outreach, and education safeguarding patient privacy." It is more effective to have the Department of Health oversee the medical use of marijuana program.

The Department of Health is better equipped to handle a medical program and address the needs of the medical community. This in turn will save millions in taxpayer money with the Department of Health running a public health program. The Narcotics Enforcement Division works from a control and enforcement position which is inconsistent with the original intention of the medical use of marijuana program. The medical cannabis program was conceived out of concern for the health of the seriously ill and should be in the Department that focuses on that issue.

Placement in the Narcotics Enforcement Division is antiethical to the original intent of the statement measure. By placing it in there it prevents many from registering (patients, caregivers, and physicians) due to intimidation of dealing with a division focused on enforcement. With less registered this risks arrests and results in taxpayer money being spent on enforcement not effective health program management.

The law requires Department of Health to set up a protocol for adding new covered medical conditions for which research indicates that cannabis may be helpful. This provision is in current law, but has never been implemented. This is the only part of the medical marijuana law for which DOH is responsible. If the entire program were housed in Department of Health, it would be more likely to activate this provision. Medical research has advanced in the past 13 years and there are many new conditions/ailments/diseases for which medical cannabis has been shown to be helpful.

I appreciate your time and consideration. Transferring the program to the Department of Health will result in saving taxpayer money and more effective program management of a concept that was introduced out of concern for the seriously ill.

Sincerely,
Cara Rand

Cara Rand
PO Box 240299
Honolulu. Hawaii 96824

Dr. Myron Berney, ND. LAc. Additional Testimony

SUPPORT

HB 668, HD1	RELATING TO HEALTH.
(HSCR478)	Transfers the medical use of marijuana program, from the Department of Public Safety to the Department of Health by June 30, 2014. Requires report, with transfer plan and timeline, to the legislature prior to the 2014 regular session.
Status	Effective July 1, 2013.

DATE: Friday, February 22, 2013

TIME:1:30 P.M.

PLACE:Conference Room 308

In addition to the support for this essential bill which would transfer the Medical Marijuana Health Care programs to persons qualified in Health Care and Public Health.

In order to protect seriously ill patients Please modify a short form bill to PREVENT and PROHIBIT the expenditure or spending of any funds for Marijuana Law Enforcement including police, attorneys, courts, jails and penitentiaries only fund Parole or Pardon of Marijuana Crimes.

Last year alone the State lost over $69.25 million dollars in retail GET to underground retail sales of Pakalolo. $69.25 Million Dollars in GET Tax Revenue lost annually

The State Lost Out of $69.25 Million Dollars in GET Tax Revenue to Black Market Sales of Marijuana last year from retail sales alone.
22% of Hawaii Residents are over 18, There are 1,392,313 residents in Hawaii =
306,308 adults over 18 in Hawaii. If they are using one oz a month of Pakalolo at $400/oz =
$122,523,544 a month spent on Marijuana x 4.71% Sales Tax =
$5,770,858 GET Tax NOT Collected per month=
$69,250,307 GET Retail Tax not collected from Black Market sales of Pakalolo Annually.

For what? What exactly was gained by loosing $ 69,250,307 GET Retail Tax? The reality on the street is that anybody that want's marijuana probably know at least 3 or 4 people that can get them some pot.

Yes, there will be some expense in moving the administrative duties to the appropriate Department.

The expense seems bloated and ballooned, not unusual in government affairs and administration, although a price well spent for the Protection of Health Care and the Promotion of the Public Health.

Which States Budgets Are Benefiting From Medical Marijuana -- and Who Is Missing Out?

California
Tax rate: **5% state,** various municipal on dispensary sales.
Revenue: Up to **$100 million** by the end of this fiscal year.

Colorado
Tax rate: **Varies based on locality.**
Revenue: Over **$20 million** a year.

Washington
Tax rate: **25% (proposed).**
Revenue: **$1.9 billion over five years** (estimated).

Rhode Island
Tax rate: None at the moment, **4% profits, plus 7% sales** on the imminent dispensaries.
Revenue: Up to **$700,000** when the program is fully operational.
Arizona
Tax rate: **6.6% of sales.**
Revenue: Modest at the moment, but could grow to tens of millions annually.

Maine
Tax rate: **5% of sales, 7% on food items**
Revenue: **$650,000** within a couple years, according to estimates.

New Mexico
Tax rate: **Varies by locality.**
Revenue: **$700,000** annually according to the most optimistic projections, with an important asterisk.

Michigan
Tax rate: **Exempt.**
Revenue: Around **$9 million**, extrapolating from 2011 figures.

Hawaii
Lost over &69.25 Million in GET 2012!
Tax rate: **Proposed** flat tax, pending approval of dispensaries.
Revenue: **Uncertain,** estimated low five figures.

Montana
Tax rate: **Only application fees.**
Revenue: At least **$500,000** a year

The purpose of this bill is to protect and promote the Public Health and improve the administration of the Medical Marijuana Health Care Program.

The Medical Marijuana Program is a Health Care Program and must be administered by persons in Government that have the expertise and attitude to promote health care and the public health.

Persons in Health Care want to help people and improve the Public Health.
We hear from the public testimony that Public Safety, NED, the Police and the Attorneys STRONGLY OPPOSE Marijuana and Medical Marijuana.

The Cops in Hawaii go far beyond Federal Drug Enforcement Policy on Medical Marijuana into deliberate and aggressive harm to seriously ill patients.
Federal Policy:

Obama's statements on recreational use mirror the federal policy toward states that allow marijuana use for medical purposes.

"We are not focusing on backyard grows with small amounts of marijuana for use by seriously ill people," said Lauren Horwood, a spokeswoman for U.S. Attorney Benjamin Wagner in Sacramento. "We are targeting money-making commercial growers and distributors who use the trappings of state law as cover, but they are actually abusing state law."

The State of Hawaii and County Cops deliberately focus specifically on Medical Marijuana Patients! Why, because these Public Employees continue to Claim the Marijuana has no Medical Use in Violation of Hawaii State Law.

Doctors and Firemen want to save lives and help people.

Cops are Out to Get the Bad Guy, the seriously ill patient trying to grow their own necessary, medically appropriate and reasonably safe medicine. Local Cops are in Violation of Federal Policy and in Violation of the intent of State Law, and the Ruling by the Hawaii Supreme Court on Medical Care on necessary, appropriate and reasonable health care.

Clearly the Cops are the wrong people to be managing Medicine.

Medical Care is a Protected Relationship.

Health Care is protected under the Federal Right of Privacy.

Yes, there will be some expense in moving the administrative duties to the appropriate Department.

The expense seems bloated and ballooned, not unusual in government affairs and administration, although a price well spent for the Protection of Health Care and the Promotion of the Public Health.

Public Safety is not qualified to evaluate the health risk/health benefit ratio

They have absolutely no qualifications, education or training in Medicine.

The education and training that they do have actually disqualifies them completely from Medical Care or Medical Mangement.

The only reason why Public Safety is involved is to harm seriously ill patients, to deny health care access and to keep Marijuana Illegal at any cost.

It essential to Stop the Crimes coming out of the Law Enforcement Community directed against seriously ill patients. **If they don't fully support the Medical Marijuana Program as an essential part of health care delivery then they should not be employed by the State of Hawaii.**

If they harm or conspire to harm health care access to Medical Marijuana, by presenting adverse testimony, that is also a criminal act. They might have the education and training to evaluate and testify about the social and economic harm that comes from the Black Market and the harm that comes from the current Prohibition of Marijuana, but it is unlikely that would admit to their anti-social psychopathic past, ongoing and future acts of domestic terrorism.

Since they do not agree with current medical science, since they live in a false reality not supported by medical professionals, that alone fits the definition of Psychosis. Because they present False Medical Testimony they are criminals, high crimes and misdemeanors.

FINTestimony

From: Daryl Matthews [daryl.matthews@gmail.com]
Sent: Thursday, February 21, 2013 4:56 PM
To: FINTestimony
Subject: HB 668, HD 1 – Relating to Health

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: Daryl Matthews, MD, PhD
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support

As a physician who has practiced in Hawaii for over 30 years I would like to offer the following in support of this measure:

Confidential health information about patients belongs in the Department of Health not in the Department of Public Safety. These are seriously ill patients and it makes much more sense that they should register with the health authorities than with law enforcement. The Department of Health has expertise in keeping health information about patients confidential as they already do so for a number of illnesses and other conditions. I understand that on one occasion the Department of Public Safety released the names of medical marijuana patients and their caregivers and physicians to the media. Besides being a huge breach of privacy, it adds to a distrust of the agency. Even under the best circumstances it is intimidating for patients and doctors to have to deal with a police agency over getting their medication.This must surely deter both patients and doctors from participating in the program. To the extent that this happens, the very purpose of the medical marijuana law is defeated.

I hope that this measure is approved by the Committee and that ultimately this unfortunate situation will be corrected by the Legislature.

Thank you for the opportunity to provide the Committee with this testimony.

Respectfully submitted,

Daryl Matthews, MD PhD

FINTestimony

From: Ra Richards [kantspel@gmail.com]
Sent: Thursday, February 21, 2013 5:23 PM
To: FINTestimony
Cc: Rocky Holck; mumclinic@aol.com; forecharlie@msn.com
Subject: Strong support for HB 668 HD1 relating to my health

To: Representative Sylvia Luke, Committee Chair
Representative Scott Nishimoto, Committee Vice-Chair
Representative Aaron Ling Johanson, Committee Vice-Chair
From: rick richards
RE: HB 668, HD 1 – Relating to Health
Hearing: Friday, February 22, 2013, room 308, 1:30 pm
Position: Strong Support

I have spinal arthritis and medical marijuana greatly improves my quality of life.

Ra Richards

I am a sixty year old male with Ankylosing Spondylitis. Ankylosing spondylitis is a long-term disease that causes inflammation of the joints between the spinal bones, and the joints between the spine and pelvis. It eventually causes the affected spinal bones to join together. It is sometimes known as Spinal Arthritis and is a very debilitating and chronic condition. I was diagnosed at Loma Linda University Medical Center many years ago and I have suffered with this painful disease for over 25 years. Along with the spinal problems, I have peripheral joint involvement in my feet, knees, and elbows that produce painful swelling and has resulted in 10 to 20 per cent joint contractures in my left arm and both legs. I also have iritis in my right eye, which is arthritis of the iris of the eye.

Medical Marijuana is very beneficial in the treatment of my disease. I am able to get some relief from the constant pain. I usually take Medical Marijuana only in the evenings to obtain some relief from the chronic pain. As is common with chronic disease, I often suffer from major depression. Medical Marijuana helps to ease my depression also.

There is absolutely no doubt that Medical Marijuana has improved my quality of life a great deal and is an integral part of my treatment along with Bupropion, Tramadol, Carisoprodol, Cyclobenziprine, Prednisone, Cafergot and Atropine Sulfate. Some of these drugs cause stomach problems and Medical Marijuana helps combat those symptoms also.

Please don't take Medical Marijuana away from me and the thousands of other patients that benefit from it's use. Cancer, Glaucoma and many other diseases are helped by the use of Medical Marijuana. This is a known fact. The Federal Government is wrong in their statement that there are no medical uses for Marijuana. I believe this is an attempt by the big drug companies to deceive and manipulate the American Public.

If you need any further information about me or my disease, feel free to contact me and I will be happy to cooperate and help in any manner possible.

Sincerely,

Rick Richards

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The transfer to the Department of Health is worth the money/appropriation to ensure medical cannabis patients, caregivers, and physicians receive the care and attention that they deserve:

- **The transfer to the Department of Health will allow patients/caregivers/physicians to have access to information about the program that will help me stay within the law.**
- **The Department of Health is better equipped to handle a medical program and address the needs of the medical community.**
- **The Department of Health is committed to the well being of the medical cannabis patients, caregivers and physicians.**
- **By putting the right money towards the transfer to the Department of Health, Hawaii's medical cannabis program will be comparable to other states with medical cannabis program and no longer behind the times.**

Over the past 13 years, the NED has not shown that it is qualified to manage a public health program:

- **The NED does not maintain a website on the program and has limited and hard to find information about the program on its current website. Such Information is necessary for patients, caregivers, and physicians trying to stay within the law.**
- **The NED does no public health outreach to inform qualifying patients of the existence of the program. Instead it works from an enforcement and control posture that is inconsistent with managing a health program.**
- **The NED requires physicians to obtain application forms for patients whereas other states (e.g. Oregon and Colorado) provide and accept forms from patients themselves and post the blank forms on their websites.**
- **In the past, the NED has violated patient confidentiality and put Hawaii's sick people at risk by releasing the names and addresses of the registered patients, caregivers and physicians to the media.**

Hawaii's Medical Cannabis program is a health program, not a narcotics enforcement program:

- **The medical cannabis program is a public health program conceived out of concern for the health of the seriously ill. It belongs in Hawaii's Department of Health.**
- **Of the 18 states plus District of Columbia which have medical marijuana programs, only Hawai'i and Vermont house them in a law enforcement agency. Other states have placed the program in a state health department.**
- **Placement in the NED is antithetical to the legislative intent of the measure and to the stated mission of the NED; it is a public health program intended to serve the seriously ill.**
- **Many patients, caregivers, and physicians are intimidated by dealing with a narcotics enforcement agency; they therefore do not register and face the threat of arrest by state or local authorities.**
- **The program's placement in NED is in part responsible for the reluctance of many physicians to certify patients. Physicians are concerned that their program applications are reviewed by the same entity that deals with the Drug Enforcement Agency daily on issues of over-prescribing, "doctor shopping" and the like.**
- **The law requires DOH to set up a protocol for adding new covered medical conditions for which research indicates that cannabis may be helpful. *This provision is in current law, but has never been implemented. This is the only part of the medical marijuana law for which DOH is responsible* . If the entire program were housed in DOH, it would be more likely to activate this provision. Medical research has advanced in the past 13 years and there are many new conditions/ailments/diseases for which medical cannabis has been shown to be helpful.**

Sent from my BlackBerry
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FINTestimony

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 21, 2013 5:43 PM
To: FINTestimony
Cc: bigisland@hawaii.rr.com
Subject: Submitted testimony for HB668 on Feb 22, 2013 13:30PM

HB668
Submitted on: 2/21/2013
Testimony for FIN on Feb 22, 2013 13:30PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Richard Baker	Individual	Support	No

Comments: To: Rep. Sylvia Luke, Chair Rep. Scott Nishimoto, Vice Chair Rep. Aaron Ling Johanson, Vice Chair and the Members of the Committee on Finance From: Richard Baker RE: HB 668 HD1 Relating to Health Position: SUPPORT -Moving the administration of the program from the Department of Public Safety to the Department of Health was one of the top priorities recommended last year by the Medical Cannabis Working Group. -The medical marijuana program should be in a department that has the experience of working with groups of patients and health programs. Easily accessible and easily understandable information on how the program works and outreach for the program are not currently available; this work would more likely be accomplished by a department with the experience and background of implementing other health programs. -By placing the program in the Department of Public Safety, a law enforcement approach rather than a public health approach is being used to administer the program. Current patients and physicians have expressed concern about dealing with a narcotics enforcement agency. The original intent of the law was to create a public health program out of concern for patients with serious or chronic illnesses. -There is also general concern about the records being kept in a law enforcement agency and who may also have access to them. Patients would have more confidence in a health agency as they handle other sensitive and private information about patients. -In a serious breach of privacy, in June 2008, the Department of Public Safety released the entire list of the then 4,000 patients, their addresses, the location of their marijuana plants, license information, and the names of their physicians to Peter Sur, reporter for the Hawaii Tribune-Herald. - Another good reason to move the program is that the Department of Health has the responsibility of considering new medical conditions that would qualify for the program. It seems reasonable that a single agency should be responsible for all aspects of the program.

Please note that testimony submitted less than 24 hours prior to the hearing , improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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