Committee Report

REGULAR CALENDAR

February 22, 2017

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Majority of the Committee on Health, Human Services and Elderly Affairs to which was referred HB 157,

AN ACT adding chronic pain to qualifying conditions under therapeutic use of cannabis. Having considered the same, report the same with the recommendation that the bill OUGHT TO PASS.

Rep. Jerry Knirk

FOR THE MAJORITY OF THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

MAJORITY
COMMITTEE REPORT

Committee:	**Health, Human Services and Elderly Affairs**
Bill Number:	**HB 157**
Title:	**adding chronic pain to qualifying conditions under therapeutic use of cannabis.**
Date:	**February 22, 2017**
Consent Calendar:	**REGULAR**
Recommendation:	**OUGHT TO PASS**

STATEMENT OF INTENT

This bill adds chronic pain to the list of qualifying conditions for the therapeutic use of cannabis. The recent review of the literature by the National Academy of Sciences, Engineering and Medicine determined that there is conclusive evidence that cannabis is effective for the treatment of chronic pain in adults. The use of cannabis in the treatment of a person with chronic pain will likely allow a lower dose of opioid to be used and may completely replace the use of opioids in some patients. This is important given the substantial risks of chronic opioid therapy.

Vote 12-6.

Rep. Jerry Knirk
FOR THE MAJORITY

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

Health, Human Services and Elderly Affairs

HB 157, adding chronic pain to qualifying conditions under therapeutic use of cannabis. **MAJORITY: OUGHT TO PASS. MINORITY: INEXPEDIENT TO LEGISLATE.**

Rep. Jerry Knirk for the **Majority** of Health, Human Services and Elderly Affairs. This bill adds chronic pain to the list of qualifying conditions for the therapeutic use of cannabis. The recent review of the literature by the National Academy of Sciences, Engineering and Medicine determined that there is conclusive evidence that cannabis is effective for the treatment of chronic pain in adults. The use of cannabis in the treatment of a person with chronic pain will likely allow a lower dose of opioid to be used and may completely replace the use of opioids in some patients. This is important given the substantial risks of chronic opioid therapy. **Vote 12-6.**

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

COMMITTEE: Health Human Services and Elderly Affairs

BILL NUMBER: HB 157

TITLE: adding Chronic pain to qualifying Conditions under Therapeutic use of Cannabis

DATE: 2-22-17 **CONSENT CALENDAR:** YES ☐ NO ☒

☒ **OUGHT TO PASS**

☐ **OUGHT TO PASS W/ AMENDMENT**

☐ **INEXPEDIENT TO LEGISLATE**

☐ **INTERIM STUDY** (Available only 2nd year of biennium)

Amendment No. _____

STATEMENT OF INTENT:

This bill adds chronic pain to the list of qualifying conditions for the therapeutic use of cannabis. The recent review of the literature by the National Academy of Sciences, Engineering and Medicine determined that there is conclusive evidence that cannabis is effective for the treatment of chronic pain in adults. The use of cannabis in the treatment of a person with chronic pain will likely allow a lower dose of opioid to be used and may completely replace the use of opioids in some patients. This is important given the substantial risks of chronic opioid therapy

COMMITTEE VOTE: 12-6

RESPECTFULLY SUBMITTED,

Rep. Jerry Knirk
For the Committee

- Copy to Committee Bill File
- Use Another Report for Minority Report

Rev. 02/01/07 - Yellow

REGULAR CALENDAR

February 22, 2017

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Minority of the Committee on Health, Human Services and Elderly Affairs to which was referred HB 157,

AN ACT adding chronic pain to qualifying conditions under therapeutic use of cannabis. Having considered the same, and being unable to agree with the Majority, report with the following resolution: RESOLVED, that it is INEXPEDIENT TO LEGISLATE.

Rep. William Marsh

FOR THE MINORITY OF THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

MINORITY
COMMITTEE REPORT

Committee:	**Health, Human Services and Elderly Affairs**
Bill Number:	**HB 157**
Title:	**adding chronic pain to qualifying conditions under therapeutic use of cannabis.**
Date:	**February 22, 2017**
Consent Calendar:	**REGULAR**
Recommendation:	**INEXPEDIENT TO LEGISLATE**

STATEMENT OF INTENT

As long as the DEA classes cannabis as a Schedule I drug, the minority remains uncomfortable with further expanding this program. Further, existing legislation set up a committee to evaluate potential additions to this program and that committee has not yet been given opportunity to do its job.

Rep. William Marsh
FOR THE MINORITY

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

Health, Human Services and Elderly Affairs

HB 157, adding chronic pain to qualifying conditions under therapeutic use of cannabis. **INEXPEDIENT TO LEGISLATE.**

Rep. William Marsh for the **Minority** of Health, Human Services and Elderly Affairs. As long as the DEA classes cannabis as a Schedule I drug, the minority remains uncomfortable with further expanding this program. Further, existing legislation set up a committee to evaluate potential additions to this program and that committee has not yet been given opportunity to do its job.

Original: House Clerk
Cc: Committee Bill File

MINORITY REPORT

COMMITTEE: Health Human Services.

BILL NUMBER: HB 157

TITLE: Adding chronic pain to qualifying conditions under therapeutic use of cannabis.

DATE: 2/22 **CONSENT CALENDAR:** YES ☐ NO ☒

☐ **OUGHT TO PASS**

☐ **OUGHT TO PASS W/ AMENDMENT**

☒ **INEXPEDIENT TO LEGISLATE**

☐ **INTERIM STUDY** (Available only 2nd year of biennium)

Amendment No. _____

STATEMENT OF INTENT:

As long as the DEA classes cannabis as a Schedule I drug, we remain uncomfortable with further expanding this program. Further, existing legislation set up a committee to evaluate potential additions to this program and that committee has not yet been given opportunity to do its job.

COMMITTEE VOTE: _____

RESPECTFULLY SUBMITTED,

Rep. William Marsh

For the Minority

WILLIAM MARSH.

• Copy to Committee Bill File

Rev. 02/01/07 - Blue

Voting Sheets

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 157

BILL TITLE: adding chronic pain to qualifying conditions under therapeutic use of cannabis.

DATE: 2/22/17

LOB ROOM: 205

MOTION: (Please check one box)

☒ OTP ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # ______ (*if offered*)

☐ Interim Study (2nd year)

Moved by Rep. Kniuk Seconded by Rep. M. MacKay Vote: 12-6

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # ______ (*if offered*)

☐ Interim Study (2nd year)

Moved by Rep. ______ Seconded by Rep. ______ Vote: ______

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # ______ (*if offered*)

☐ Interim Study (2nd year)

Moved by Rep. ______ Seconded by Rep. ______ Vote: ______

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # ______ (*if offered*)

☐ Interim Study (2nd year)

Moved by Rep. ______ Seconded by Rep. ______ Vote: ______

CONSENT CALENDAR: ~~X~~ YES X NO

Minority Report? X Yes ______ No If yes, author, Rep: Marsh Motion 12-6 Y N

Respectfully submitted: Bill Nelson

Rep Bill Nelson, Clerk

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

2017 SESSION

2/15/2017 3:50:33 PM
Roll Call Committee Registers Report

HHS&EA

Bill #: 157 **Title:** Relative To qualifying medical conditions under the therapeutic use of cannabis law

PH Date: 1/25/17 Exec Session Date: 2/32/17

Motion: OTP Amendment #:

MEMBER	YEAS	NAYS
Kotowski, Frank R. Chariman Stephen Schmidt		5
LeBrun, Donald L. Vice Chairman		6
McMahon, Charles E.	1	
Nelson, Bill G. Clerk		1
Guthrie, Joseph A. Carolyn Matthews		2
Donovan, Daniel A.	2	
Fothergill, John	—	
Bove, Martin N.	3	
Edwards, Jess	4	
Fedolfi, Jim		
Marsh, William M.		3
Pearson, Mark		
MacKay, James R.	5	
Freitas, Mary C.	6	
Gordon, Pamela S.	7	
Snow, Kendall A. Cindy Rosenwald	8	
MacKay, Mariellen J.	9	
Long, Patrick T.	10	
Knirk, Jerry	11	
Messmer, Mindi F.	12	
Salloway, Jeffrey C.	1	4
TOTAL VOTE:	12	6

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

2017 SESSION

2/15/2017 3:50:33 PM
Roll Call Committee Registers Report

HHS&EA

Bill #: 157 **Title:** Relative To qualifying medical conditions under the therapeutic use of Cannabis law

PH Date: 1/25/17 Exec Session Date: 2/22/2017

Motion: Amend w. Hdvsd by Rep. Knirk Amendment #: 2017-0366h

MEMBER	YEAS	NAYS
Kotowski, Frank R. Chariman Stephen Schmidt		
LeBrun, Donald L. Vice Chairman		
McMahon, Charles E.		
Nelson, Bill G. Clerk		
Guthrie, Joseph A. Carolyn ~~Matthews~~ Mathews		
Donovan, Daniel A.		
Fothergill, John		
Bove, Martin N.		
Edwards, Jess		
Fedolfi, Jim		
Marsh, William M.		
Pearson, Mark		
MacKay, James R.		
Freitas, Mary C.		
Gordon, Pamela S.		
Snow, Kendall A. Cindy Rosenwald		
MacKay, Mariellen J.		
Long, Patrick T.		
Knirk, Jerry		
Messmer, Mindi F.		
Salloway, Jeffrey C.		
TOTAL VOTE:		

Hearing Minutes

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 157

BILL TITLE: **adding chronic pain to qualifying conditions under therapeutic use of cannabis.**

DATE: **January 25, 2017**

LOB ROOM: **Rep. Hall** **Time Public Hearing Called to Order: 10:03 a.m.**

Time Adjourned: 10:05 a.m.

Committee Members: **Reps. Donovan, J. Edwards, Fedolfi, M. Pearson, Freitas, P. Long and Salloway**

Bill Sponsors:
Rep. Schleien **Rep. E. Edwards** **Rep. Fisher**
Rep. Zaricki **Rep. Josephson**

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Combined Hearing
HB 157, HB 158, HB 159, HB 160
1/25/2017 Rep. Hall

HB - 157 -10:03 a.m - Accepted Bill - Will be discussed in conjunction with other bills that are similar. After all 4 bills are accepted.

After acceptance of HB 157, HB 158, HB 159, HB 160 the Public Hearing began
Time Public Hearing Called to Order: 10:20 am
Time Adjourned - 12:05 pm

Rep. Schleien introduced the bill. Provided 2 amendments 2017-0110h - 2017-0366h
Stephen Boulton - Supports - Chronic pain is with him 24 hours a day. He did not like the medical use of opioids. He has a state card to use cannabis and it has helped significantly. While he is covered, there are others who are not.
Matt Simon – Marijuana Policy Project – support
There are many types of medications.
Should MD's broad discretion to prescribe medications. We have many in our medicine cabinets.
Do we need to add one condition at a time or leave it to MD's
Q. Would he explain different strains. He did Matt Simon
Q. – What is pain? Followed by 3 other questions
A. – I am not a MD
States that have approved cannabis have seen as a decrease in opioids.
Q. – Should a patient be made aware that the Federal Govt considers this illegal?
A. – Yes some types of sign off
Q.- Are people going out of state? Yes
Heather Brown – self – supports bill – she is speaking in favor of all the bills has PTSD and pain couldn't care for children and had constant pain. Why should I be forced to decide what is best for me – feel better using cannabis or have this paid etc.
Mathew Kipp Mile High PMP supports all bills. Different types of cannabis helps different conditions. We need to identify what types help what
Hon Joseph Lachance – self – supports all the bills 100% total disable Vet. Has PTSD and pain. VA got him hooked on opioids and Jack Daniels cannabis has saved his life. Vet community support cannabis use.

Dr. Milly Rossignol (MD) opposes HB 158 there is proof that opioids work. There is not enough evidence that cannabis works there can be a cannabis use disorder, (addiction). She welcomes studies that tell what conditions it will help and the strain of cannabis that works with that condition.
Devon Cheffee – ACLU of NH. Supports all bills. Residents should have the right to use what works.
*Anniha Stanley Smith _CAPHN – opposes all bills. Suggest that all this go back to the state council on the use of therapeutic cannabis youth access had increased. We need strong control. Wants evidence based therapies. Youth have a low perception have harm from cannabis. Kids start at a young age (11 boys – 13 girls) There is research proof that it can help a few specific conditions. All therapies should be reviewed for evidenced practices.
Heather Mullins – self – supports all bills. Feels that data supports use. His dad has benefited from use for PTSD and pain from back.
Erica Golter – self – Approved NH card holder supports bill HB 158 & HB 160. Discussed how cannabis works.
*Kate Frey –New Futures – opposes all bills. A designated council is already in place to review all these things. Each condition should be reviewed separately using evidence based data. Counsel should review all conditions those in place and those proposed.
Derek Cloutier – Ashby, MA. New England Vets Alliance – supports. Has PTSD and it has helped drastically most Vets coming back use alcohol – no number available.
Ellen Brown – Cotuit, MA –New England Vet Alliance Inc. – Supports – She works with Vets and sees that it works. Vets should take what they want.
Rick Naya – NH Norm and other organizations – A Grower of cannabis supports all bills. Use should be between person and doctor.
Q. – Is there a test to determine pain. No test as such. Doctor asks patient to tell them on a scale of 1 – 10.
Chase Roll – Canterbury, NH – New England Veteran Alliance – supports all bills has PTSD
James Alkermansh- Newport, NH – supports HB 160
Dawn Withington – Concord – Supports bill. She self-medicates as her condition does not qualify. Was on opioids and now on cannabis for 30 days. Do we need to make people criminals?

Closed - Public Hearing at 12:05 pm on HB 157,HB 158,HB 159,HB 160

Respectively submitted,

Rep. Bill Nelson, Clerk

After acceptance of bills 157, 158, 159, 160
the hearing began 10:20 - adjourned 12:05

157 10:03 — Accepted Bill - will be discussed in conjunction with other bills that are similar after all 4 bills are accepted

158 10:06 —

159 10:09 —

160 10:15 —

Matt Simon – Marijuana Policy Project – supports
There are many types of medications

should MD's ~~be given~~ broad discretion ~~of~~ To prescribe medications. We have many in our med. cabinets. Do we need To add one condition at a Time or leave it To MD's.

Q – What is pain. ~~What~~ Followed by 3 other questions
(A) I am Not ~~a~~ MD

States that have approved cannabis have seen as a decrease in opiods

Q should a patient be made aware that the Fed Govt considers this illegal.
(B) Yes – some Type of sign off

Q Are people going out of state. Yes.

Heather Brown – self – supports bill –
she is speaking in favor off all the bills
Has PTSD & Pain couldn't ~~Could~~ care for children & ~~pain~~ had constant pain.
why should I be forced To decide what is best for ~~me~~ me – ~~feel~~ feel better using cannabis or have the pain etc.

mile high pmp.

Mathew Kipp supports all bills.

Different Types of cannabis helps different conditions. We need To identify what Types help what

Hon
Rep. Joseph LaChance - self - supports all the bills
100% Total disabled Vet. Has PTSD + pain
Vet got him hooked on opiods + Jack Daniels
Cannabis has saved his life.
It helps
Vet community support cannabis use

Dr. Molly Rossignol (MD) Opposes SB
there is proof that opiods work
~~use is not~~
there is not enough evidence that Cannabis works
there can be a Cannabis use disorder, (addiction)

~~Can cannabis be used To get someone off~~
~~of opiods~~
she welcomes studies that Tell
what it will be be conditions it
will help + the strain of Cannabis
that works with that condition

Devon Chetfee - ACLU of NM. Supports all bills. Residents should have the right to use what works.

~~Anita Sta~~

* Annika Stanley-Smith - CAPHN - opposes All bill suggest that all this go back to the state council on the use of Therapeutic cannabis Youth access has increased, ~~We~~ we need strong control. ~~It is the~~ Wants evidence based ~~decisions~~ therapies Youth have a low perception harm ~~harm~~ from cannabis. ~~He~~ ~~By~~ Kids start at a young age (11 boys 13 girls) There is research proof that it can help a few specific conditions. All therapies should be reviewed for evidenced practices

Heather Mullins - self - supports all bills Feels that data supports use. Her dad has benefited from use for PTSD + pain from back.

~~KE~~ Erica Golfer - self - Approved NM card holder Supports bill 158 + 160 Discussed how cannabis work

* Kate Frey New Futures - opposes All bills

A designated Council is already in place to review all these things. Each condition should be reviewed seperately using evidence based data.
Council should review all conditions - those in place + those proposed

Derek Doutie - Ashby, MA. New England Vets Alliance - supports
Has PTSD + it has helped drastically
most vets coming back use Alchol - No ~~H~~ et available

Ellen Brown - COTUIT, MA. - New England Vet. Alliance ~~[illegible]~~ inc - supports
she works with Vet + see that it works.
Vets should take what they want.

Rick WAYA - NH Norm & other organizations - A ~~NH~~ Grower of cannabis
Supports All bills. Use should be between person + doctor
Q. Q - Is There a Test ~~for~~ To Determine pain. No Test of such. Doc asks patient To Tell them On A Scale of 1-10

(7)

Chase Roll – Canterbury, NH – New England Vet Alliance – supports all bills
NAS PTSD

James Akerman USA – Newport, NH – supports HB 1660

Dawn Withington – Concord – Supports bill
she self medicates as her condition does not qualify. Was on opiodes + now on cannabis for 30 days
Do we need to ~~not~~ make people criminals

closed at 12:05 {157, 158, 159, 166}

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB157 Date January 25, 2017

Committee Health Human Services and Elderly affairs

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
REP DAVID BINFORD	511 INDIAN POND RD ORFORD, NH 03777	603-272 4346	VET GROUP		X
Rep Kurt Wuelper	STRATFORD 3				✓
Matt Simon	Manchester	603-391-7450	Marijuana Policy Project	✓	
Will Anderson	Concord		self	✓	
Heather Mullins	Antrim	774-716-1240	Self	✓	
Rep Linda Gould	Dist 7				X
Rep Dick Hinch - House Majority Office					X
MATHEW KIPP	47 Russell ST	603-300-0834	MILEHigh PAC CONSULTING	✓	
Megan Tomes	47 Russell	603-785-6050		✓	
JOSEPH LACHANCE	03104	370 1767		✓	
Deron Chaffee		ACLU of NH		✓	
Rick NAYA		NH NORML		✓	
Annika Stanley-Smith		CAPHN			✓
Denis Goddard	Hopkinton	NH Liberty Alliance		✓	
Scott Murphy President	Veterans for Safe Access & Comp Care			✓	
Erica Eccher		603.332.9382		✓	
Gabrielle Holland		603-942-7331		✓	
Rep Nick Zaricki				✓	
Rep Robert Fisher	603-706-8070	Belmont/Laconia		✓	
Rep Rene Cushing		Rock 21		✓	
Rep. Elizabeth Edwards			Hills. 11	X	
David Crawford	Keene	Keene		X	
Rep. Stone			self	✓	

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB157 Date January 25, 2017

Committee Health, Human Services and Elderly affairs

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Hon Dr Joe Hannon	Lee NH			✓	
Rep Sherry Frost	Dover 16			✓	
Chase Roll	Canterbury			—	
Rep. Caleb Q. Dyer	Pelham			✓	
Kimberley Todd				✓	

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # 157 Date 1/25/17

Committee HHS

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Paul Morrissette	741 Oak Hill	731-0098	—	✓	
Lisa Powers	25 Roy St Manchester NH 03102	6033157966	—	✓	
Audrey Guido				✓	
Kevin Miller				✓	
Representative Glen Aldrich			Gilford/Meredith	✓	
Rep Don LeBrun					✓

Testimony

To: New Hampshire House Committee on Health and Human Services

January 24, 2017

RE: HB 157, HB 159, HB 197, HB 160, HB 222 allowing the addition of chronic pain, intractable pain, fibromyalgia, PTSD and myelitis to qualifying conditions.

I am currently a Pain Specialist who provides certification for my chronic pain patients for Medical Cannabis as part of my treatment regimes. I have found the current qualifying conditions unnecessarily restrictive and as a former member of the Therapeutic Cannabis Advisory committee I expressed my concerns that this would be the case once certifications were initiated.

The majority of my patients suffer from chronic upper, mid and/or low back pain, Fibromyalgia, PTSD, Osteoarthritis, Multiple Sclerosis and headache pain. Many if not most have tried many forms of treatment including medications, interventional injections, surgery as well as, conservative treatments such as chiropractic, acupuncture and massage. Many patients in my practice have found medical marijuana effective as a sleep, pain and muscle spasm treatment. This modality has allowed me to keep narcotic and sedative medications as low as possible while giving patients relief from their all-consuming pain. I have had family members who were skeptical about the use of marijuana for medications tell me how grateful they are that they have the ability to use this for their loved ones pain. I believe that there are many more qualifying conditions which should be added and the dispensaries should be compelled to get product to those who need it at a reasonable cost. For returning Veterans PTSD is a major condition which contributes to chronic pain and depression. We need to add this condition to care for our Veterans as soon as possible.

Please move forward with the addition of these conditions to the approved conditions for Therapeutic Cannabis program.

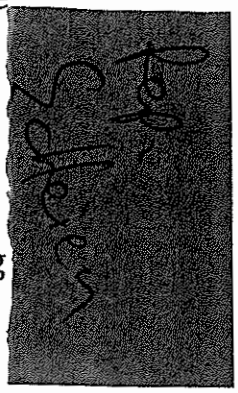
Thank you for your attention to this matter.

Kelly DeFeo CRNA, FNP-BC, DAAPM
AVH surgical Associates, Pain Clinic
7 Page Hill Rd
Berlin, NH 03570-3531
603-387-4523 Cell

Amendment introductions

Chronic pain (HB 157)

23 out of 28 state medical cannabis laws include pain as a general qualifying condition. However, in New Hampshire, medical providers can only certify patients for the therapeutic cannabis program if they experience "severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, and if their severe pain is connected to one of the qualifying conditions that is specifically listed in the law. New Hampshire's law is unique in that it requires patients to have both a qualifying condition **and** a qualifying symptom; most states require either a qualifying condition or symptom but not both.



The Senate has already passed SB 15, which creates a general qualifying condition for "severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects." This means that severe pain, as defined, would no longer have to be connected to a specific medical condition such as cancer. This would be an improvement; however, it is still a much higher standard than is required for the prescription of opioids.

I've learned that HB 157, as introduced, would basically do the same thing as SB 15 because "chronic pain" would still be tied to "severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects" by the word AND. Since opioids are often prescribed for moderate to severe chronic pain, which is a much less stringent standard, I would ask that you consider this amendment.

You'll hear testimony today about how patients who have successfully reduced or eliminated their need for opioids by substituting medical cannabis. Making it easier for doctors to recommend cannabis for moderate to severe chronic pain can be an important tool in addressing the opiate problem, so it's time that we start giving doctors more discretion to do what they think is best for their patients.

PTSD (HB 160)

This draft amendment follows the same structure of the draft amendment to HB 157: it would create a general qualifying condition for post-traumatic stress disorder. I've been told that this is necessary because, once again, of the AND between condition and symptom. There are not currently any symptoms of PTSD listed in the law, so it would be insufficient to merely add PTSD to the list of qualifying conditions.

17-0516
01/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Seventeen

AN ACT relative to the law regarding therapeutic use of cannabis.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Use of Cannabis for Therapeutic Purposes. Amend RSA 126-X:1, IX(a) to read as follows:

IX.(a)(1) "Qualifying medical condition" means the presence of:

[~~(1)~~] ***(A)*** Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C currently receiving antiviral treatment, amyotrophic lateral sclerosis, muscular dystrophy, Crohn's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, epilepsy, lupus, Parkinson's disease, Alzheimer's disease, ulcerative colitis, or one or more injuries that significantly interferes with daily activities as documented by the patient's provider; and

[~~(2)~~] ***(B)*** A severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy-induced anorexia, wasting syndrome, agitation of Alzheimer's disease, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms[.]***; or***

(2) "Qualifying medical condition" also means severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects.

2 Effective Date. This act shall take effect 60 days after its passage.

Medical Marijuana Access Can Help Fight the Opioid Epidemic

Allowing people who suffer from chronic pain to use marijuana helps reduce opiate use.

- A recent study found **a 48% reduction in patients' opioid use** after three months of medical marijuana treatment.[1] A survey of 542 patients using cannabis in addition to opioids found that 39% reduced their opioid dosage and another 39% stopped using opioids altogether.[2]
- Health Affairs reported that doctors in a state where marijuana was legal prescribed an average of **1,826 fewer doses of painkillers per year** to patients enrolled in Medicare Part D — which resulted in significant cost savings.[3]
- Scientists have found that when cannabis is used in combination with prescription opioids, it increases their pain-relieving properties, so patients can reduce their dosage and get the same effect.[4]
- Researchers at Columbia University's School of Public Health found that, in states that passed medical marijuana laws, fewer drivers killed in car crashes tested positive for opioids after the laws went into effect.[5]

Medical marijuana access is also associated with reduced opioid overdose deaths.

- A study published in the Journal of the American Medical Association in 2014 found that **opioid overdose deaths were reduced by 25% in states with effective medical marijuana laws.**[6]

No credible studies have ever supported the theory that the physical effects of marijuana are a gateway to opiate use.

- "There is no evidence that marijuana serves as a stepping stone on the basis of its particular physiological effect." - Institute of Medicine[7]
- "Overall, research does not support a direct causal relationship between regular marijuana use and other illicit drug use." - Drug Enforcement Administration[8]

In fact, available evidence suggests that cannabis is an "exit drug" that can help people struggling to stop using alcohol and opioids.

- An international team recently conducted one of the most comprehensive surveys of its kind, which examined 60 studies on cannabis and mental health, and found that: "Research suggests that people may be using cannabis as an exit drug to reduce use of substances that are potentially more harmful, such as opioid pain medication." - Zach Walsh, Psychology Professor at the University of British Columbia and lead author of the study[9]

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[1] Staci A. Gruber, *et al.* "Splendor in the Grass? A Pilot Study Assessing the Impact of Medical Marijuana on Executive Function," *Front. Pharmacol.*, 13 Oct. 2016, Vol. 7.
[2] The Cannabis and Opioid Survey." Healer.com, 4 Oct. 2016.
[3] Ashley C. Bradford *et al.* "Medical Marijuana Laws Reduce Prescription Medication Use In Medicare Part D," *Health Aff.* July 2016, Vol. 35 no. 7.
[4] Abrams, Donald *et al.* "Cannabinoid-Opioid interaction in chronic pain," *Clinical Pharmacology & Therapeutics*, vol.90, no. 6 (2011).
[5] June H. Kim, *et al.*, "State Medical Marijuana Laws and the Prevalence of Opioids Detected Among Fatally Injured Drivers," *Am. J. of Pub. Health*, Nov. 2016, Vol. 106 no.11.
[6] Marcus A. Bachhuber, *et. al.*, "Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2010," *JAMA Intern Med.* Oct. 2014, Vol. 174 no. 10.
[7] *Marijuana and Medicine: Assessing the Science*, Institute of Medicine of the National Academy of Sciences (1999).
[8] Denial of Petition to Initiate Proceedings to Reschedule Marijuana, Federal Register, Doc. # 2016-17954, 8/12/16.
[9] University of British Columbia, "Marijuana could help treat drug addiction, mental health, study suggests," ScienceDaily, Nov. 16, 2016.

Medical Cannabis Laws and Chronic Pain

Twenty-three of the 28 state medical cannabis laws allow patients to qualify if they suffer from pain.[1] This ensures patients with a variety of excruciating conditions — from phantom limb pain to rare diseases like multiple congenital cartilaginous exostoses — are allowed to use a far less dangerous treatment option than prescription painkillers. Cannabis is also an important option for pain patients who do not respond to other treatments.

The variation in the different medical cannabis states, with some being extremely restrictive and others making it easier for patients with chronic pain to have the option of medical cannabis, can be seen below.

Language	State(s)
Any condition qualifies if a physician — or in D.C., a medical practitioner — believes cannabis may alleviate it	California and Washington, D.C.
"A disease, medical condition, or its treatment that is chronic, debilitating, and produces ... **chronic pain**"	Vermont
"A chronic or debilitating disease or medical condition, or treatment [for such conditions, which produces] ... **severe pain**"	Colorado, Hawaii, and Maryland
"A medical condition or treatment for a medical condition that produces ... **severe pain**"	Nevada and Oregon
"A chronic or debilitating disease or its treatment that produces ... **severe pain**"	Alaska
"A chronic or debilitating disease or medical condition or its treatment that produces ... **severe and chronic pain**"	Arizona and Michigan
"A chronic or debilitating disease or medical condition, or its treatment, that produces ... **debilitating, chronic pain**"	Rhode Island
"Pain that is either... **chronic and severe or intractable.**"	Ohio
"**Painful peripheral neuropathy**" and "**severe chronic pain**" with objective proof and two physician certifications	New Mexico

[1] The New York Department of Health announced on December 1, 2016 that it plans to add chronic pain as a qualifying condition. It is not included yet because it must go through a rule-making process before it is officially added.

Language	State(s)
Severe, debilitating pain "that has not responded to previously prescribed medication or surgical measures for more than 3 months **or for which other treatment options produced serious side effects"**	Delaware, North Dakota
"Intractable pain ... [which is] unrelieved by standard medical treatments and medications"	Washington
"**Severe chronic or intractable pain** in which conventional therapeutic intervention and opiate therapy is contraindicated or ineffective."	Pennsylvania
Any debilitating medical condition that the physician believes cannabis may alleviate qualifies if it is "of the same kind or class as or comparable to those enumerated;" which are serious conditions such as HIV/AIDS and cancer.	Florida
Intractable pain that has not responded to ordinary medical or surgical measures for more than six months.	Maine and Arkansas
A condition causing "**intractable pain ...** and progressing to such an extent that **one or more of a patient's major life activities is substantially limited.**"	Massachusetts
Intractable pain — "a pain state in which the cause of the pain cannot be removed or otherwise treated with the consent of the patient and which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts."	Minnesota
"**Severe chronic pain** that is persistent pain of severe intensity **that significantly interferes with daily activities** as documented by the patient's treating physician and by: (i) Objective proof of the etiology of the pain, including relevant and necessary diagnostic tests that may include but are not limited to the results of an x-ray, computerized tomography scan, or magnetic resonance imaging; or (ii) Confirmation of that diagnosis from a second physician who is independent of the treating physician and who conducts a physical examination."	Montana

The Endocannabinoid System – How does Marijuana Work Therapeutically? Dr. Dustin Sulak Explains.

February 25, 2016
Popular, United Patients Group

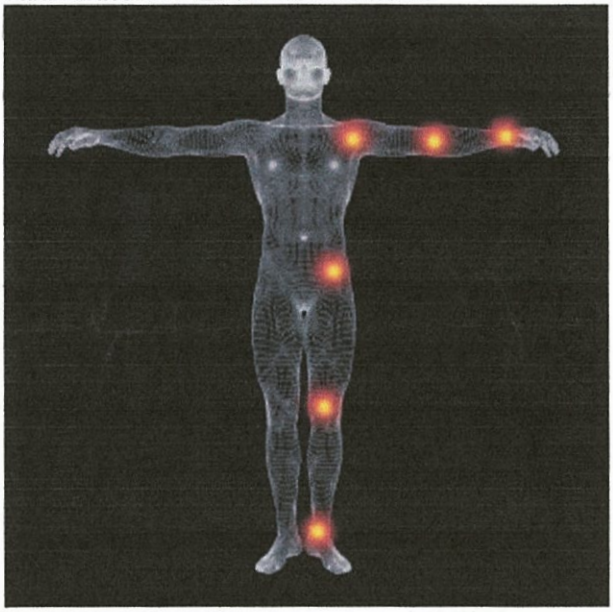
← state of maine Doctor Dustin, Sulak

At our integrative medical clinics in Maine and Massachusetts, my colleagues and I treat over 18,000 patients with a huge diversity of diseases and symptoms. In one day I might see cancer, Crohn's disease, epilepsy, chronic pain, multiple sclerosis, insomnia, Tourette's syndrome and eczema, just to name a few. All of these conditions have different causes, different physiologic states, and vastly different symptoms. The patients are old and young. Some are undergoing conventional

therapy. Others are on a decidedly alternative path. Yet despite their differences, almost all of my patients would agree on one point: ***cannabis helps their condition***.

How can one herb help so many different conditions? How can it provide both palliative and curative actions? How can it be so safe while offering such powerful effects? The search to answer these questions has led scientists to the discovery of a previously unknown physiologic system, a central component of the health and healing of every human and almost every animal: The Endogenous Cannabinoid System, also known as the Endocannabinoid System or ECS.

The ECS has three basic components: endocannabinoids, cannabinoid receptors, and hydrolytic enzymes that break down endocannabinoids. Endocannabinoids



aremolecules produced by cells that have activity similar to THC and the other phytocannabinoids (plant-derived cannabinoids). They are synthesized on the cell membrane from omega-6 fatty acid precursors. Both endo – and phytocannabinoids act on cannabinoid receptors, known as CB1 and CB2, found throughout the body. Stimulating the CB receptors leads to a variety of physiologic processes inside the cell. Finally, enzymes responsible for the breakdown and recycling of endocannabinoids, MAGL and FAAH, modulate the activity of the ECS.

Sea squirts, newts, rodents, and all vertebrate species share the endocannabinoid system as an essential part of life and adaptation to environmental changes. By comparing the genetics of cannabinoid receptors in different species, scientists estimate that the endocannabinoid system evolved in primitive animals over 600

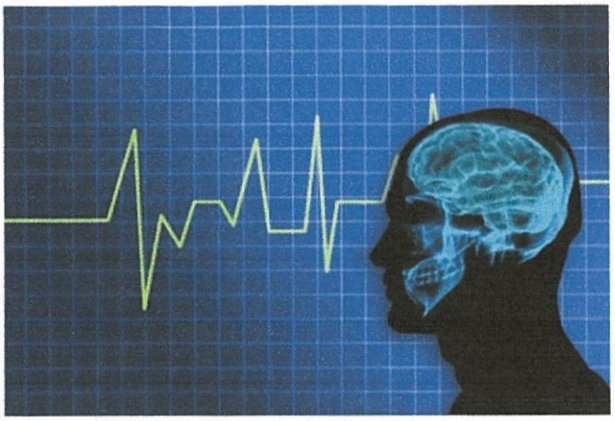
million years ago, long before the cannabis plant evolved 34 million years ago.

The ECS is perhaps the most important physiologic system involved in establishing and maintaining human health. Endocannabinoids and their receptors are found throughout the body: in the brain, organs, connective tissues, glands, and immune cells. In each tissue, the cannabinoid system performs different tasks, but the goal is always the same: ***homeostasis***, the maintenance of a stable internal environment despite fluctuations in the external environment. Cannabinoids promote homeostasis at every level of biological life, from the sub-cellular, to the organism, and perhaps to the community and beyond.

Endocannabinoids are found at the intersection of the body's various systems, allowing communication and coordination between different cell types. At the site of an injury, for example, cannabinoids can be found decreasing the release of activators and sensitizers from the injured tissue, stabilizing the nerve cell to prevent excessive firing, and calming nearby immune cells to prevent release of pro-inflammatory substances. Three different mechanisms of action on three different cell types for a single purpose: minimize the pain and damage caused by the injury.

The endocannabinoid system, with its complex actions in our immune system, nervous system, and all of the body's organs, is literally a bridge between body and mind. By understanding this system we begin to see a mechanism that explains how states of consciousness can promote health or disease.

In addition to regulating our internal and cellular homeostasis, cannabinoids caninfluence a person's relationship with the external environment. Socially, the administration of cannabinoids (especially THC) can alter human behavior, often promoting sharing, humor, and creativity. By mediating neurogenesis (the growth of new brain cells), neuronal plasticity (forming new connections



between brain cells), and learning, cannabinoids may directly influence a person's open-mindedness and ability to move beyond limiting patterns of thought and behavior from past situations. Reformatting these old patterns is an essential part of health in our quickly changing environment.

As we continue to sort through the emerging science of cannabis and cannabinoids, one thing remains clear: a functional cannabinoid system is essential for health. From embryonic implantation on the wall of our mother's uterus, to nursing and growth, to responding to injuries, endocannabinoids help us survive in a quickly changing and increasingly hostile environment. A body of evidence is now emerging that links endocannabinoid deficiency to a variety of diseases, including migraine, fibromyalgia, irritable bowel syndrome, and even infant colic. As I realized this, I began to wonder: can an individual enhance his/her cannabinoid system by taking supplemental cannabis? Beyond treating symptoms, beyond even curing disease, can cannabis help us prevent disease and promote health by stimulating an ancient system that is hard-wired into all of us?

I now believe the answer is yes. Research has shown that small doses of cannabinoids from cannabis can signal the body to make more endocannabinoids and build more cannabinoid receptors. This may be why many first-time cannabis users don't feel an effect, but by their second or third time using the herb they have increased cannabinoid sensitivity and are ready to respond. More receptors increase a person's sensitivity to cannabinoids; smaller doses have

cont...

Read more info at
healer.com
or Google
Dr. Dustin Sulak.

Also, You Tube
has many videos.

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State of New Hampshire
Inter-Department Communication

DATE: February 13, 2014

FROM: Michael K. Brown Senior Assistant Attorney General
Attorney General's Office
Frank C Fredericks, Attorney
Attorney General's Office

SUBJECT: Request for Advice on Interpretation of Therapeutic Cannabis Law, RSA 126-X

TO: Mary P. Castelli, Department of Health and Human Services, Senior Director, Office of Operations Support

I. Introduction

On February 5, 2014, the New Hampshire Department of Health and Human Services ("the Department"), Office of Operation Support requested from the New Hampshire Office of the Attorney General advice on the interpretation of New Hampshire's Therapeutic Cannabis Law, RSA 126-X. Specifically, the Department requests advice on two issues of law:

1. Whether under RSA 126-X, the Department should issue qualifying patient and designated caregiver registry identification cards prior to the availability of a lawful source from which New Hampshire residents may obtain cannabis; and

2. How may the Department implement RSA 126-X:1, IX(b), which provides for the recognition of qualifying medical conditions that are not expressly enumerated in RSA 126-X:1, IX(a)'s list of medical conditions that qualify for the therapeutic cannabis use?

In response to question one, it is the opinion of the Office of the Attorney General that the Department should not issue qualifying patient and designated caregiver registry identification cards prior to the availability of a lawful source of cannabis in New Hampshire as RSA 126-X does not contemplate the purchase or sale of cannabis from any source other than an alternative treatment center ("ATC"), as defined by RSA 126-X:1, I. In response to question two, it is the opinion of the Office of the Attorney General that the Department should develop a procedure though which citizens whose medical conditions do not fall within the express terms RSA 126-X, IX(a) can formally request review of their condition and their need for therapeutic cannabis use.

II. Analysis

A. The Issuance of Qualifying Patient Registry Identification Cards

i. Timeframes Under RSA 126-X

RSA 126-X:6, I provides, in relevant part, that "Not later than one year after the effective date of this chapter, the department shall adopt rules pursuant to RSA 541-A governing:

(a) The form and content of applications for the issuance and renewals of registry identification cards for qualifying patients and designated caregivers;
(b) The form and content of providers' written certifications; [and]
(c) Procedures for considering, approving, and denying applications for issuance and renewals of registry identification cards, and for revoking registry identification cards; . . .

RSA 126-X:6, I(a)-(c). Thus, while the above statutory mandate pertains to the development of the form and content of applications and procedures for considering applications by July 23, 2014, it does not establish a date by which the Department must begin to accept applications or issue registry identification cards.

Similarly, RSA 126-X:6, III(a) sets forth that "Not later than 18 months after the effective date of this section, the department shall adopt rules, pursuant to RSA 541-A, governing alternative treatment centers and the manner in which it shall consider applications for registration certificates for alternative treatment centers . . . ." Thus like RSA 126-X:6's establishment of a July 23, 2014 deadline by which the Department is to create rules regarding the application process for patient and caregiver registration identification cards, RSA 126-X:6, III provides for a January 23, 2015, deadline by which the Department must produce rules regarding the governing of ATCs and application process for obtaining ATC registration certificates. RSA 126-X:6, therefore, provides dates by which the Department must have certain evaluative procedures and processes in place, but does not establish a date by which the Department must issue the resultant qualifying patient and designated caregiver registry identification cards or ATC registration certificates.

RSA 126-X:7, I supplies such a deadline for the Department's issuance of ATC registration certificates stating that "Within 18 months of the effective date of this section, provided that at least 2 applications have been submitted that score sufficiently high to receive a certificate, the department shall issue alternative treatment center registration certificates to the 2 highest-scoring applicants." Therefore, while RSA 126-X:7 establishes a date by which the Department must issue two ATC registration certificates, there is no such temporal requirement regarding the Department's issuance of qualifying patient and designated caregiver registry identification cards.

ii. The Department is Not Required to Accept or Issue Patient and Caregiver Registry Identification Cards Until the ATCs are Operational

1. RSA 126-X Does Not Provide for Any Form of Cannabis Cultivation or Sale Other than By ATCs

RSA 126-X:1, I defines ATC as "a not-for-profit entity registered under RSA 126-X:7 that acquires, possesses, cultivates, manufacturers, delivers, sells, supplies, and dispenses cannabis, and related supplies and educational materials, to qualifying patients and alternative treatment centers." The statute does not grant any other person or entity the right to engage in cultivating, manufacturing, selling, supplying, or dispensing cannabis. *See generally* RSA 126-X. Without operational ATCs, there is no legal means for a qualifying patient or designated caregiver to obtain cannabis. Therefore, the Department's issuance of qualifying patient and designated caregiver registry identification cards prior to the opening of any ATC would have the effect of prematurely entitling persons to RSA 126-X:5's affirmative defense to cannabis-related crimes before the medication is made available through a lawful and accountable source.

2. RSA 126-X Provides for the Close Regulation of ATCs Further Indicating the Legislature's Intent that Only These Centers Are Permitted to Cultivate and Sell Cannabis Under the Law

An examination of RSA 126-X:8, I–XVIII demonstrates that the legislature aimed to subject ATCs to comprehensive regulation and significant state oversight in order to: carefully control distribution; prevent diversion; maintain quality control; and develop a database regarding the effectiveness of particular cannabis strains and methods of delivery. This extensive regulation of the cannabis produced and distributed in New Hampshire pursuant to RSA 126-X:8, further indicates that the legislature intended the state-sanctioned and Department-monitored ATCs to be the sole legal cultivators and dispensers of cannabis in this state.

For example, in regard to control of cannabis distribution, RSA 126-X: 8, IV(c) provides that in moving cannabis from a cultivation site to the ATC, the ATC agent must label the transported cannabis with the ATC's name, registry number as well as the time, date, origin, and destination of the cannabis and the amount and form of the cannabis. Additionally, in regard to prevention of diversion, RSA 126-X: 8, XV(c) requires that "All cultivation of cannabis shall take place in an enclosed, locked facility registered with the department . . . ." Further, in regard to quality control, RSA 126-X: 8, X, mandates that ATCs only use organic pesticides in cannabis. Finally, with regard to data collection, RSA 128-X:8, XVI(b) requires ATCs to "collect data on strains used and methods of delivery for qualifying conditions and symptoms, any side effects experienced and therapeutic effectiveness for each patient . . ."

Based on the examples provided above, which are merely a few of the numerous controls that ATCs must comply with under RSA 126-X, it is evident that the legislature did not intend for qualifying patients to receive cannabis from any source not held to these high standards.

Consequently, until ATCs are operational the Department should refrain from issuing qualifying patient and designated caregiver registry identification cards.

3. Therapeutic Use, as Defined by RSA 126-X:1, XIII, Does Not Extend to Beyond ATCs, Qualifying Patients, and Designated Caregivers

RSA chapter 126-X protects only the "therapeutic use" of cannabis. RSA 126-X:2, I(A). Under the statute, therapeutic use is defined as "the acquisition, possession, cultivation, preparation, use, delivery, transfer, or transportation of cannabis . . . relating to the administration of cannabis to treat or alleviate a qualifying patient's qualifying medical condition." RSA 126-X:1, XIII. RSA chapter 126-X, therefore, only envisions three therapeutic users of cannabis that may legally acquire cannabis in this state: 1) ATCs; 2) qualifying patients; and 3) designated caregivers.[1] RSA 126-X:1, I, VI, X. Cultivation of cannabis by qualifying patients and designated caregivers is expressly prohibited. RSA 126-X:1, XIII. Cultivation is, therefore, reserved entirely to ATCs. Similarly, the definition of ATC includes the phrase "sells, supplies, and dispenses cannabis" and the term "manufacture," while the definitions of qualifying patient, designated caregiver, and therapeutic use do not. RSA 126-X:1, I, VI, X. Thus, under RSA chapter 126-X, only ATCs can engage in the acts of cultivating, manufacturing, selling, supplying, and dispensing cannabis and, as a result, until the ATCs are operational, cannabis cannot be legally cultivated, sold, supplied or dispensed in New Hampshire. As stated above, until a legal source exists by which qualifying patients and designated caregivers can obtain cannabis, the Department need not issue registry identification cards.

B. Recognition of Qualifying Medical Conditions that are Not Expressly Enumerated in RSA 126-X:1, IX(a)'s List of Permitted Medical Conditions

i. Qualifying Medical Conditions

RSA 126-X:1, IX establishes a two-prong test to determine whether a patient's medical condition qualifies for the therapeutic use of cannabis. The first prong consists of a list of specified qualifying medical diagnoses. These include: cancer, glaucoma, muscular dystrophy and several other medical diagnoses. RSA 126-X:1, IX(a)(1). A patient satisfies the first prong if a physician has diagnosed the patient with one of these specific illnesses. *See id.* The second prong consists of a list of qualifying symptoms/conditions that are coincident with a diagnosis from prong one and is severely debilitating or terminal.[2] These include, for example, elevated intraocular pressure, wasting syndrome, and severe pain that has not responded to previously prescribed medication or surgical measures. RSA 126-X:1, IX(a)(2). Therefore, if the patient has a diagnosis from prong one and a symptom/condition from prong two that is severely

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[1] RSA 126-X does permit some limited therapeutic use by visiting qualifying patients, however, this does not include the right to purchase or obtain cannabis in this state. *See* RSA 126-X:2, V ("A visiting qualifying patient shall not cultivate or purchase cannabis in New Hampshire or obtain cannabis from alternative treatment centers or from a qualifying New Hampshire patient.")

[2] The qualifying symptom/condition under the second prong may also result from the treatment of a diagnosed illness provided for under the first prong. RSA 126-X:1, IX(a)(2).

debilitating or terminal, the Department may approve the patient's application for therapeutic use of cannabis.

In addition to the two-prong test delineated above, RSA 126-X:1, IX(b) provides that "the department may include a medical condition that is not listed in subparagraph (a) that the department determines, on a case by case basis, is severely debilitating or terminal, based upon written request of the provider who furnishes written certification to the department." Therefore, the Department need not limit qualifying patients to those who suffer from the express list of diagnoses provided in RSA 126-X:1, IX(a)(1), but may expand the qualifying conditions on a case by case basis. *See* RSA 126-X:1, IX(b).

The Department requests guidance on how it should interpret and implement RSA 126-X:1, IX(b)'s elasticity in regard to qualifying medical conditions. When examining RSA 126-X, IX as a whole, two legislative considerations are apparent. First, the legislature's explicit enumeration of qualifying conditions in RSA 126-X:1, IX(a)(1) evidences an intent that the Department not take an all inclusive approach expanding the qualifying conditions under RSA 126-X:1, IX(b). If, for example, the Department accepted without further examination every physician certification averring that cannabis is required to treat a severely debilitating condition, the RSA 126-X:1, IX(b) exception would swallow RSA 126-X:1, IX(a)'s deliberate limitations on qualifying medical conditions. While this is the case, the existence of RSA 126-X:1, IX(b) as a means of permitting therapeutic use of cannabis for medical conditions not provided in RSA 126-X:1, IX(a) indicates that the legislature sought to ensure that those who could demonstrate a true medical need for cannabis are not foreclosed from obtaining the medication by an overly rigid interpretation of the law.

The Department should, therefore, create a procedure that strikes a balance between: 1) limiting the therapeutic use of cannabis to conditions that medical professionals have firmly established as treatable by cannabis; and 2) those circumstances where medical research is still developing or where medical professionals believe that the therapeutic use of cannabis will provide benefit in a specific case and have valid scientific evidence to support this conclusion.

ii. Connecticut Procedure

The procedure developed by the State of Connecticut is instructive. Similar to RSA 126-X:1, XI(a) discussed above, Connecticut's palliative use of marijuana statute defines its qualifying medical conditions by listing specific diagnoses and conditions that are approved for the therapeutic use of cannabis, and like RSA 126-X:1, XI(b) also includes language that permits expansion of the list with agency approval. More specifically, the statute reads:

> Debilitating medical condition means (A) cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome, Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, posttraumatic stress disorder, or (B) any medical condition, medical treatment or disease approved by the Department of Consumer Protection pursuant to regulations adopted under section 21a-408m.

Conn. Gen. Stat. § 21a-408(2)(A)-(B).

The Connecticut regulation cited in the statute provides for the creation of a board designated to review written petitions to the commissioner of the Department of Consumer Protection and, following such review, to author a written recommendation as to whether the commissioner should add the condition at issue to the list of debilitating medical conditions under the Connecticut law. *See* Conn. Agencies Reg. § 21a-408-12(a)–(b). Under the Connecticut regulation the petition must include:

> (1) The extent to which the medical condition, medical treatment or disease is generally accepted by the medical community and other experts as a valid, existing medical condition, medical treatment or disease;
>
> (2) If one or more treatments for the condition, rather than the condition itself, are alleged to be the cause of a patient's suffering, the extent to which the treatments causing suffering are generally accepted by the medical community and other experts as valid treatments for the condition;
>
> (3) The extent to which the condition or the treatments thereof cause severe or chronic pain, severe nausea, spasticity or otherwise substantially limits one or more major life activities of the patient;
>
> (4) The availability of conventional medical therapies, other than those that cause suffering, to alleviate suffering caused by the condition or the treatment thereof;
>
> (5) The extent to which evidence that is generally accepted among the medical community and other experts supports a finding that the use of marijuana alleviates suffering caused by the condition or the treatment thereof;
>
> (6) Any information or studies known to the petitioner regarding any beneficial or adverse effects from the use of marijuana in patients with the medical condition, medical treatment or disease that is the subject of the petition; and
>
> (7) Letters of support from physicians or other licensed health care professionals knowledgeable about the condition, treatment or disease.

§ 21a-408-12(c)(1-7).

If a written petition satisfies the above requirements, "the commissioner shall refer the written petition to the board for a public hearing at the next board meeting." Conn. Agencies Reg. § 21a-408-12(e). Following the public hearing, "the board shall consider the public comments and any additional information or expertise made available to the board for each proposed debilitating medical condition considered at the hearing." § 21a-408-12(i). In its written recommendation to the commissioner the board includes:

> (1) Whether the medical condition, medical treatment or disease is debilitating;
>
> (2) Whether marijuana is more likely than not to have the potential to be beneficial to treat or alleviate the debilitation associated with the medical condition, medical treatment or disease; and
>
> (3) Other matters that the board considers relevant to the approval or the denial of the petition.

Id. Based on the recommendation of the board, the commissioner determines whether to accept the condition at issue as a debilitating medical condition for which the therapeutic use of cannabis is warranted and permitted. *See* § 21a-408-12(k).

The Department is not, pursuant to RSA 126-X, IX(b), required to utilize a procedure identical to the Connecticut system set out above when considering whether a medical condition not expressly provided for under RSA 126-X, IX(b) justifies the therapeutic use of cannabis. In fact, differences would likely be required as the New Hampshire statute refers to expansion on a case by case basis whereas the Connecticut law appears to refer to expansion on a condition or diagnosis basis.[3] The Connecticut regulation is merely an illustration of a procedure that balances the need for clinical support of the efficacy of the therapeutic use of cannabis as to particular condition with the need to maintain an avenue through which citizens whose conditions do not fall within the express terms RSA 126-X, IX(a) can formally request review of their condition and their need for therapeutic cannabis use.

[3] The case by case basis requirement will also likely require the Department to take steps to ensure that the patient-applicant's medical information is kept confidential throughout the process.

III. Conclusion

For the reasons provided above, it is the opinion of the Office of the Attorney General that:

1. The Department should not issue patient and caregiver registry identification cards prior to the availability of a lawful source of cannabis in New Hampshire as RSA 126-X does not contemplate the purchase of cannabis from any source other than an ATC, as defined by RSA 126-X:1, I; and

2. The Department should develop a procedure though which citizens whose medical conditions do not fall within the express terms RSA 126-X, IX(a) can formally request review of their condition and their need for therapeutic cannabis use.

Sincerely,

Michael K. Brown
Senior Assistant Attorney General
Civil Bureau
(603) 271-3650

Doc# 1003737

Testimony to the House Health, Human Services and Elderly Affairs Committee in Opposition to HB157, HB158, HB159, HB160, HB197, HB222, and HB472 (relative to changing the qualifying conditions for Therapeutic Marijuana).
January 25, 2017

The Capital Area Public Health Network strongly opposes the aforementioned House bills because they could result in adverse health and public safety consequences, particularly among New Hampshire's youth.

Hello, I would like to start by thanking the committee for their service to New Hampshire and for the opportunity to speak to this complex issue. My name is Annika Stanley-Smith, I live in Goffstown and I work for the Capital Area Public Health Network as a Substance Misuse Prevention Coordinator in Concord. I am here to share how these bills could negatively impact New Hampshire's youth and other vulnerable populations.

I work with schools, businesses, and communities, including Concord and 23 of its surrounding towns to turn back the tide on addiction. A big proponent of the work I do for these towns is looking at the data to see what the highest needs are and researching evidence based programs and practices that are proven to prevent or reduce substance use. Some of that data is really complex and I use my peers, the New Hampshire Center for Excellence, and the experts the Bureau of Drug and Alcohol services to sort through everything and find the best fit for each town. The data around what are effective or ineffective uses of therapeutic marijuana is equally, if not more complex. It's something that should be reviewed and evaluated in a similar way. We believe that this time intensive task should be taken on by the Therapeutic Cannabis Advisory Council so that no decisions are made in haste that results in increased substance use.

Our other concern with the aforementioned bills is that they could increase the access to youth use of marijuana. According to the 2015 National Survey on Drug Use and Health, New Hampshire ranks 1st in the Nation in past 30 alcohol use among 12 -17 year olds. Alcohol is the most used drug in New Hampshire in part because alcohol is the easiest drug to access. The younger someone uses alcohol or other drugs like marijuana the greater their chances for developing an addiction According to a 2014 study, " participants who used cannabis before the age of 14 years were 4 times more likely to have a history of cannabis dependence ". [1] These poor rankings can have adverse affects on a large scale. These bills could send a message to youth that there is little risk or harm associated with marijuana use. Studies show that there are negative cognitive affects of long –term or heavy use of marijuana. You may think that it is the parent's job to protect youth from alcohol and other drugs but the cost of child who is abusing substances is felt by the whole community. "High levels of cannabis use are related to poorer

[1] Impact of age at onset of cannabis use on cannabis dependence and driving under the influence in the United States.
Le Strat Y, Dubertret C, Le Foll B.
Accid Anal Prev. 2014 Dec 24;76C:1-5. doi: 10.1016/j.aap.2014.12.015. [Epub ahead of print]
PMID:25543035 [PubMed - as supplied by publisher]

educational outcomes, lower income, greater welfare dependence and unemployment"[2] New Hampshire is not Colorado but it would be negligent not to learn from their experiences in expanding access to marijuana. In the Rocky Mountain High Intensity Drug Trafficking Area Preliminary report on The Legalization of Marijuana in Colorado, they found that from the school years of 2010, 2011, and 2012 "drug related expulsions/suspensions increased to an average of 5,217. This is a 37 percent increase"[3] from the three previous years. At the same time as this increase, access to marijuana in Colorado was hugely expanded to include 108,000 new patients and 532 new dispensaries. So, it's very important to consider all the ramifications before expanding the qualifying conditions for Therapeutic Marijuana and allowing home cultivation.

New Hampshire is already struggling to deal with the Opioid Epidemic and these bills could effectively be increasing the access to youth and creating more drug dependency. I urge you, as someone who works to change New Hampshire's ranking, to consider the consequences that these bills could have on our youth and our entire state. Thank you for your time.

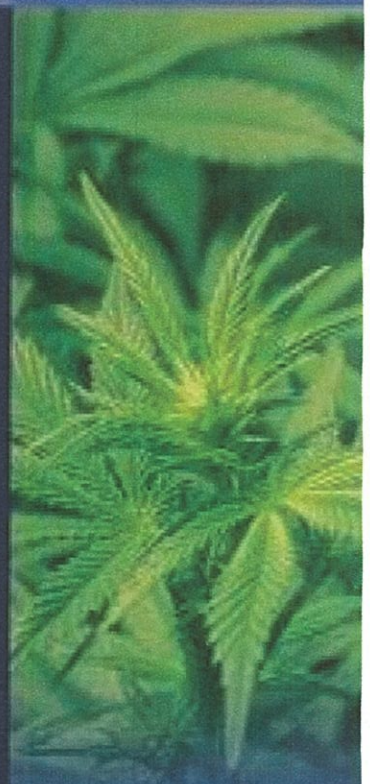
Annika Stanley-Smith
Substance Misuse Prevention Coordinator
Capital Area Public Health Network
46 South Main Street
Concord, NH 03301
603-224-2595 x 224

[2] Fergusson, DM, Boden, JM., Cannabis use and later life outcomes, Addiction, 2008

[3] Rocky Mountain HIDTA. (2013). *The Legalization of Marijuana in Colorado: The Impact*. Retrieved February 17, 2015, from http://www.rmhidta.org/html/FINAL%20Legalization%20of%20MJ%20in%20Colorado%20The%20Impact.pdf

MEDICAL CANNABIS
ADVISORY BOARD RECOMMENDATIONS

- Chronic Pain Due to Trauma
- Chronic Pain Syndrome
- Chronic Post-Operative Pain
- Intractable Pain
- Osteoarthritis
- Autism
- Irritable Bowel Syndrome
- Post-Traumatic Stress Syndrome



What Is Chronic Pain?

Pain is a complex phenomenon made up of physical, mental and social components. At a basic level, the ability to perceive pain has helped people survive throughout the ages. Without feeling the uncomfortable sensation when you touch a stove, which causes you to remove your hand, the heat from the stove would end up causing far more damage to the cells in your hand, than it did before you felt the pain.

In essence, pain is the body's way of letting you know something is wrong. However, it is when pain fails to subside, despite removing the initial cause, that it become pathologic, and known as chronic pain.
Chronic pain can have a wide range of causes and can be associated with a number of different disease processes, thus the ability to diagnose chronic pain syndromes has been a widely debated topic within the medical community for many years.

Earlier this year, the American Pain Society, released a **framework** which attempts to account for all of the various factors that encompass chronic pain syndromes: physical, pathological, neurobiological, psychological, and social. Broadly speaking, however, the origins of chronic pain can be categorized into visceral (internal organs), somatic (skin and deep tissue), and neurogenic (nerves).

The Institute of Medicine reports that common chronic pain affects approximately 100 million Americans adults at a cost of $560-635 billion in direct medical treatment cost and lost productivity. However, while the impact of chronic pain is wide reaching across the population, its effect on the individual person is unique; there is variation in the source(s), severity, duration, response to treatment and psychological impact from person to person.

Conventional Therapies For Chronic Pain

Given the variety in the spectrum of chronic pain, it is no wonder why clinicians at times find difficulty in helping patients manage their chronic pain. This difficulty in management has contributed in part to the wide range of therapies which are used to treat chronic pain, such as aspirin, ibuprofen and other drugs which are classified broadly as non-steroidal anti-inflammatory drugs (NSAIDs) and can be purchased over over the counter.

These medications may work well for short term relief of mild to moderate pain, but they can create side effects such as ulcers and potentially damage the liver when used continuously, such as in a chronic pain scenario. It is for these reasons that most clinicians avoid relying on this type of medication for long term pain relief.

A more powerful alternative to NSAIDs are the opiates, such as morphine, oxycodone, codeine, and hydromorphone. The drugs have been well **described** in the scientific literature, and work by affecting the body's natural opioid receptors to prevent the nerves responsible for sending pain signals from firing.

These medications have the ability to provide tremendous pain relief and provide clinicians the opportunity to perform life-saving therapies which would otherwise be impossible (e.g. surgery). However, in the treatment of chronic pain, opioids therapy by itself can become problematic for patients – the body begins to develop a tolerance to these medications, thus the dose required in order to get symptomatic relief continues to increase over time.

Additionally, the side effects of taking opioids (sedation, nausea, constipation, and potential respiratory depression and death) make physicians reluctant to continue to raise dosages for patients out of fear of causing dependence. This fear is not ill-conceived either; in 2007, the US Substance and Mental Health Services Administration **declared** that the dependence on and abuse of pharmaceutical medications is the fastest growing form of problematic substance use in America.

therapeutic intervention. Given the growing need for clinicians to transition away from an opiate dependent treatment protocol for chronic pain, hopefully these breakthroughs happen sooner rather than later. Naturally, the relaxation of government prohibition would go a long way towards supporting these efforts.

Malik Burnett, MD

Dr. Malik Burnett is a physician advocate who completed his medical and business training at Duke University. He believes that a public which is better informed about the science behind cannabis will be able to use cannabis safely and experience its many benefits. He is currently a Policy Manager in the Office of National Affairs at the Drug Policy Alliance in Washington DC and a contributor for Medical Jane.

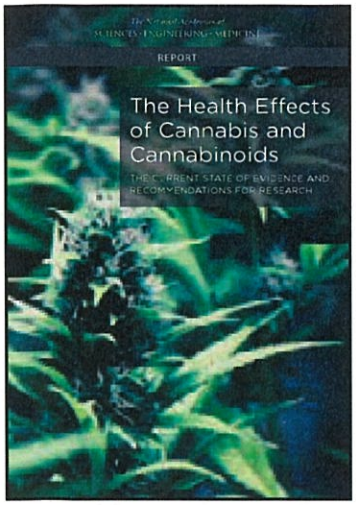
Provided by:

Executive Directors of NH NORML
NH Live Free Foundation
Rick Naya
Erica Golter

THE HEALTH EFFECTS OF CANNABIS AND CANNABINOIDS

COMMITTEE'S CONCLUSIONS

January 2017



In the report *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research,* an expert, ad hoc committee of the National Academies of Sciences, Engineering, and Medicine presents nearly 100 conclusions related to the health effects of cannabis and cannabinoid use.

The committee developed standard language to categorize the weight of the evidence regarding whether cannabis or cannabinoids used for *therapeutic* purposes are an effective or ineffective treatment for certain prioritized health conditions, or whether cannabis or cannabinoids used primarily for *recreational* purposes are statistically associated with certain prioritized health conditions. The box on the next page describes these categories and the general parameters for the types of evidence supporting each category.

The numbers in parentheses after each conclusion correspond to chapter conclusion numbers. Each blue header below links to the corresponding chapter in the report, providing much more detail regarding the committee's findings and conclusions. To read the full report, please visit **nationalacademies.org/CannabisHealthEffects.**

CONCLUSIONS FOR: THERAPEUTIC EFFECTS

There is conclusive or substantial evidence that cannabis or cannabinoids are effective:

- For the treatment for chronic pain in adults (cannabis) (4-1)
- Antiemetics in the treatment of chemotherapy-induced nausea and vomiting (oral cannabinoids) (4-3)
- For improving patient-reported multiple sclerosis spasticity symptoms (oral cannabinoids) (4-7a)

There is moderate evidence that cannabis or cannabinoids are effective for:

- Improving short-term sleep outcomes in individuals with sleep disturbance associated with obstructive sleep apnea syndrome, fibromyalgia, chronic pain, and multiple sclerosis (cannabinoids, primarily nabiximols) (4-19)

There is limited evidence that cannabis or cannabinoids are effective for:

- Increasing appetite and decreasing weight loss associated with HIV/AIDS (cannabis and oral cannabinoids) (4-4a)
- Improving clinician-measured multiple sclerosis spasticity symptoms (oral cannabinoids) (4-7a)
- Improving symptoms of Tourette syndrome (THC capsules) (4-8)
- Improving anxiety symptoms, as assessed by a public speaking test, in individuals with social anxiety disorders (cannabidiol) (4-17)
- Improving symptoms of posttraumatic stress disorder (nabilone; one single, small fair-quality trial) (4-20)

There is limited evidence of a statistical association between cannabinoids and:

- Better outcomes (i.e., mortality, disability) after a traumatic brain injury or intracranial hemorrhage (4-15)

There is limited evidence that cannabis or cannabinoids are *ineffective* for:

- Improving symptoms associated with dementia (cannabinoids) (4-13)
- Improving intraocular pressure associated with glaucoma (cannabinoids) (4-14)
- Reducing depressive symptoms in individuals with chronic pain or multiple sclerosis (nabiximols, dronabinol, and nabilone) (4-18)

DEFINITIONS OF WEIGHTS OF EVIDENCE

The committee used the following standardized language to categorize the weight of the evidence regarding cannabis or cannabinoid use for the prioritized health conditions:

CONCLUSIVE evidence

For therapeutic effects: There is strong evidence from randomized controlled trials to support the conclusion that cannabis or cannabinoids are an effective or ineffective treatment for the health endpoint of interest.

For other health effects: There is strong evidence from randomized controlled trials to support or refute a statistical association between cannabis or cannabinoid use and the health endpoint of interest.

For this level of evidence, there are many supportive findings from good-quality studies with no credible opposing findings. A firm conclusion can be made, and the limitations to the evidence, including chance, bias, and confounding factors, can be ruled out with reasonable confidence.

SUBSTANTIAL evidence:

For therapeutic effects: There is strong evidence to support the conclusion that cannabis or cannabinoids are an effective or ineffective treatment for the health endpoint of interest.

For other health effects: There is strong evidence to support or refute a statistical association between cannabis or cannabinoid use and the health endpoint of interest.

For this level of evidence, there are several supportive findings from good-quality studies with very few or no credible opposing findings. A firm conclusion can be made, but minor limitations, including chance, bias, and confounding factors, cannot be ruled out with reasonable confidence.

MODERATE evidence:

For therapeutic effects: There is some evidence to support the conclusion that cannabis or cannabinoids are an effective or ineffective treatment for the health endpoint of interest.

For other health effects: There is some evidence to support or refute a statistical association between cannabis or cannabinoid use and the health endpoint of interest.

For this level of evidence, there are several findings from good- to fair-quality studies with very few or no credible opposing findings. A general conclusion can be made, but limitations, including chance, bias, and confounding factors, cannot be ruled out with reasonable confidence.

LIMITED evidence:

For therapeutic effects: There is weak evidence to support the conclusion that cannabis or cannabinoids are an effective or ineffective treatment for the health endpoint of interest.

For other health effects: There is weak evidence to support or refute a statistical association between cannabis or cannabinoid use and the health endpoint of interest.

For this level of evidence, there are supportive findings from fair-quality studies or mixed findings with most favoring one conclusion. A conclusion can be made, but there is significant uncertainty due to chance, bias, and confounding factors.

NO or INSUFFICIENT evidence to support the association:

For therapeutic effects: There is no or insufficient evidence to support the conclusion that cannabis or cannabinoids are an effective or ineffective treatment for the health endpoint of interest.

For other health effects: There is no or insufficient evidence to support or refute a statistical association between cannabis or cannabinoid use and the health endpoint of interest.

For this level of evidence, there are mixed findings, a single poor study, or health endpoint has not been studied at all. No conclusion can be made because of substantial uncertainty due to chance, bias, and confounding factors.

There is no or insufficient evidence to support or refute the conclusion that cannabis or cannabinoids are an effective treatment for:

- Cancers, including glioma (cannabinoids) (4-2)
- Cancer-associated anorexia cachexia syndrome and anorexia nervosa (cannabinoids) (4-4b)
- Symptoms of irritable bowel syndrome (dronabinol) (4-5)
- Epilepsy (cannabinoids) (4-6)
- Spasticity in patients with paralysis due to spinal cord injury (cannabinoids) (4-7b)
- Symptoms associated with amyotrophic lateral sclerosis (cannabinoids) (4-9)
- Chorea and certain neuropsychiatric symptoms associated with Huntington's disease (oral cannabinoids) (4-10)
- Motor system symptoms associated with Parkinson's disease or the levodopa-induced dyskinesia (cannabinoids) (4-11)
- Dystonia (nabilone and dronabinol) (4-12)
- Achieving abstinence in the use of addictive substances (cannabinoids) (4-16)
- Mental health outcomes in individuals with schizophrenia or schizophreniform psychosis (cannabidiol) (4-21)

CONCLUSIONS FOR: CANCER

There is moderate evidence of *no* statistical association between cannabis use and:

- Incidence of lung cancer (cannabis smoking) (5-1)
- Incidence of head and neck cancers (5-2)

There is limited evidence of a statistical association between cannabis smoking and:

- Non-seminoma-type testicular germ cell tumors (current, frequent, or chronic cannabis smoking) (5-3)

There is no or insufficient evidence to support or refute a statistical association between cannabis use and:

- Incidence of esophageal cancer (cannabis smoking) (5-4)
- Incidence of prostate cancer, cervical cancer, malignant gliomas, non-Hodgkin lymphoma, penile cancer, anal cancer, Kaposi's sarcoma, or bladder cancer (5-5)
- Subsequent risk of developing acute myeloid leukemia/acute non-lymphoblastic leukemia, acute lymphoblastic leukemia, rhabdomyosarcoma, astrocytoma, or neuroblastoma in offspring (parental cannabis use) (5-6)

CONCLUSIONS FOR: CARDIOMETABOLIC RISK

There is limited evidence of a statistical association between cannabis use and:

- The triggering of acute myocardial infarction (cannabis smoking) (6-1a)
- Ischemic stroke or subarachnoid hemorrhage (6-2)
- Decreased risk of metabolic syndrome and diabetes (6-3a)
- Increased risk of prediabetes (6-3b)

There is no evidence to support or refute a statistical association between *chronic effects* of cannabis use and:

- The increased risk of acute myocardial infarction (6-1b)

CONCLUSIONS FOR: RESPIRATORY DISEASE

There is substantial evidence of a statistical association between cannabis smoking and:

- Worse respiratory symptoms and more frequent chronic bronchitis episodes (long-term cannabis smoking) (7-3a)
- There is moderate evidence of a statistical association between cannabis smoking and:
- Improved airway dynamics with acute use, but not with chronic use (7-1a)
- Higher forced vital capacity (FVC) (7-1b)

There is moderate evidence of a statistical association between *the cessation* of cannabis smoking and:

- Improvements in respiratory symptoms (7-3b)

There is limited evidence of a statistical association between cannabis smoking and:

- An increased risk of developing chronic obstructive pulmonary disease (COPD) when controlled for tobacco use (occasional cannabis smoking) (7-2a)

There is no or insufficient evidence to support or refute a statistical association between cannabis smoking and:

- Hospital admissions for COPD (7-2b)
- Asthma development or asthma exacerbation (7-4)

CONCLUSIONS FOR: IMMUNITY

There is limited evidence of a statistical association between cannabis smoking and:

- A decrease in the production of several inflammatory cytokines in healthy individuals (8-1a)

There is limited evidence of *no* statistical association between cannabis use and:

- The progression of liver fibrosis or hepatic disease in individuals with viral Hepatitis C (HCV) (daily cannabis use) (8-3)

There is no or insufficient evidence to support or refute a statistical association between cannabis use and:

- Other adverse immune cell responses in healthy individuals (cannabis smoking) (8-1b)
- Adverse effects on immune status in individuals with HIV (cannabis or dronabinol use) (8-2)
- Increased incidence of oral human papilloma virus (HPV) (regular cannabis use) (8-4)

CONCLUSIONS FOR: INJURY AND DEATH

There is substantial evidence of a statistical association between cannabis use and:

- Increased risk of motor vehicle crashes (9-3)

There is moderate evidence of a statistical association between cannabis use and:

- Increased risk of overdose injuries, including respiratory distress, among pediatric populations in U.S. states where cannabis is legal (9-4b)

There is no or insufficient evidence to support or refute a statistical association between cannabis use and:

- All-cause mortality (self-reported cannabis use) (9-1)
- Occupational accidents or injuries (general, non-medical cannabis use) (9-2)
- Death due to cannabis overdose (9-4a)

CONCLUSIONS FOR: PRENATAL, PERINATAL, AND NEONATAL EXPOSURE

There is substantial evidence of a statistical association between maternal cannabis smoking and:

- Lower birth weight of the offspring (10-2)

There is limited evidence of a statistical association between maternal cannabis smoking and:

- Pregnancy complications for the mother (10-1)
- Admission of the infant to the neonatal intensive care unit (NICU) (10-3)

There is insufficient evidence to support or refute a statistical association between maternal cannabis smoking and:

- Later outcomes in the offspring (e.g., sudden infant death syndrome, cognition/academic achievement, and later substance use) (10-4)

CONCLUSIONS FOR: PSYCHOSOCIAL

There is moderate evidence of a statistical association between cannabis use and:

- The impairment in the cognitive domains of learning, memory, and attention (acute cannabis use) (11-1a)

There is limited evidence of a statistical association between cannabis use and:

- Impaired academic achievement and education outcomes (11-2)
- Increased rates of unemployment and/or low income (11-3)
- Impaired social functioning or engagement in developmentally appropriate social roles (11-4)

There is limited evidence of a statistical association between *sustained abstinence from* cannabis use and:

- Impairments in the cognitive domains of learning, memory, and attention (11-1b)

CONCLUSIONS FOR: MENTAL HEALTH

There is substantial evidence of a statistical association between cannabis use and:

- The development of schizophrenia or other psychoses, with the highest risk among the most frequent users (12-1)

There is moderate evidence of a statistical association between cannabis use and:

- Better cognitive performance among individuals with psychotic disorders and a history of cannabis use (12-2a)
- Increased symptoms of mania and hypomania in individuals diagnosed with bipolar disorders (regular cannabis use) (12-4)
- A small increased risk for the development of depressive disorders (12-5)
- Increased incidence of suicidal ideation and suicide attempts with a higher incidence among heavier users (12-7a)
- Increased incidence of suicide completion (12-7b)
- Increased incidence of social anxiety disorder (regular cannabis use) (12-8b)

There is moderate evidence of *no* statistical association between cannabis use and:

- Worsening of negative symptoms of schizophrenia (e.g., blunted affect) among individuals with psychotic disorders (12-2c)

There is limited evidence of a statistical association between cannabis use and:

- An increase in positive symptoms of schizophrenia (e.g., hallucinations) among individuals with psychotic disorders (12-2b)
- The likelihood of developing bipolar disorder, particularly among regular or daily users (12-3)
- The development of any type of anxiety disorder, except social anxiety disorder (12-8a)
- Increased symptoms of anxiety (near daily cannabis use) (12-9)
- Increased severity of posttraumatic stress disorder symptoms among individuals with posttraumatic stress disorder (12-11)

There is no evidence to support or refute a statistical association between cannabis use and:

- Changes in the course or symptoms of depressive disorders (12-6)
- The development of posttraumatic stress disorder (12-10)

CONCLUSIONS FOR: PROBLEM CANNABIS USE

There is substantial evidence that:

- Stimulant treatment of attention deficit hyperactivity disorder (ADHD) during adolescence is *not* a risk factor for the development of problem cannabis use (13-2e)
- Being male and smoking cigarettes are risk factors for the progression of cannabis use to problem cannabis use (13-2i)
- Initiating cannabis use at an earlier age is a risk factor for the development of problem cannabis use (13-2j)

There is substantial evidence of a statistical association between:

- Increases in cannabis use frequency and the progression to developing problem cannabis use (13-1)
- Being male and the severity of problem cannabis use, but the recurrence of problem cannabis use does not differ between males and females (13-3b)

There is moderate evidence that:

- Anxiety, personality disorders, and bipolar disorders are *not* risk factors for the development of problem cannabis use (13-2b)
- Major depressive disorder is a risk factor for the development of problem cannabis use (13-2c)
- Adolescent ADHD is *not* a risk factor for the development of problem cannabis use (13-2d)
- Being male is a risk factor for the development of problem cannabis use (13-2f)
- Exposure to the combined use of abused drugs is a risk factor for the development of problem cannabis use (13-2g)
- Neither alcohol nor nicotine dependence alone are risk factors for the progression from cannabis use to problem cannabis use (13-2h)
- During adolescence the frequency of cannabis use, oppositional behaviors, a younger age of first alcohol use, nicotine use, parental substance use, poor school performance, antisocial behaviors, and childhood sexual abuse are risk factors for the development of problem cannabis use (13-2k)

There is moderate evidence of a statistical association between:

- A persistence of problem cannabis use and a history of psychiatric treatment (13-3a)
- Problem cannabis use and increased severity of posttraumatic stress disorder symptoms (13-3c)

There is limited evidence that:

- Childhood anxiety and childhood depression are risk factors for the development of problem cannabis use (13-2a)

CONCLUSIONS FOR: ABUSE OF OTHER SUBSTANCES

There is moderate evidence of a statistical association between cannabis use and:

- The development of substance dependence and/or substance abuse disorder for substances including alcohol, tobacco, and other illicit drugs (14-3)

There is limited evidence of a statistical association between cannabis use and:

- The initiation of tobacco use (14-1)
- Changes in the rates and use patterns of other licit and illicit substances (14-2)

CONCLUSIONS FOR: CHALLENGES AND BARRIERS IN CONDUCTING CANNABIS AND CANNABINOID RESEARCH

There are several challenges and barriers in conducting cannabis and cannabinoid research, including:

- There are specific regulatory barriers, including the classification of cannabis as a Schedule I substance, that impede the advancement of cannabis and cannabinoid research (15-1)
- It is often difficult for researchers to gain access to the quantity, quality, and type of cannabis product necessary to address specific research questions on the health effects of cannabis use (15-2)
- A diverse network of funders is needed to support cannabis and cannabinoid research that explores the beneficial and harmful effects of cannabis use (15-3)
- To develop conclusive evidence for the effects of cannabis use for short- and long-term health outcomes, improvements and standardization in research methodology (including those used in controlled trials and observational studies) are needed (15-4)

TO READ THE FULL REPORT AND VIEW RELATED RESOURCES, PLEASE VISIT
NATIONALACADEMIES.ORG/CANNABISHEALTHEFFECTS

Amendments

Rep. Schleien, Hills. 37
January 24, 2017
2017-0110h
01/10

Amendment to HB 157

NOT used

Amend the bill by replacing section 1 with the following:

1 Use of Cannabis for Therapeutic Purposes; Definitions. Amend RSA 126-X:1, IX(a) to read as follows:

IX.(a)***(1)*** "Qualifying medical condition" means the presence of:

[~~(1)~~] ***(A)*** Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C currently receiving antiviral treatment, amyotrophic lateral sclerosis, muscular dystrophy, Crohn's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, epilepsy, lupus, Parkinson's disease, Alzheimer's disease, ulcerative colitis, or one or more injuries that significantly interferes with daily activities as documented by the patient's provider; and

[~~(2)~~] ***(B)*** A severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy-induced anorexia, wasting syndrome, agitation of Alzheimer's disease, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms.

(2) "Qualifying medical condition" also means moderate to severe chronic pain.

Rep. Knirk, Carr. 3
February 7, 2017
2017-0366h
01/03

Amendment to HB 157

Withdrawn by Rep Knirk

Amend the title of the bill by replacing it with the following:

AN ACT relative to qualifying medical conditions under the therapeutic use of cannabis law.

Amend the bill by replacing section 1 with the following:

1 Therapeutic Use of Cannabis; Definition. Amend RSA 126-X:1, IX(a) to read as follows:

IX.(a) "Qualifying medical condition" means:

(1) The presence of:

[~~(1)~~] ***(A)*** Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C currently receiving antiviral treatment, amyotrophic lateral sclerosis, muscular dystrophy, Crohn's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, epilepsy, lupus, Parkinson's disease, Alzheimer's disease, ulcerative colitis, ***chronic pain,*** or one or more injuries that significantly interferes with daily activities as documented by the patient's provider; and

[~~(2)~~] ***(B)*** A severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy-induced anorexia, wasting syndrome, agitation of Alzheimer's disease, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms***; or***

(2) Any other condition or symptom which the treating provider deems appropriate for therapeutic cannabis.

2017-0366h

AMENDED ANALYSIS

This bill adds chronic pain to the qualifying medical conditions under therapeutic use of cannabis. This bill also authorizes a treating provider to determine a condition or symptom appropriate as a qualifying medical condition for the purpose of therapeutic use of cannabis.

Bill as Introduced

HB 157 - AS INTRODUCED

2017 SESSION

17-0114
01/09

HOUSE BILL ***157***

AN ACT adding chronic pain to qualifying conditions under therapeutic use of cannabis.

SPONSORS: Rep. Schleien, Hills. 37; Rep. E. Edwards, Hills. 11; Rep. Fisher, Belk. 9; Rep. Zaricki, Hills. 6; Rep. Josephson, Graf. 11

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill adds chronic pain to the qualifying medical conditions under therapeutic use of cannabis.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 157 - AS INTRODUCED

17-0114
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Seventeen

AN ACT adding chronic pain to qualifying conditions under therapeutic use of cannabis.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Use of Cannabis for Therapeutic Purposes; Definitions. Amend RSA 126-X:1, IX(a)(1) to read as follows:

(1) Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C currently receiving antiviral treatment, amyotrophic lateral sclerosis, muscular dystrophy, Crohn's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, epilepsy, lupus, Parkinson's disease, Alzheimer's disease, ulcerative colitis, ***chronic pain,*** or one or more injuries that significantly interferes with daily activities as documented by the patient's provider; and

2 Effective Date. This act shall take effect 60 days after its passage.