

Bill as  
Introduced

HB 573-FN - AS INTRODUCED

2013 SESSION

13-0279

04/01

HOUSE BILL      **573-FN**

AN ACT            relative to the use of marijuana for medicinal purposes.

SPONSORS:       Rep. Schlachman, Rock 18; Rep. Vaillancourt, Hills 15; Rep. Robertson, Ches 6;  
Rep. Wright, Carr 8; Rep. Renzullo, Hills 37; Rep. LeBrun, Hills 32;  
Rep. DeSimone, Rock 14; Rep. Kidder, Merr 5; Rep. Gale, Hills 28; Rep. Lovejoy,  
Rock 36; Sen. Woodburn, Dist 1; Sen. Reagan, Dist 17; Sen. Fuller Clark, Dist 21;  
Sen. Cataldo, Dist 6

COMMITTEE:      Health, Human Services and Elderly Affairs

---

ANALYSIS

This bill permits the use of marijuana for medicinal purposes in New Hampshire.

-----

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

*In the Year of Our Lord Two Thousand Thirteen*

AN ACT                      relative to the use of marijuana for medicinal purposes.

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

1            1 Findings.

2            I. Modern medical research has discovered beneficial uses for marijuana in treating or  
3            alleviating the pain, nausea, and other symptoms associated with a variety of debilitating medical  
4            conditions, as found by the National Academy of Sciences' Institute of Medicine in March 1999.

5            II. Subsequent studies since the 1999 National Academy of Sciences' Institute of Medicine  
6            report continue to show the therapeutic value of marijuana in treating a wide array of debilitating  
7            medical conditions. These include relief of the neuropathic pain caused by multiple sclerosis,  
8            HIV/AIDS, and other illnesses that often fails to respond to conventional treatments and relief of  
9            nausea, vomiting, and other side effects of drugs used to treat HIV/AIDS and hepatitis C, increasing  
10           the chances of patients continuing on life-saving treatment regimens.

11           III. Marijuana has many currently accepted medical uses in the United States, having been  
12           recommended by thousands of licensed physicians to at least 500,000 patients in states with medical  
13           marijuana laws. Marijuana's medical utility has been recognized by a wide range of medical and  
14           public health organizations, including the American Academy of HIV Medicine, the American  
15           College of Physicians, the American Nurses Association, the American Public Health Association, the  
16           Leukemia & Lymphoma Society, and many others.

17           IV. Data from the Federal Bureau of Investigation's Uniform Crime Reports and the  
18           Compendium of Federal Justice Statistics shows that approximately 99 out of every 100 marijuana  
19           arrests in the United States are made under state law, rather than under federal law.  
20           Consequently, changing state law will have the practical effect of protecting from arrest the vast  
21           majority of seriously ill patients who have a medical need to use marijuana.

22           V. Alaska, California, Colorado, the District of Columbia, Hawaii, Maine, Michigan,  
23           Montana, Nevada, New Mexico, New Jersey, Oregon, Vermont, Rhode Island, and Washington have  
24           removed state-level criminal penalties from the medical use and cultivation of marijuana. New  
25           Hampshire joins in this effort for the health and welfare of its citizens.

26           VI. States are not required to enforce federal law or prosecute people for engaging in  
27           activities prohibited by federal law. Therefore, compliance with this act does not put the state of  
28           New Hampshire in violation of federal law.

29           VII. State law should make a distinction between the medical and non-medical uses of  
30           marijuana. Hence, the purpose of this act is to protect patients with debilitating medical conditions,  
31           as well as their physicians and designated caregivers, from arrest and prosecution, criminal and  
32           other penalties, and property forfeiture if such patients engage in the medical use of marijuana.

VIII. The people of the state of New Hampshire declare that they enact this act pursuant to the police power to protect the health of its citizens that is reserved to the state of New Hampshire and its people under the 10th Amendment to the United States Constitution.

2 New Chapter; Use of Marijuana for Medicinal Purposes. Amend RSA by inserting after chapter 126-V the following new chapter:

CHAPTER 126-W

USE OF MARIJUANA FOR MEDICINAL PURPOSES

126-W:1 Definitions. In this chapter:

I. "Alternative treatment center" means a not-for-profit entity registered under RSA 126-W:8 that acquires, possesses, cultivates, manufactures, delivers, transfers, transports, sells, supplies, or dispenses marijuana, or related supplies and educational materials, to a registered qualifying patient who has designated it, either by dispensing it directly to the registered qualifying patient or by dispensing it to his or her registered designated caregiver.

II. "Alternative treatment center agent" means a principal officer, board member, employee, manager, or volunteer of a registered alternative treatment center who is 21 years of age or older.

III. "Cardholder" means a qualifying patient, a designated caregiver, or an alternative treatment center agent who has been issued and possesses a valid registry identification card.

IV. "Chronic or terminal disease" means 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, agitation of Alzheimer's disease, or multiple sclerosis.

V. "Debilitating medical condition" means the presence of both:

(a) A chronic or terminal disease; and

(b) Symptoms or treatment results that include at least one of the following: cachexia or wasting syndrome, severe pain that has not responded to previously prescribed medication or surgical measures for more than 3 months, severe nausea, severe vomiting, seizures, or severe, persistent muscle spasms.

VI. "Department" means the department of health and human services.

VII. "Designated caregiver" means an individual who is at least 21 years of age including a licensed health care professional, but who is not a qualifying patient, and who has agreed to assist with a patient's medical use of marijuana, including acquiring medical marijuana from an alternative treatment center and delivering it to the qualifying patient, and who has never been convicted of any drug-related offense. Except for a licensed health care professional, a designated caregiver may serve as a designated caregiver for only one qualifying patient at a time.

VIII. "Marijuana" means all parts of any plant of the Cannabis genus of plants, whether growing or not; the seeds thereof; the resin extracted from any part of such plant; and every compound, salt, derivative, mixture, or preparation of such plant, its seeds, or resin. Such term does



1 not include the mature stalks of such plants, fiber produced from such stalks, oil, or cake made from  
2 the seeds of such plants, any other compound, salt, derivative, mixture, or preparation of such  
3 mature stalks (except the resin extracted therefrom), fiber, oil or cake, or the sterilized seeds of such  
4 plants which are incapable of germination.

5 IX. "Medical use" means the acquisition, possession, preparation, use, delivery, transfer, or  
6 transportation of marijuana or paraphernalia relating to the administration of marijuana to treat or  
7 alleviate a registered qualifying patient's debilitating medical condition or symptoms or results of  
8 treatment associated with the registered qualifying patient's debilitating medical condition.

9 X. "Physician" means an individual licensed to prescribe drugs to humans under RSA 329  
10 and who possesses certification from the United States Drug Enforcement Administration to  
11 prescribe controlled substances, except that in relation to a visiting qualifying patient, "physician"  
12 means an individual licensed to prescribe drugs to humans in the state of the patient's residence and  
13 who possesses certification from the United States Drug Enforcement Administration to prescribe  
14 controlled substances.

15 XI. "Qualifying patient" means an individual who has been diagnosed by a physician as  
16 having a debilitating medical condition.

17 XII. "Registry identification card" means a document issued by the department that  
18 identifies an individual as a qualifying patient, a designated caregiver, or a registered alternative  
19 treatment center agent.

20 XIII. "Seedling" means a marijuana plant that has no flowers and is less than 12 inches in  
21 height and less than 12 inches in diameter. A seedling shall meet all three criteria set forth in this  
22 paragraph.

23 XIV. "Usable marijuana" means the dried leaves and flowers of the marijuana plant and any  
24 mixture or preparation thereof, but does not include the seeds, stalks, and roots of the plant and does  
25 not include the weight of any non-marijuana ingredients combined with marijuana and prepared for  
26 consumption as food or drink.

27 XV. "Visiting qualifying patient" means a patient with a debilitating medical condition who  
28 is not a resident of New Hampshire or who has been a resident of New Hampshire for fewer than 30  
29 days.

30 XVI. "Written certification" means a document signed by a physician stating that in the  
31 physician's professional opinion, after having completed a full assessment of the qualifying patient's  
32 medical history and current medical condition made in the course of a bona fide physician-patient  
33 relationship as defined in RSA 329:1-c of at least 3 months in duration, the qualifying patient has a  
34 debilitating medical condition, and the potential benefits of the medical use of marijuana would  
35 likely outweigh the health risks for the qualifying patient. The written certification shall be valid for  
36 up to one year and shall specify the qualifying patient's debilitating medical condition, which also  
37 shall be noted in the qualifying patient's medical records.

126-W:2 Protections for the Medical Use of Marijuana.

I. A qualifying patient who has been issued and possesses a registry identification card shall not be subject to arrest, prosecution, or penalty, or denied any right or privilege, including but not limited to a civil penalty or disciplinary action by a court or occupational or professional licensing board or bureau, for the medical use of marijuana in accordance with this chapter, if the qualifying patient possesses an amount of usable marijuana that does not exceed 2 ounces. A qualifying patient shall remain subject to the provisions of RSA 126-W:5.

II. A designated caregiver who has been issued and possesses a registry identification card shall not be subject to arrest, prosecution, or penalty, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a court or occupational or professional licensing board or bureau, for assisting a qualifying patient to whom he or she is connected through the department's registration process with the medical use of usable marijuana in accordance with this chapter, if the designated caregiver possesses an amount of marijuana that does not exceed 2 ounces of usable marijuana. A designated caregiver shall remain subject to the provisions of RSA 126-W:5.

III.(a) A qualifying patient is presumed to be lawfully engaged in the medical use of marijuana in accordance with this chapter if the qualifying patient possesses a registry identification card and possesses an amount of marijuana that does not exceed the amount allowed under this chapter.

(b) A designated caregiver is presumed to be lawfully engaged in assisting with the medical use of marijuana in accordance with this chapter if the designated caregiver possesses a registry identification card and possesses an amount of marijuana that does not exceed the amount allowed under this chapter.

(c) The presumptions made in subparagraphs (a) and (b) may be rebutted by evidence that conduct related to marijuana was not for the purpose of treating or alleviating the registered qualifying patient's debilitating medical condition or symptoms or effects of the treatment associated with the debilitating medical condition, in accordance with this chapter.

IV.(a) An alternative treatment center may accept marijuana seeds, seedlings, plants, or useable marijuana from other registered alternative treatment centers in New Hampshire. An alternative treatment center may transfer or sell marijuana seeds, seedlings, plants, or usable marijuana to other registered alternative treatment centers in New Hampshire.

(b) An alternative treatment center may accept a donation of marijuana seeds or seedlings, without compensation, from individuals and entities from jurisdictions outside of New Hampshire who are authorized to cultivate medical marijuana in their home state.

(c) Individuals and entities from jurisdictions outside of New Hampshire who are authorized to cultivate medical marijuana in their home state shall not be subject to arrest, prosecution, or penalty, or denied any right or privilege for donating marijuana seeds or seedlings to alternative treatment centers in New Hampshire.

1 V.(a) No school or landlord may refuse to enroll or lease to, or otherwise penalize, an  
2 individual solely for his or her status as a registered qualifying patient or a designated caregiver,  
3 unless failing to do so would put the school or landlord in violation of federal law or regulations.

4 (b) For the purposes of medical care, including organ transplants, a registered qualifying  
5 patient's authorized use of marijuana in accordance with this chapter shall be considered the  
6 equivalent of the authorized use of any other medication used at the direction of a physician, and  
7 shall not constitute the use of an illicit substance.

8 (c) Unless a failure to do so would constitute a violation of federal law or federal  
9 regulations, an employer shall not discriminate against an individual in hiring, termination, or any  
10 term or condition of employment, or otherwise penalize an individual, based upon either of the  
11 following:

12 (1) The individual's status as a registered qualifying patient or registered designated  
13 caregiver; or

14 (2) A registered qualifying patient's positive drug test for marijuana components or  
15 metabolites, unless the patient used or possessed, or was under the influence of or impaired by  
16 marijuana on the premises of the place of employment. For purposes of this chapter, "impaired"  
17 includes but is not limited to instances where the registered qualifying patient is not able to safely  
18 perform essential job tasks.

19 VI. A person otherwise entitled to custody of, or visitation or parenting time with, a minor  
20 shall not be denied such a right solely for conduct allowed under this chapter and there shall be no  
21 presumption of neglect or child endangerment.

22 VII. A registered designated caregiver who is a licensed health care professional may receive  
23 compensation for costs associated with assisting a registered qualifying patient who has designated  
24 the designated caregiver to assist him or her with the medical use of marijuana. Such compensation  
25 shall not constitute the sale of controlled substances.

26 VIII. A physician shall not be subject to arrest, prosecution, or penalty, or denied any right  
27 or privilege, including but not limited to a civil penalty or disciplinary action by the New Hampshire  
28 board of medicine or any other occupational or professional licensing board or bureau, solely for  
29 providing written certifications or for otherwise stating that, in the physician's professional opinion,  
30 a patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to  
31 treat or alleviate the patient's debilitating medical condition or symptoms or effects of treatment  
32 associated with the debilitating medical condition, provided that nothing shall prevent a professional  
33 licensing board from sanctioning a physician for failing to properly evaluate a patient's medical  
34 condition or otherwise violating the standard of care.

35 IX. Any marijuana, marijuana paraphernalia, licit property, or interest in licit property that  
36 is possessed, owned, or used in connection with the medical use of marijuana as allowed under this  
37 chapter, or acts incidental to such use, shall not be seized or forfeited.

1 X. An individual shall not be subject to arrest, prosecution, or penalty, or denied any right or  
2 privilege, including but not limited to a civil penalty or disciplinary action by a court or occupational  
3 or professional licensing board or bureau, simply for being in the presence or vicinity of the medical  
4 use of marijuana as allowed under this chapter.

5 XI. A registry identification card, or its equivalent, that is issued under the laws of another  
6 state, district, territory, commonwealth, or insular possession of the United States that allows, in the  
7 jurisdiction of issuance, a visiting qualifying patient to possess marijuana for medical purposes, shall  
8 have the same force and effect as a registry identification card issued by the department, provided  
9 that a debilitating medical condition as defined in RSA 126-W:1, V exists.

10 XII. Any cardholder who transfers marijuana to an individual who is not a cardholder under  
11 this chapter shall be guilty of a class B felony, shall have his or her registry identification card  
12 revoked, and shall be subject to other penalties as provided in RSA 318-B:26. The department may  
13 revoke the registry identification card of any cardholder who violates any provision of this chapter,  
14 and the cardholder shall be subject to any other penalties established in law for the violation.

15 XIII. The protections provided to cardholders in this section shall exist only upon  
16 presentation of a valid registry identification card.

17 126-W:3 Departmental Administration.

18 I. Except as provided for in paragraphs II and III, the department shall issue registry  
19 identification cards to qualifying patients who submit all of the following information:

20 (a) Written certification as defined in RSA 126-W:1, XVI.

21 (b) Application or renewal fee.

22 (c) Name, residential and mailing address, and date of birth of the qualifying patient,  
23 except that if the applicant is homeless, no residential address is required.

24 (d) Name, address, and telephone number of the qualifying patient's physician.

25 (e) Name, address, and date of birth of the qualifying patient's designated caregiver, if any.

26 (f) Name and address of the alternative treatment center that the qualifying patient  
27 designates; a qualifying patient may designate no more than one alternative treatment center at any  
28 time.

29 (g) A statement signed by the qualifying patient, pledging not to divert marijuana to  
30 anyone who is not allowed to possess marijuana pursuant to this chapter and acknowledging that  
31 their diversion of marijuana is punishable by a class B felony and revocation of one's registry  
32 identification card, in addition to other penalties for the illegal sale of marijuana.

33 (h) A complete set of fingerprints for the qualifying patient's designated caregiver, if any.

34 (i) A signed statement from the designated caregiver, if any, agreeing to be designated  
35 as the patient's designated caregiver and pledging not to divert marijuana to anyone who is not  
36 allowed to possess marijuana pursuant to this chapter and acknowledging that their diversion of  
37 marijuana is punishable by a class B felony and revocation of one's registry identification card, in  
38 addition to other penalties for the illegal sale of marijuana.

1           II. The department shall not issue a registry identification card to a qualifying patient who  
2 is under the age of 18 unless:

3           (a) The qualifying patient's physician has explained the potential risks and benefits of  
4 the medical use of marijuana to the custodial parent or legal guardian with responsibility for health  
5 care decisions for the qualifying patient; and

6           (b) The custodial parent or legal guardian with responsibility for health care decisions  
7 for the qualifying patient consents in writing to:

8               (1) Allow the qualifying patient's medical use of marijuana;

9               (2) Serve as the qualifying patient's designated caregiver;

10              (3) Control the acquisition of the marijuana and the frequency of the medical use of  
11 marijuana by the qualifying patient; and

12           (c) The custodial parent or legal guardian completes an application on behalf of the minor.

13           III. The department shall verify the information contained in an application or renewal  
14 submitted pursuant to this section, and shall approve or deny an application or renewal within 15  
15 days of receiving it. The department may deny an application or renewal only if the applicant did  
16 not provide the information required pursuant to this section, the applicant previously had a registry  
17 identification card revoked for violating the provisions of this chapter, or if the department  
18 determines that the information provided was falsified. An applicant who is aggrieved by a  
19 department decision may request an administrative hearing at the department.

20           IV. The department shall require a state and federal criminal records check on each person  
21 who is applying to be a designated caregiver or an alternative treatment center agent. The  
22 department shall request the department of safety to perform the state and federal criminal records  
23 check and the department of safety shall complete such records checks and convey the findings of  
24 such checks to the department within 30 days of the request. The department and the department of  
25 safety may exchange necessary data including fingerprint data with the Federal Bureau of  
26 Investigation without disclosing that the records check is related to the provisions of RSA 126-W and  
27 acts permitted by it. The department and the department of safety shall destroy each set of  
28 fingerprints obtained pursuant to this chapter after the criminal records check is complete.

29           V. The department shall issue a registry identification card to the designated caregiver, if  
30 any, who is named in a qualifying patient's approved application and who qualifies under this  
31 chapter. The department shall notify the qualifying patient who has designated someone to serve as  
32 his or her designated caregiver if a registry identification card will not be issued to the individual.

33           VI. The department shall issue registry identification cards to qualifying patients and to the  
34 designated caregivers within 5 days of approving an application or renewal. Each registry identification  
35 card shall expire one year after the date of issuance, unless the physician states in the written  
36 certification that he or she believes the qualifying patient would benefit from medical marijuana only  
37 until a specified earlier date, then the registry identification card shall expire on that date.

1 (a) In the case of qualified patients and designated caregivers, registry identification  
2 cards shall contain all of the following:

3 (1) Name, mailing address, and date of birth of the qualifying patient.

4 (2) If the cardholder is a designated caregiver, the designated caregiver's name,  
5 address, and date of birth.

6 (3) The date of issuance and expiration date of the registry identification card.

7 (4) A random 10-digit identification number, containing at least 4 numbers and at  
8 least 4 letters, that is unique to the cardholder.

9 (5) A photograph of the cardholder.

10 (6) A statement that the cardholder is permitted under state law to possess  
11 marijuana pursuant to this chapter for the medical use of the qualifying patient.

12 (b) In the case of a registered alternative treatment center agent, registry identification  
13 cards shall contain all of the following:

14 (1) Name, mailing address, and date of birth of the cardholder.

15 (2) The name and address of the alternative treatment center.

16 (3) The date of issuance and expiration date of the registry identification card.

17 (4) A random 10-digit identification number, containing at least 4 numbers and at  
18 least 4 letters, that is unique to the cardholder.

19 (5) A photograph of the cardholder.

20 (6) A statement that the cardholder is permitted to engage in activities for the  
21 alternative treatment center to cultivate and provide medical marijuana to qualified patients and  
22 designated caregivers in accordance with this chapter and a designation as to whether the person is  
23 a principal officer, board member, employee, or volunteer.

24 VII. The department shall track the number of registered qualifying patients who have  
25 designated each alternative treatment center and issue a monthly written statement to the  
26 alternative treatment center identifying the number of registered qualifying patients who have  
27 designated that alternative treatment center along with the registry identification numbers of each  
28 patient and each patient's designated caregivers.

29 VIII. In addition to the monthly reports, the department shall also provide written notice to an  
30 alternative treatment center which identifies the names and registration identification numbers of a  
31 qualifying patient and his or her designated caregivers whenever any of the following events occur:

32 (a) A qualifying patient designates the alternative treatment center to serve his or her  
33 needs under this chapter;

34 (b) An existing registered qualifying patient revokes the designation of the alternative  
35 treatment center because he or she has designated a different alternative treatment center instead; or

36 (c) A registered qualifying patient who has designated the alternative treatment center  
37 loses his or her status as a registered qualifying patient under this chapter.

IX. The following notifications and department responses are required:

(a) A registered qualifying patient shall notify the department of any change in his or her name, address, or designated caregiver within 10 days of such change.

(b) A registered qualifying patient or alternative treatment center agent who fails to notify the department of any of these changes shall be guilty of a violation, punishable by a fine of no more than \$150. If the qualifying patient's certifying physician notifies the department in writing that either the qualifying patient has ceased to suffer from a debilitating medical condition or that the physician no longer believes the patient would receive benefit from the medical use of marijuana, the card is null and void upon notification by the department to the qualifying patient.

(c) A registered designated caregiver or alternative treatment center agent shall notify the department of any change in his or her name or address within 10 days of such change. A registered designated caregiver or alternative treatment center agent who fails to notify the department of any of these changes shall be guilty of a violation, punishable by a fine of no more than \$150.

(d) When a qualifying patient, designated caregiver, or alternative treatment center agent notifies the department of any change to a name, address, alternative treatment center, or designated caregiver, the department shall issue the cardholder a new registry identification card with a new random 10-digit identification number within 15 days of receiving the updated information and a \$10 fee.

(e) A registered qualifying patient who no longer has a debilitating medical condition and the patient's registered designated caregiver and alternative treatment center shall return all registry identification cards associated with that qualifying patient to the department within 48 hours of receiving the diagnosis by the patient's physician. When a registered qualifying patient dies, the family or designated caregiver shall notify the designated alternative treatment center within 24 hours, the alternative treatment center shall make arrangements to pick up any remaining supply of marijuana within 48 hours of receiving such notification, and the protections of this chapter shall no longer apply.

(f) If a cardholder loses his or her registry identification card, he or she shall notify the department and submit a \$10 fee within 10 days of losing the card. Within 5 days after such notification, the department shall issue a new registry identification card with a new random 10-digit identification number.

X. Mere possession of, or application for, a registry identification card shall not constitute probable cause or reasonable suspicion, nor shall it be used to support the search of the individual or property of the individual possessing or applying for the registry identification card. The possession of, or application for, a registry identification card shall not preclude the existence of probable cause if probable cause exists on other grounds.

1 XI.(a) The department shall create and maintain a confidential registry of registered  
2 qualifying patients, designated caregivers, and alternative treatment center agents who have  
3 applied for and are entitled to receive a registry identification card in accordance with the provisions  
4 of this chapter.

5 (b)(1) Except as specifically provided in this chapter, no person shall be permitted to  
6 gain access to any information about qualifying patients, designated caregivers, and alternative  
7 treatment center agents in the department's confidential registry, or any information otherwise  
8 maintained by the department about physicians and alternative treatment centers, except for  
9 authorized employees of the department in the course of their official duties and authorized  
10 employees of local and state law enforcement agencies who have stopped or arrested an individual  
11 who claims to be engaged in the medical use of marijuana. Authorized employees of local and state  
12 law enforcement agencies shall be granted access to the information within the department's  
13 confidential registry only for the purpose of verifying that an individual who has presented a registry  
14 identification card to the state or local law enforcement official is lawfully in possession of such card.  
15 In addition, if a state or local law enforcement agent has obtained a search or arrest warrant for a  
16 specific individual or address for which the law enforcement agent has probable cause to believe  
17 possesses, cultivates, or distributes marijuana, the department shall confirm or deny whether the  
18 individual or location is a registered qualifying patient, designated caregiver, or alternative  
19 treatment center agent.

20 (2) An employer, landlord, court, administrative hearings officer, or health care  
21 provider that has been presented with a registry identification card by a person asserting that they  
22 are entitled to protections under RSA 126-W:2 may contact the department to verify the validity of  
23 the registry identification card. The department shall verify a registry identification card to an  
24 employer, landlord, court, or health care provider who requests verification pursuant to this  
25 paragraph, provided that the employer, landlord, court, or health care provider provides the random  
26 identification card number on the registry identification card. In verifying the validity of a registry  
27 identification card, the department shall confirm only whether a card bearing the random  
28 identification card number is valid and the name of the person to whom it was issued.

29 (c) An individual shall be guilty of a class B misdemeanor for breaching the  
30 confidentiality of information obtained pursuant to this chapter, except that department employees  
31 shall be exempt for notifying law enforcement officials about falsified or fraudulent information  
32 submitted to the department, provided the employee who suspects that falsified or fraudulent  
33 information has been submitted confers with his or her supervisor, and both agree that  
34 circumstances exist that warrant the notification.

35 XII. The department shall submit to the legislature an annual report that does not disclose  
36 any identifying information about qualifying patients, designated caregivers, or physicians, but does  
37 contain, at a minimum, all of the following information:



- (a) The number of applications and renewals filed for registry identification cards.
- (b) The number of qualifying patients and designated caregivers approved in the state.
- (c) The number of alternative treatment centers registered in the state.
- (d) The nature of the debilitating medical conditions of the qualifying patients.
- (e) The number of registry identification cards revoked.
- (f) The number of physicians providing written certifications for qualifying patients.

XIII. Where a state or local law enforcement agency encounters an individual who, during the course of an investigation, credibly asserts that he or she is a registered qualifying patient or registered designated caregiver or encounters a registered alternative treatment center, the law enforcement agency shall not provide any information from any marijuana-related investigation of the individual or entity to any law enforcement authority that does not recognize the protection of this chapter and any prosecution of the individual or entity for a violation of this chapter shall be conducted pursuant to the laws of this state. This paragraph shall not apply in cases where the state or local law enforcement agency has probable cause to believe the person is distributing marijuana to a person who is not allowed to possess it under this chapter, nor shall it prevent the sharing of information if the primary offense is unrelated to marijuana.

XIV. The application for qualifying patients' registry identification cards shall include a question asking whether the patient would like the department to notify him or her of any clinical studies regarding marijuana's risk or efficacy that seek human subjects. The department shall inform those patients who answer in the affirmative of any such studies it is notified of that will be conducted in the United States.

126-W:4 Department Rules. Not later than one year after the effective date of this chapter, the department shall adopt rules, pursuant to RSA 541-A, governing the manner in which it shall consider applications for issuance and renewals of registry identification cards for qualifying patients and designated caregivers. The department's rules shall establish application and renewal fees for registry identification cards in accordance with the following:

I. The fee structure by the department for alternative treatment centers and registry identification cards shall generate revenues sufficient to offset all state expenses of implementing and administering this chapter; however,

II. The department may accept donations from private sources without the approval of the governor and council in order to reduce the application and renewal fees.

126-W:5 Prohibitions, Restrictions, and Limitations on the Use of Medical Marijuana.

I. A registered qualifying patient may use medical marijuana on privately-owned real property only with the permission of the property owner or in the case of leased property with the permission of the tenant in possession of the property, except that a tenant shall not allow a qualified patient to smoke medical marijuana on rented property if smoking on the property violates the lease or the lessor's rental policies that apply to all tenants at the property. However, a tenant

1 in possession may permit a qualified patient to use medical marijuana on leased property by  
2 ingestion or inhalation through vaporization even if smoking is prohibited by the lease or rental  
3 policies. For purposes of this chapter, vaporization shall mean the inhalation of marijuana without  
4 the combustion of the marijuana.

5 II. Nothing in this chapter shall exempt any person from arrest or prosecution for:

6 (a) Being under the influence of marijuana while:

7 (1) Operating a motor vehicle, commercial vehicle, boat, or vessel, or any other  
8 vehicle propelled or drawn by power other than muscular power;

9 (2) In his or her place of employment, without the written permission of the  
10 employer; or

11 (3) Operating heavy machinery or handling a dangerous instrumentality.

12 (b) The use or possession of marijuana by a qualified patient or other cardholder:

13 (1) For purposes other than alleviating symptoms as permitted by this chapter; or

14 (2) In a manner that endangers the health, well-being, or safety of another person.

15 (c) The smoking of marijuana in any public place, including:

16 (1) A school bus, public bus, or other public vehicle;

17 (2) A workplace or place of employment, without the written permission of the  
18 employer;

19 (3) The grounds of any preschool or primary or secondary school;

20 (4) Any correctional facility; or

21 (5) Any public park, public beach, public recreation center, public field, or youth  
22 center.

23 III. Nothing in this chapter shall be construed to require:

24 (a) A governmental, private, or any other health insurance provider, health care plan, or  
25 medical assistance program to be liable for any claim for reimbursement for the medical use of  
26 marijuana.

27 (b) Any individual or establishment in lawful possession of property to allow a guest,  
28 client, customer, or other visitor to use marijuana on or in that property. This chapter shall not limit  
29 an individual or entity in lawful possession of property, or an agent of such individual or entity, from  
30 expelling an individual who uses marijuana without permission from their property and from  
31 seeking civil and criminal penalties for the unauthorized use of marijuana on their property.

32 (c) Any accommodation of any medical use of marijuana on the property or premises of  
33 any place of employment or on the property or premises of any jail, correctional facility, or other type  
34 of penal institution where prisoners reside or persons under arrest are detained. This chapter shall  
35 in no way limit an employer's ability to discipline an employee for ingesting marijuana in the  
36 workplace or working while under the influence of marijuana.

(d) A landlord to permit a qualified patient to use marijuana in any common areas of leased property.

(e) A landlord to permit a qualified patient to smoke marijuana on any or in any leased property, except that a landlord may not prohibit the medical use of marijuana on leased property by a qualified patient through means other than smoking, including but not limited to the ingestion of medical marijuana or the inhalation through vaporization, as long as the tenant in possession of the property provides permission to the qualified patient to use medical marijuana in the rented property.

IV. Fraudulent representation to a law enforcement official of any fact or circumstance relating to the medical use of marijuana to avoid arrest or prosecution shall be punishable by a fine of \$500, which shall be in addition to any other penalties that may apply for making a false statement or for the use of marijuana other than use undertaken pursuant to this chapter.

126-W:6 Affirmative Defense. Except as provided in RSA 126-W:5, it is an affirmative defense to any prosecution of an offense involving marijuana intended for medical use that:

I. The defendant is a qualifying patient in possession of a valid registry identification card and at the time of arrest or prosecution was in possession of a quantity of marijuana that was not more than is allowed under this chapter; or

II. The defendant is a designated caregiver in possession of a valid registry identification card and at the time of arrest or prosecution was in possession of a quantity of marijuana that was not more than is allowed under this chapter; and

III. The qualifying patient or the qualifying patient's designated caregiver was engaged in the acquisition, possession, preparation, use, or transportation of marijuana, paraphernalia, or both, relating to the administration of marijuana solely to treat or alleviate the qualifying patient's debilitating medical condition or symptoms or effects of treatment associated with the qualifying patient's debilitating medical condition.

126-W:7 Enforcement.

I. If the department fails to issue a valid registry identification card in response to a completed application for issuance or renewal submitted by a qualifying patient by certified mail pursuant to this chapter within 20 days of the application for issuance or renewal, the registry identification card shall be deemed granted, and a copy of the registry identification application or renewal shall be deemed a valid registry identification card.

II. If the department fails to issue a valid registry identification card in response to a completed application for issuance or renewal submitted by an alternative treatment center agent or a designated caregiver by certified mail pursuant to this chapter within 45 days of the application for issuance or renewal, the registry identification card shall be deemed granted, and a copy of the registry identification application or renewal shall be deemed a valid registry identification card.

III. If at any time after one year following the effective date of this chapter the department is not accepting applications, including if it has not adopted rules allowing qualifying patients to submit applications, a notarized statement by a qualifying patient containing the information required in an application, pursuant to RSA 126-W:3, I together with a written certification shall be deemed a valid registry identification card.

126-W:8 Alternative Treatment Centers.

I. An alternative treatment center registered under this section may acquire, possess, cultivate, manufacture, deliver, transfer, transport, supply, or dispense marijuana, marijuana paraphernalia, and related supplies and educational materials, to registered qualifying patients who have designated it as their alternative treatment center and to their registered designated caregivers for the registered qualifying patients' medical use. An alternative treatment center may receive consideration for providing the goods and services allowed by this section. An alternative treatment center may cultivate and possess whichever of the following quantities is greater: (a) 96 marijuana plants, 96 seedlings, and 32 ounces of usable marijuana; or (b) 6 plants, 6 seedlings, and 2 ounces for each registered qualifying patient who has designated the alternative treatment center to provide him or her with marijuana for medical use. An alternative treatment center may also possess marijuana seeds, stalks, and unusable roots.

II.(a) Not later than one year 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, including, but not necessarily limited to, rules governing:

- (1) The form and content of registration and renewal applications.
- (2) Oversight requirements.
- (3) Security requirements, which shall include at a minimum, lighting, physical security, video security, alarm requirements, measures to prevent loitering, and on-site parking.
- (4) Sanitary requirements.
- (5) Electrical safety requirements.
- (6) The specification of acceptable forms of picture identification that an alternative treatment center may accept when verifying a sale.
- (7) Personnel requirements including how many volunteers an alternative treatment center is permitted to have and requirements for supervision.
- (8) Labeling standards.
- (9) Procedures for suspending or terminating the registration of alternative treatment centers that violate the provisions of this section or the rules adopted pursuant to this section, procedures for appealing penalties, and a schedule of penalties.
- (10) Procedures for inspections and investigations.

1 (11) Advertising restrictions, including a prohibition of misrepresentation and unfair  
2 practices.

3 (12) Permissible hours of operation.

4 (13) The fees for the processing and review of applications for registration as an  
5 alternative treatment center for the registration and regulation of an alternative treatment center  
6 after it has been approved by the department. Such fees shall be established in an amount that  
7 covers all costs of the department and other state agencies, as applicable, for the review,  
8 registration, and regulation of alternative treatment centers.

9 (14) Such other matters as are necessary for the fair, impartial, stringent, and  
10 comprehensive administration of this chapter.

11 (b) The department shall adopt rules with the goal of protecting against diversion and  
12 theft, without imposing an undue burden on the registered alternative treatment centers or  
13 compromising the confidentiality of registered qualifying patients and their registered designated  
14 caregivers.

15 (c) Within 30 days of the adoption of rules, the department shall begin accepting  
16 applications for the operation of alternative treatment centers.

17 (d) Within 18 months of the effective date of this section, provided that at least 3  
18 applications have been submitted that score sufficiently high to receive a certificate, the department shall  
19 issue alternative treatment center registration certificates to the three highest-scoring applicants.

20 (e) Any time an alternative treatment center registration certificate is revoked, is  
21 relinquished, or expires, the department shall accept applications for a new alternative treatment  
22 center and issue registration certificates to the applicant who scores the highest.

23 (f) If at any time after one year after the effective date of this section, fewer than 3  
24 alternative treatment centers hold valid registration certificates in New Hampshire, the department  
25 shall accept applications for a new alternative treatment center. Except as provided in  
26 subparagraph (g), no more than 3 alternative treatment centers may hold valid registration  
27 certificates at one time.

28 (g) If at any time after 2 years after the effective date of this section, the report issued  
29 pursuant to RSA 126-W:9 determines that 3 alternative treatment centers are not sufficient to ensure  
30 access to registered qualifying patients throughout the state, the department shall accept applications for  
31 up to 2 additional alternative treatment centers and issue registration certificates to the appropriate  
32 number of applicants who score the highest. The number of additional alternative treatment centers  
33 shall be determined by the department, based on the report issued pursuant to RSA 126-W:9.

34 III.(a) An alternative treatment center applicant must submit a completed department-  
35 approved application form with all required documentation and a non-refundable fee in an amount  
36 set by department rule. The alternative treatment center application and supporting materials must  
37 include, at a minimum:

- 1                   (1) The legal name, articles of incorporation, and bylaws of the alternative treatment  
2 center.
- 3                   (2) The proposed physical address of the alternative treatment center, if a precise  
4 address has been determined, or, if not, the general location where it would be located. This may  
5 include a second location for the cultivation of medical marijuana.
- 6                   (3) A description of the enclosed, locked facility that would be used in the cultivation  
7 of marijuana by the alternative treatment center.
- 8                   (4) The name, address, and date of birth of each principal officer and board member  
9 of the alternative treatment center and a complete set of fingerprints for each of them. The board of  
10 directors for the non-profit must include at least one physician, nurse, or pharmacist licensed to  
11 practice in New Hampshire and at least 3 patients qualified to register as registered qualifying  
12 patients.
- 13                   (5) Proposed security and safety measures that comply with the rules issued  
14 pursuant to 126-W:8, II (a)(4), including a description of interior and exterior lighting and security  
15 systems.
- 16                   (6) Written procedures, including for cultivation, inventory control, food preparation,  
17 if any, quality control, record keeping and incident reporting.
- 18                   (7) Copies of educational materials that would be provided.
- 19                   (8) The distance from any pre-existing private or public school.
- 20                   (9) A copy of the proposed policy regarding services to registered patients who cannot  
21 afford to purchase marijuana for medical purposes.
- 22                   (10) Information demonstrating the applicant's knowledge of organic growing  
23 methods to be used in their growing and cultivation of marijuana.
- 24                   (11) Steps that will be taken to ensure the quality of the marijuana, including purity  
25 and consistency of dose.
- 26                   (12) A start-up timetable which provides an estimated time from registration of the  
27 dispensary to full operation, and the assumptions used for the basis of those estimates.
- 28                   (13) Information showing the applicant's experience running a non-profit or other  
29 business.
- 30                   (14) A full description of a staffing plan that will provide accessible business hours,  
31 safe growing and cultivation, and maintenance of confidential information regarding grow sites and  
32 the identity of patient information.
- 33                   (15) A description of any additional services that will be available to patients.
- 34                   (b) Any time one or more alternative treatment center registration applications are  
35 being considered, the department shall also allow for comment by the public and shall solicit input  
36 from registered qualifying patients, registered designated caregivers, and the towns or cities where  
37 the applicants would be located.

1 (c) Each time an alternative treatment center certificate is granted, the decision shall be  
2 based on the overall health needs of qualified patients and the safety of the public. The department  
3 shall evaluate applications for alternative treatment center registration certificates using an  
4 impartial and numerically scored competitive bidding process developed by the department in  
5 accordance with this chapter. The department shall require applicants to meet a minimum score to  
6 be considered. The registration considerations shall include the following criteria:

7 (1) The suitability of the proposed location or locations, including compliance with  
8 any local zoning laws and geographic convenience to patients from throughout the state of  
9 New Hampshire to alternative treatment centers if the applicant were approved.

10 (2) The proposed alternative treatment center's plan for operations and services,  
11 including its staffing and training plans, whether it has sufficient capital to operate, and ability to  
12 provide a steady supply of marijuana to the registered qualifying patients in the state.

13 (3) The principal officer and board members' character and relevant experience,  
14 including any training or professional licensing related to medicine, pharmaceuticals, natural  
15 treatments, botany, or marijuana cultivation and preparation and their experience running a non-  
16 profit organization or business.

17 (4) The applicant's plan for making medical marijuana available on an affordable  
18 basis to registered qualifying patients enrolled in Medicaid or receiving Supplemental Security  
19 Income or Social Security Disability Insurance.

20 (5) The applicant's plan for safe and accurate packaging and labeling of medical  
21 marijuana, including the applicant's plan for ensuring that all medical marijuana is free of  
22 contaminants.

23 (6) The sufficiency of the applicant's plans for record keeping and inventory control.  
24 Records shall be considered confidential health care information under New Hampshire law and are  
25 intended to be deemed protected health care information for purposes of the federal Health  
26 Insurance Portability and Accountability Act of 1996, as amended. Any dispensing records that a  
27 registered alternative treatment center is required to keep shall keep track of transactions according  
28 to registered qualifying patients', registered designated caregivers', and registered alternative  
29 treatment centers' registry identification numbers, rather than their names, to protect their  
30 confidentiality.

31 (7) The sufficiency of the applicant's plans for safety and security, including  
32 proposed location and security devices employed.

33 (8) Whether the entity possesses or has the right to use sufficient land, buildings,  
34 and equipment to properly carry out its duties as an alternative treatment center.

35 (d) After an alternative treatment center is approved, but before it begins operations, it  
36 shall submit the registration and regulation fee paid to the department in accordance with the rules  
37 adopted by the department.

1 (e) Except as provided in subparagraph (h), the department shall issue each alternative  
2 treatment center agent a registry identification card or renewal card within 15 days of receipt of the  
3 person's name, address, and date of birth and a fee in an amount established by the department.  
4 Each card shall specify that the cardholder is a principal officer, board member, agent, volunteer, or  
5 employee of an alternative treatment center and shall contain the following:

6 (1) The name, address, and date of birth of the alternative treatment center agent.

7 (2) The legal name of the alternative treatment center with which the alternative  
8 treatment center agent is affiliated.

9 (3) A random identification number that is unique to the cardholder.

10 (4) The date of issuance and expiration date of the registry identification card.

11 (5) A photograph of the cardholder.

12 (f) Except as provided in this section, the department shall not issue a registry  
13 identification card to any principal officer, board member, agent, volunteer, or employee of an  
14 alternative treatment center who has been convicted of a drug-related offense. The department shall  
15 conduct a background check of each principal officer, board member, agent, volunteer, or employee in  
16 order to carry out this provision. The department shall notify the alternative treatment center in  
17 writing of the reason for denying the registry identification card. The department may grant such  
18 person a registry identification card if the department determines that the offense was for conduct  
19 that occurred prior to the effective date of this chapter or that was prosecuted by an authority other  
20 than the state of New Hampshire and for which the provisions of this chapter would otherwise have  
21 prevented a conviction.

22 (g) A registration identification card of an alternative treatment center agent shall  
23 expire one year after its issuance, or upon the expiration of the registered organization's registration  
24 certificate, whichever occurs first.

25 (h) Notwithstanding any other provision of law, information required to be submitted to  
26 the department on an application for an alternative treatment center identifying the locations where  
27 marijuana is proposed to be grown, cultivated, harvested, and otherwise prepared for distribution to  
28 registered qualifying patients, registered caregivers, and alternative treatment centers, if such  
29 location is different from the location of the alternative treatment center, and any other department  
30 records identifying such location, shall be considered to be confidential information and not subject  
31 to disclosure pursuant to RSA 91-A, provided that such information may be disclosed to a law  
32 enforcement agency upon request for purposes of enforcement under this chapter.

33 IV.(a) An alternative treatment center's registration shall expire 2 years after its  
34 registration certificate is issued. The alternative treatment center may submit a renewal application  
35 beginning 60 days prior to the expiration of its registration certificate.

36 (b) The department shall grant an alternative treatment center's renewal application  
37 within 30 days of its submission if the following conditions are all satisfied:



(1) The alternative treatment center submits the required fee, which shall be refunded within 30 days if the renewal application is rejected.

(2) The department has not suspended the alternative treatment center's registration for violations of this chapter or rules adopted pursuant to this chapter.

(3) The alternative treatment center is complying with the requirements in paragraph VI.

(4) The inspections authorized by paragraph V and the report, provided pursuant to subparagraph VI(h), do not raise serious concerns about the continued operation of the alternative treatment center applying for renewal.

(c) If the department determines that any of the conditions listed in subparagraphs (b)(1)-(4) do not exist, the department shall begin an open application process for the operation of an alternative treatment center. In granting a new registration certificate, the department shall consider factors listed in subparagraphs III(a) and III(c).

(d) The department shall issue a 30-day temporary registration certificate to an alternative treatment center after that center's registration would otherwise expire if the following conditions are all satisfied:

(1) The alternative treatment center has applied for a renewal, but the department has not yet come to a decision.

(2) The alternative treatment center requested a temporary registration certificate.

(3) The alternative treatment center has not had its registration certificate revoked due to violations of this chapter or rules adopted pursuant to this chapter.

V. Alternative treatment centers shall be subject to reasonable inspection by the department of health and human services. During an inspection, the department may review the alternative treatment center's records, including its confidential dispensing records, which shall track transactions according to registered qualifying patients' registry identification numbers to protect their confidentiality.

VI.(a) An alternative treatment center shall be operated on a not-for-profit basis for the benefit of its patients. An alternative treatment center need not be recognized as a tax-exempt organization by the Internal Revenue Service.

(b) An alternative treatment center may not be located in a residential district or within 500 feet of the property line of a pre-existing public or private school or playground.

(c) An alternative treatment center shall notify the department within 10 days of when an alternative treatment center agent ceases to be associated with and/or work at the alternative treatment center. His or her registry identification card shall be deemed null and void and the person shall be liable for any other penalties that may apply to the person's non-medical use of marijuana.

(d) An alternative treatment center shall notify the department in writing of the name, address, and date of birth of any proposed new alternative treatment center agent and shall submit

1 a fee in an amount established by the department for a new registry identification card before a new  
2 agent or employee begins working at the alternative treatment center, and shall submit a complete  
3 set of fingerprints for the prospective alternative treatment center agent.

4 (e) An alternative treatment center shall implement appropriate security measures to  
5 deter and prevent the unauthorized entrance into areas containing marijuana and the theft of  
6 marijuana, and shall ensure that each location has an operational security alarm system.

7 (f) The operating documents of an alternative treatment center shall include procedures  
8 for the oversight of the alternative treatment center and procedures to ensure accurate record  
9 keeping.

10 (g) Each alternative treatment center shall keep the following records, dating back at  
11 least one year:

12 (1) Records of the disposal of marijuana that is not distributed by the alternative  
13 treatment center to registered patients who have designated the alternative treatment center to  
14 cultivate for them.

15 (2) A record of each transaction, including the amount of marijuana dispensed, the  
16 amount of consideration, and the registry identification number of the registered qualifying patient  
17 or registered designated caregiver.

18 (h) Each alternative treatment center shall:

19 (1) Conduct an initial comprehensive inventory of all medical marijuana, including  
20 usable marijuana available for dispensing and mature marijuana plants at each authorized location  
21 on the date the alternative treatment center first dispenses medical marijuana.

22 (2) Conduct a monthly comprehensive inventory of all medical marijuana, including  
23 usable marijuana available for dispensing, mature marijuana plants, and seedlings at each  
24 authorized location on the date the alternative treatment center first dispenses medical marijuana.

25 (i) An alternative treatment center shall submit a department-approved incident report  
26 form on the next business day after it discovers a reportable incident. The report shall indicate the  
27 nature of the breach and the corrective actions taken by the alternative treatment center. For  
28 purposes of reporting, an incident includes:

29 (1) Confidential information accessed or disclosed in violation of department rules;

30 (2) Loss of inventory by theft or diversion;

31 (3) Unauthorized intrusion into the alternative treatment center or the one  
32 permitted additional location, if any;

33 (4) Any known violation of this chapter or department rules by an alternative  
34 treatment center agent; and

35 (5) Any other incident that the department by rule requires to be reported.

36 (j) Alternative treatment centers cannot use pesticides in marijuana cultivation unless  
37 pesticides become authorized for application on marijuana.

1 (k) No marijuana or paraphernalia at an alternative treatment center shall be visible  
2 from any public or other property.

3 (l) An alternative treatment center is prohibited from acquiring, possessing, cultivating,  
4 manufacturing, delivering, transferring, transporting, supplying, or dispensing marijuana for any  
5 purpose except to assist patients who are allowed to use marijuana pursuant to this chapter with the  
6 medical use of marijuana directly or through the registered qualifying patients' designated  
7 caregivers.

8 (m) An alternative treatment center shall submit an annual report to the department  
9 which shall provide information required by the department in order to allow the department to  
10 evaluate whether the alternative treatment center is adequately providing patients with access to  
11 medical marijuana

12 VII.(a) Each time an alternative treatment center agent dispenses marijuana to a registered  
13 qualifying patient directly or through the qualifying patient's registered designated caregiver, he or  
14 she shall consult the alternative treatment center's records to verify that the records do not indicate  
15 that the dispensing of marijuana would cause the registered qualifying patient to receive more  
16 marijuana than is permitted in a 10-day period. Each time marijuana is dispensed, the alternative  
17 treatment center agent shall record the date the marijuana was dispensed and the amount  
18 dispensed. All records shall be kept according to the registry identification number of the registered  
19 qualifying patient and registered designated caregiver, if any.

20 (b) Except as provided in subparagraph (c), a registered qualifying patient is not allowed  
21 to obtain more than one ounce of usable marijuana directly or through the qualifying patient's  
22 registered designated caregiver during a 10-day period.

23 (c) After providing an opportunity for patients, experts, researchers, and physicians to be  
24 heard, the department may issue a rule adjusting the limit specified in subparagraph (a) to an  
25 amount that is reasonably necessary for a 10-day supply.

26 VIII.(a) No registered alternative treatment center shall be subject to the following:

27 (1) Prosecution for the acquisition, possession, cultivation, manufacture, delivery,  
28 transfer, transport, sale, supply, or dispensing of marijuana, or related supplies for medical purposes  
29 in accordance with the provisions of this chapter and any rule adopted by the department pursuant  
30 to this chapter.

31 (2) Inspection and search by a law enforcement agency, except pursuant to  
32 paragraph V or upon a search warrant issued by a court or judicial officer.

33 (3) Seizure of marijuana, except upon any order issued by a court or judicial officer.

34 (4) Imposition of any penalty or denied any right or privilege including, but not  
35 limited to, imposition of a civil penalty or disciplinary action by an occupational or professional  
36 licensing board or entity, solely for acting in accordance with this chapter to assist registered  
37 qualifying patients or registered designated caregivers with the medical use of marijuana.

1 (b) No alternative treatment center agent shall be subject to arrest, prosecution, search,  
2 seizure, or penalty in any manner, or denied any right or privilege including, but not limited to, civil  
3 penalty or disciplinary action by a business, occupational, or professional licensing board or entity,  
4 solely for working for or with an alternative treatment center to engage in acts permitted by this  
5 chapter.

6 (1) Except when transporting marijuana in accordance with subparagraphs (2) or (3),  
7 registered alternative treatment center agents are only allowed to possess and manufacture  
8 marijuana at the registered alternative treatment center location or locations for which the  
9 alternative treatment center agent is registered. Volunteers are only allowed to possess and  
10 manufacture marijuana at a registered alternative treatment center location. Volunteers cannot  
11 dispense marijuana.

12 (2) Distributions of marijuana for medical use to a registered qualifying patient or a  
13 registered caregiver for use by a registered qualifying patient shall be labeled with a trip ticket to  
14 identify the alternative treatment center, the patient's registry number, or the caregiver's number,  
15 the amount and form, the time and date of origin, and destination of the product.

16 (3) An alternative treatment center with a growing location in addition to the  
17 location of the alternative treatment center shall label the marijuana that is being moved between  
18 the growing location and the alternative treatment center with a trip ticket that identifies the  
19 alternative treatment center by registry number, the time, date, origin, and destination of the  
20 material being transported, and the amount and form of marijuana and marijuana material that is  
21 being transported. Marijuana shall be transported only by a registered alternative treatment center  
22 agent who is not a volunteer.

23 IX.(a)(1) An alternative treatment center shall not possess an amount of marijuana that  
24 exceeds whichever of the following quantities is greater: (a) 96 marijuana plants, 96 seedlings, and  
25 32 ounces of useable marijuana; or (b) 6 plants, 6 seedlings, and 2 ounces for each registered  
26 qualifying patient who has designated the alternative treatment center to provide him or her with  
27 marijuana for medical use.

28 (2) An alternative treatment center may possess marijuana seeds, stalks, and  
29 unusable roots.

30 (b) An alternative treatment center or registered alternative treatment center agent  
31 shall not dispense, deliver, or otherwise transfer marijuana to a person other than:

32 (1) A registered qualifying patient who has designated the relevant alternative  
33 treatment center; or

34 (2) Such patient's registered designated caregiver.

35 (c) A person found to have violated subparagraph (b) of this section shall not be a  
36 registered alternative treatment center agent, and such person's registry identification card shall be  
37 immediately revoked.

1 (d) Except as provided in subparagraph III(f), no person who has been convicted of a  
2 drug-related offense shall be a registered alternative treatment center agent unless the department  
3 has determined that the person's conviction was for the medical use of marijuana or assisting with  
4 the medical use of marijuana and issued the person a registry identification card as provided under  
5 subparagraph III(g). A person who is employed by or is an agent, volunteer, principal officer, or  
6 board member of an alternative treatment center who violates this paragraph shall be guilty of a  
7 violation punishable by a fine of up to \$1,000. A subsequent violation of this paragraph shall be a  
8 misdemeanor.

9 (e) All cultivation of marijuana shall take place in an enclosed, locked facility, which can  
10 only be accessed by alternative treatment center agents.

11 X. All marijuana dispensed by an alternative treatment center shall include a label  
12 specifying the percent of tetrahydrocannabinol contained in the marijuana, the weight of the  
13 marijuana, and any other information the department requires to appear on the label. The label  
14 shall also specify that the marijuana is for medical use and that diversion is a class B felony  
15 requiring revocation of one's registry identification card.

16 XI. An alternative treatment center must provide educational materials about marijuana to  
17 registered patients and their registered primary caregivers. Each alternative treatment center shall  
18 have an adequate supply of up-to-date educational material available for distribution. Educational  
19 materials shall be available for inspection by the department upon request. The educational  
20 material shall at least include information about the following:

21 (a) Strains of marijuana, routes of administration, and their different effects. Alternative  
22 treatment centers shall have educational materials available to assist in the selection of prepared  
23 marijuana. Alternative treatment centers shall provide tracking sheets to registered patients and  
24 registered primary caregivers who request them to keep track of the strains used and their effects.

25 (b) How to achieve proper dosage for different modes of administration. Emphasis shall  
26 be on using the smallest amount possible to achieve the desired effect. The impact of potency must  
27 also be explained.

28 (c) Information on tolerance, dependence, and withdrawal must be provided. Alternative  
29 treatment centers are not required to continue to furnish marijuana for medical purposes if it is  
30 believed that a registered qualifying patient or designated caregiver is abusing marijuana or other  
31 substances.

32 (d) Information regarding substance abuse signs and symptoms must be available, as  
33 well as referral information.

34 (e) Information on whether the alternative treatment center's marijuana and associated  
35 products meet organic certification standards.

36 (f) An alternative treatment center shall provide to each registered qualifying patient  
37 and registered designated caregiver receiving marijuana a safety insert, which the department may,

1 at its discretion, inspect and approve, which shall include but not be limited to: (1) methods for  
2 administration of medical marijuana; and (2) a description of potential side effects qualifying  
3 patients could experience while using medical marijuana.

4 XII. Each alternative treatment center shall develop, implement, and maintain on the  
5 premises employee and agent policies and procedures to address the following requirements:

6 (a) A job description or employment contract developed for all employees and a volunteer  
7 agreement for all volunteers, which includes duties, authority, responsibilities, qualifications, and  
8 supervision.

9 (b) Training in and adherence to confidentiality laws.

10 (c) The proper use of security measures and controls that have been adopted.

11 (d) Specific procedural instructions on how to respond to an emergency.

12 XIII. Each alternative treatment center shall maintain a personnel record for each  
13 alternative treatment center agent that includes an application for employment or to volunteer and a  
14 record of any disciplinary action taken.

15 XIV. Each alternative treatment center shall develop, implement, and maintain on the  
16 premises an on-site training curriculum, or enter into contractual relationships with outside  
17 resources capable of meeting employee training needs, which includes, but is not limited to, the  
18 following topics:

19 (a) Professional conduct, ethics, and patient confidentiality; and

20 (b) Developments in the field of the medical use of marijuana.

21 XV. All alternative treatment centers shall prepare training documentation for each  
22 employee and have employees sign a statement indicating the date, time, and place the employee  
23 received said training and topics discussed, to include name and title of presenters. The alternative  
24 treatment center shall maintain documentation of an employee's and a volunteer's training for a  
25 period of at least 6 months after termination of an employee's period of employment or the  
26 volunteer's period of voluntary service.

27 XVI. A physician shall not:

28 (a) Accept, solicit, or offer any form of pecuniary remuneration from or to an alternative  
29 treatment center, except if the physician is employed by an alternative treatment center.

30 (b) Offer a discount or other thing of value to a patient who uses or agrees to use a  
31 particular alternative treatment center.

32 (c) Examine a patient for purposes of diagnosing a debilitating medical condition at a  
33 location where medical marijuana is sold or distributed.

34 (d) Hold an economic interest in an alternative treatment center if the physician certifies  
35 the debilitating medical condition of a patient for participation in the medical marijuana program.

36 126-W:9 Annual Report. The commissioner of the department of health and human services  
37 shall report annually on the medical marijuana program established under this chapter to the

oversight committee on health and human services established under RSA 126-A:13. The report shall be filed with the chairperson of the committee by November 1 of each year beginning with November 1, 2013. The commissioner's report shall include the following areas:

I. The ability of registered qualifying patients and registered designated caregivers in all areas of the state to obtain timely access to medical marijuana.

II. The effectiveness of alternative treatment centers individually and together in serving the needs of registered qualifying patients and registered caregivers, including the provision of educational and support services.

III. Physician participation in the medical marijuana program.

IV. The number of designated caregivers and the number of registered qualifying patients, by county.

V. Sufficiency of the regulatory and security safeguards contained in this chapter to ensure that access to and use of marijuana cultivated is provided only to cardholders authorized for such purposes.

VI. Any illegal distribution or diversion of marijuana cultivated pursuant to this chapter to individuals who are not cardholders.

VII. Any other issues related to the implementation of the medical use of marijuana permitted under this chapter that the committee shall request.

VIII. A detailed summary of the reports submitted by alternative treatment centers as required under RSA 126-W:8, VI(i).

126-W:10 Severability. If any provision of this chapter or the application thereof to any individual or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared to be severable.

3 Effective Date. This act shall take effect upon its passage.

**HB 573-FN - FISCAL NOTE**

AN ACT                    relative to the use of marijuana for medicinal purposes.

**FISCAL IMPACT:**

The Judicial Branch, Judicial Council, New Hampshire Association of Counties, New Hampshire Municipal Association, and the Departments of Corrections, Safety and Health and Human Services state this bill, as introduced, will have an indeterminable fiscal impact on state, county and local expenditures, and state and local revenue in FY 2013 and each year thereafter. There will be no impact on county revenue.

**METHODOLOGY:**

The Judicial Branch states this bill would enact RSA 126-W relative to the use of marijuana for medicinal purposes. The Branch identified seven sections in the bill that may result in additional costs and four sections of the bill that could result in savings to the Branch.

The potential costs could arise from the following:

- Proposed RSA 126-W:2, XII makes it a class B felony to sell marijuana to an individual who is not a cardholder;
- Proposed RSA 126-W:3, III provides for administrative hearings in the Department of Health and Human Services if an individual is aggrieved by a Department decision. Such hearings could result in appeals to the Supreme Court which has discretionary review of such appeals;
- Proposed RSA 126-W:3, IX(b) and (c) make it a violation with a maximum fine of \$150 for a qualifying patient or designated caregiver to fail to notify the Department of any change in name or address;
- Proposed RSA 126-W:3, XI(c) makes it a class B misdemeanor to breach the confidentiality of information obtained pursuant to the chapter;
- Proposed RSA 126-W:5, IV provides for a \$500 fine for a fraudulent representation to a law enforcement official of any fact or circumstance relating to the use of medicinal marijuana to avoid arrest or prosecution;
- Proposed RSA 126-W:6 allows medical use of marijuana to be an affirmative defense in any prosecution of an offense involving marijuana. This defense has the potential to elongate trials; and



- Proposed RSA 126-W:8, IX(d) makes it a violation for the first offense and a misdemeanor for subsequent offense for and agent, volunteer, officer, or board member of an alternative treatment center to have been convicted of a drug-related offense.

Potential savings could result from the following:

- Proposed RSA 126-W:2, I provides that a qualifying patient is not subject to arrest, prosecution, or penalty for the medical use of marijuana if the patient has no more than two ounces of marijuana;
- Proposed RSA 126-W:2, II provides a designated care giver is not subject to arrest, prosecution, or penalty for the medical use of marijuana if the caregiver has no more than two ounces of marijuana;
- Proposed RSA 126-W:2, IV provides that an alternative treatment center may accept marijuana seeds, seedlings, plants or usable marijuana; and
- Proposed RSA 126-W:8, VIII provides no registered alternative treatment center, nor one of its agents, shall be subject to arrest, or prosecution for any marijuana related offense provided the center or agent was acting in accordance with the chapter.

The Branch has no information on which to estimate the bill's impact on the number of felonies, misdemeanors, or violations that would be tried or avoided, and therefore cannot provide an accurate estimate of the fiscal impact on state revenue and expenditures. The Branch can, however, provide information on the cost of processing each type of case. The Branch states the average cost of processing a routine felony case in the superior court will be \$405.37 in FY 2014 and \$415.78 in FY 2015. In the district division of the circuit court, the average cost of processing a class A misdemeanor will be \$62.71 in FY 2014 and \$64.40 in FY 2015; the average cost of processing a class B misdemeanor will be \$44.32 in FY 2014 and \$45.84 in FY 2015; and the average cost of processing a violation-level offense will be \$42.85 in FY 2014 and \$44.36 in FY 2015. The Branch states these cost estimates are based on data that is more than seven years old and does not reflect the changes to the courts over that same period of time or the impact these changes may have on the processing of these types of cases. Additionally, the Branch states that if a single case were to be appealed to the New Hampshire Supreme Court, the fiscal impact would be in excess of \$10,000.

The Judicial Council states the bill may slightly increase Council expenditures. The Council assumes a very small number of people who suffer from a debilitating medical condition are currently prosecuted each year for either the possession or manufacture of marijuana. The Council also assumes a very small number of severely ill people with the types of serious medical conditions and chronic pain issues who would be eligible for prescription marijuana under the bill would divert properly prescribed marijuana in order to sell the drug for material

gain. The Council therefore expects the legalization of marijuana possession for medicinal purposes to have no impact on Council expenditures. The Council states, however, that there is no way of knowing to what extent the introduction of licensed commercial marijuana production facilities will lead to collateral crimes unrelated to the dispensing of prescription marijuana. Should such additional crimes occur, and should arrested individuals be eligible for appointed counsel at state expense, a flat fee of \$756.25 per felony is charged by a public defender or contract attorney. If an assigned counsel attorney is used the fee is \$60 per hour with a cap of \$1,400 for a misdemeanor charge and \$4,100 for a felony charge. The Council also states additional costs could be incurred if an appeal is filed. The public defender, contract attorney, and assigned counsel rates for Supreme Court appeals are \$2,000 per case, with many assigned counsel attorneys seeking permission to exceed the fee cap. Requests to exceed the fee cap are seldom granted. Finally, expenditures would increase if services other than counsel are requested and approved by the court during the defense of a case or during an appeal. The Council cannot determine the fiscal impact as it cannot predict the number of cases which may occur.

The New Hampshire Association of Counties states to the extent fewer individuals are charged, convicted, and sentenced to incarceration in a county correctional facility, the counties may have decreased expenditures. The Association is unable to determine the number of individuals who might be charged, convicted or incarcerated as a result of this bill to determine an exact fiscal impact. The average annual cost to incarcerate an individual in a county correctional facility is approximately \$35,000. There is no impact on county revenue.

The New Hampshire Municipal Association states that while the bill may impact local law enforcement officials, it is unable to determine the fiscal impact.

The Department of Corrections states it is not able to determine the fiscal impact of this bill because it does not have sufficient detail to predict the number of individuals who would be subject to this legislation. The Department states the average annual cost of incarcerating an individual in the general prison population for the fiscal year ending June 30, 2012 was \$35,071. The cost to supervise an individual by the Department's division of field services for the fiscal year ending June 30, 2012 was \$608.

The Department of Safety states the proposed legislation requires a criminal record check through the FBI criminal records database and a New Hampshire criminal history check for all caregivers, alternative treatment center agents, principle officers, board members, and employees. The Department is not able to determine the number of additional criminal background checks that would result from the bill and cannot estimate the fiscal impact. The

Department states that if the volume of record requests becomes significant, additional personnel may be needed. The Division of State Police assumes any reduction in the number of drug cases handled by the laboratory would allow resources to be reallocated to other cases that may have been delayed, resulting in no fiscal impact to the lab.

The Department of Health and Human Services assumes the revenue generated by application fees, fines, and private donations will be sufficient to offset the cost of implementing and administering its responsibilities under the bill, however the Department is unable to estimate the potential revenue and states the revenue would not be available until FY 2014. The Department states it does not have existing staff to perform the responsibilities and assumes two additional full-time positions would be necessary. The Department's responsibilities would include the following:

- Process applications and issue and renew I.D. cards within 15 days of receiving an application;
- Issue photo I.D. cards to qualifying patients and named designated caregivers within 5 days of approving an application;
- Issue replacement I.D. cards within 5 days when cards are lost or when there is a change in name or address;
- Require a state and federal criminal record check, through the Department of Safety, for designated caregivers, principal officers, agents, and employees or volunteers of alternative treatment centers. On an annual basis, conduct annual state and federal criminal record checks and reissue I.D. cards to principal officers, agents, and employees or volunteers of alternative treatment centers;
- Create and maintain a database of qualifying patients, designated caregivers, and principal officers, agents, and employees or volunteers of alternative treatment centers;
- Issue monthly written statements to alternative treatment centers providing: the number of qualifying patients who have designated the center, registration numbers for the patient and designated caregiver, and an update of certain changes;
- Provide written notices to each treatment center as qualifying patients designate or revoke designation for that center;
- Verify the validity of a registration I.D. card for law enforcement, employer, landlord court, administrative hearing officer, or health care provider;
- Submit an annual report to the legislature providing comprehensive data on the program;
- Adopt administrative rules for the program and accept applications for alternative treatment centers within 30 days of the adoption of rules;
- Inspect alternative treatment centers to review dispensing records and receive incident reports concerning rules violations, and loss of inventory by theft or diversion;

- Provide an annual report to the Health and Human Services Oversight Committee as described in RSA 126-W:10; and
- Determine and enforce civil infractions for violations of the chapter.

The Department estimates program costs as follows:

	<b>FY 2014</b>	<b>FY 2015</b>	<b>FY 2016</b>	<b>FY 2017</b>
Build and maintain a database and voice response telephone system for law enforcement to verify I.D. cards	\$85,000	\$5,000	\$5,000	\$5,000
Licensing clerk salary (LG 11)	\$25,584	\$26,540	\$27,515	\$28,646
Licensing clerk benefits	\$21,232	\$22,851	\$24,580	\$26,475
Program specialist salary (LG 25)	\$44,753	\$46,722	\$48,770	\$50,915
Program specialist benefits	\$25,023	\$26,846	\$28,785	\$30,880
<b>Total Cost to State</b>	<b>\$201,592</b>	<b>\$127,959</b>	<b>\$134,650</b>	<b>\$141,916</b>

# Amendments

Amendment to HB 573-FN

Amend the bill by replacing all after the enacting clause with the following:

1 New Chapter; Use of Marijuana for Medicinal Purposes. Amend RSA by inserting after chapter 126-V the following new chapter:

CHAPTER 126-W

USE OF MARIJUANA FOR MEDICINAL PURPOSES

126-W:1 Definitions. In this chapter:

I. "Alternative treatment center" means a not-for-profit entity registered under RSA 126-W:7 that acquires, possesses, cultivates, manufactures, delivers, transfers, transports, sells, supplies, and dispenses marijuana, and related supplies and educational materials, to qualifying patients.

II. "Alternative treatment center agent" means a principal officer, board member, employee, manager, or volunteer of an alternative treatment center who is 21 years of age or older and has not been convicted of a drug-related offense.

III. "Cultivation location" means a locked and enclosed site, under the control of the qualifying patient or designated caregiver who has reported the location of the site to the department, where marijuana is cultivated in accordance with the provisions of this chapter. A cultivation location may be a closet, a room, a greenhouse, a building, or another enclosed area that is secured with one or more locks or other security devices.

IV. "Department" means the department of health and human services.

V. "Designated caregiver" means an individual:

- (a) Who is at least 21 years of age;
- (b) Who has agreed to assist with a qualifying patient's medical use of marijuana;
- (c) Who has never been convicted of any drug-related offense; and
- (d) Who possesses a valid registry identification card issued pursuant to RSA 126-W:4.

VI. "Marijuana" means all parts of any plant of the Cannabis genus of plants, whether growing or not; the seeds thereof; the resin extracted from any part of such plant; and every compound, salt, derivative, mixture, or preparation of such plant, its seeds, or resin. Such term shall not include the mature stalks of such plants, fiber produced from such stalks, oil, or cake made from the seeds of such plants, any other compound, salt, derivative, mixture, or preparation of such mature stalks (except the resin extracted therefrom), fiber, oil or cake, or the sterilized seeds of such plants which are incapable of germination.

VII. "Medical use" means the acquisition, possession, cultivation, preparation, use, delivery,

Amendment to HB 573-FN

- Page 2 -

transfer, or transportation of marijuana or paraphernalia relating to the administration of marijuana to treat or alleviate a qualifying patient's qualifying medical condition or symptoms or results of treatment associated with the qualifying patient's qualifying medical condition. It does not include:

- (a) The use of marijuana by a designated caregiver who is not a qualifying patient; or
- (b) Cultivation by a visiting qualifying patient; or
- (c) Cultivation by a designated caregiver or qualifying patient who is not designated as being allowed to cultivate.

VIII.(a) Except as provided in this chapter, "provider" means a physician licensed to prescribe drugs to humans under RSA 329 and who possesses certification from the United States Drug Enforcement Administration to prescribe controlled substances.

(b) If the qualifying patient's qualifying medical condition is post-traumatic stress disorder, the provider shall also be a licensed psychiatrist.

(c) For a visiting qualifying patient, "provider" means an individual licensed to prescribe drugs to humans in the state of the patient's residence and who possesses certification from the United States Drug Enforcement Administration to prescribe controlled substances.

IX. "Provider-patient relationship" means a relationship between a provider and a patient that includes:

- (a) Taking a medical history;
- (b) Performing a relevant physical examination;
- (c) Reviewing prior treatment and treatment response;
- (d) Obtaining and reviewing relevant diagnostic test results;
- (e) The provider being available for and offering follow-up care and treatment to the patient, including but not limited to patient examinations;
- (f) Creating and maintaining patient records; and
- (g) Notifying the patient's primary care provider when appropriate.

X. "Qualifying medical condition" means the presence of either:

(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, agitation of Alzheimer's disease, multiple sclerosis, or post-traumatic stress disorder; or

(b) A severely debilitating or terminal medical condition or its treatment that produces at least one of the following: wasting syndrome, severe 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, severe nausea, severe vomiting, seizures, or severe, persistent muscle spasms.

XI. "Qualifying patient" means an individual who has been diagnosed by a provider as

1 having a qualifying medical condition and who possesses a valid registry identification card issued  
2 pursuant to RSA 126-W:4.

3 XII. "Registry identification card" means a document issued by the department pursuant to  
4 RSA 126-W:4 that identifies an individual as a qualifying patient or a designated caregiver.

5 XIII. "Seedling" means a marijuana plant that has no flowers and is less than 12 inches in  
6 height and less than 12 inches in diameter.

7 XIV. "Unusable marijuana" means any marijuana, other than usable marijuana, including  
8 the seeds, stalks, and roots of the plant.

9 XV. "Usable marijuana" means the dried leaves and flowers of the marijuana plant and any  
10 mixture or preparation thereof, but does not include the seeds, stalks, and roots of the plant and does  
11 not include the weight of any non-marijuana ingredients combined with marijuana and prepared for  
12 consumption as food or drink.

13 XVI. "Visiting qualifying patient" means a patient with a qualifying medical condition who  
14 is not a resident of New Hampshire or who has been a resident of New Hampshire for fewer than 30  
15 days.

16 XVII. "Written certification" means a document signed by a provider stating that in the  
17 provider's professional opinion, after having completed a full assessment of the patient's medical  
18 history and current medical condition made in the course of a provider-patient relationship of at  
19 least 3 months in duration, the patient has a qualifying medical condition, and the potential benefits  
20 of the medical use of marijuana would likely outweigh the health risks for the qualifying patient. If  
21 the patient's qualifying medical condition is of recent or sudden onset and the certifying provider is  
22 primarily responsible for the patient's care related to his or her qualifying medical condition, the 3-  
23 month requirement for the provider-patient relationship required in this paragraph shall not apply.  
24 The date of issuance and the patient's qualifying medical condition shall be specified on the written  
25 certification.

26 126-W:2 Medical Marijuana Protections.

27 I. A qualifying patient shall not be subject to arrest by state or local law enforcement,  
28 prosecution or penalty under state or municipal law, or be denied any right or privilege for the  
29 medical use of marijuana in accordance with this chapter, if the qualifying patient possesses,  
30 cultivates, or possesses and cultivates, an amount of marijuana that does not exceed the following:

31 (a) If the qualifying patient does not have a designated caregiver, for the possession and  
32 cultivation of marijuana that occurs at the cultivation location reported to the department, or while  
33 transporting marijuana and marijuana plants and seedlings to a new cultivation location that has  
34 been reported to the department within the prior 21 days:

35 (1) Six ounces of usable marijuana;

36 (2) Any amount of unusable marijuana; and

37 (3) Four mature marijuana plants and 12 seedlings, with a total canopy of no more



1 than 100 square feet.

2 (b) If the qualifying patient is not at a cultivation location reported to the department:

3 (1) Two ounces of usable marijuana; and

4 (2) Any amount of unusable marijuana.

5 II. A designated caregiver shall not be subject to arrest by state or local law enforcement,  
6 prosecution or penalty under state or municipal law, or denied any right or privilege for the medical  
7 use of marijuana in accordance with this chapter on behalf of a qualifying patient if the designated  
8 caregiver possesses or cultivates, or both, an amount of marijuana that does not exceed the following:

9 (a) If at the cultivation location reported to the department, or while transporting  
10 marijuana and marijuana plants and seedlings to a new cultivation location that has been reported  
11 to the department within the prior 21 days:

12 (1) Six ounces of usable marijuana; and

13 (2) Any amount of unusable marijuana; and

14 (3) Four mature marijuana plants and 12 seedlings, with a total canopy of no more  
15 than 100 square feet.

16 (b) If not at a cultivation location reported to the department:

17 (1) Two ounces of usable marijuana; and

18 (2) Any amount of unusable marijuana.

19 III. A qualifying patient or designated caregiver shall not be subject to arrest by state or  
20 local law enforcement or prosecution or penalty under state or municipal law for giving marijuana to  
21 a qualifying patient or a visiting qualifying patient where nothing of value is transferred in return,  
22 or for offering to do the same, if the person giving the marijuana does not knowingly cause the  
23 recipient to possess more marijuana than is permitted by this section.

24 IV. Notwithstanding paragraph III, a designated caregiver may receive compensation for  
25 costs, not including labor, associated with assisting a qualifying patient who has designated the  
26 designated caregiver to assist him or her with the medical use of marijuana. Such compensation  
27 shall not constitute the sale of controlled substances.

28 V.(a) A qualifying patient is presumed to be lawfully engaged in the medical use of  
29 marijuana in accordance with this chapter if the qualifying patient possesses a valid registry  
30 identification card and possesses an amount of marijuana that does not exceed the amount allowed  
31 under this chapter.

32 (b) A designated caregiver is presumed to be lawfully engaged in assisting with the  
33 medical use of marijuana in accordance with this chapter if the designated caregiver possesses a  
34 valid registry identification card and possesses an amount of marijuana that does not exceed the  
35 amount allowed under this chapter.

36 (c) The presumptions made in subparagraphs (a) and (b) may be rebutted by evidence  
37 that conduct related to marijuana was not for the purpose of treating or alleviating the qualifying

1 patient's qualifying medical condition or symptoms or effects of the treatment associated with the  
2 qualifying medical condition, in accordance with this chapter.

3 VI. A valid registry identification card, or its equivalent, that is issued under the laws of  
4 another state, district, territory, commonwealth, or insular possession of the United States that  
5 allows, in the jurisdiction of issuance, a visiting qualifying patient to possess marijuana for medical  
6 purposes, shall have the same force and effect as a valid registry identification card issued by the  
7 department in this state, provided that:

8 (a) The visiting qualifying patient shall also produce a statement from his or her  
9 provider stating that the visiting qualifying patient has a qualifying medical condition as defined in  
10 RSA 126-W:1, X; and

11 (b) A visiting qualifying patient shall not cultivate marijuana in New Hampshire.

12 VII. A person otherwise entitled to custody of, or visitation or parenting time with, a minor  
13 shall not be denied such a right solely for conduct allowed under this chapter, and there shall be no  
14 presumption of neglect or child endangerment.

15 VIII. For the purposes of medical care, including organ transplants, a qualifying patient's  
16 authorized use of marijuana in accordance with this chapter shall be considered the equivalent of the  
17 authorized use of any other medication used at the direction of a provider, and shall not constitute  
18 the use of an illicit substance.

19 IX. A provider shall not be subject to arrest by state or local law enforcement, prosecution or  
20 penalty under state or municipal law, or be denied any right or privilege, including but not limited to  
21 a civil penalty or disciplinary action by the New Hampshire board of medicine or any other  
22 occupational or professional licensing entity, solely for providing written certifications or for  
23 otherwise stating that, in the provider's professional opinion, and in the context of a provider-patient  
24 relationship, a patient is likely to receive therapeutic or palliative benefit from the medical use of  
25 marijuana, provided that nothing shall prevent a professional licensing entity from sanctioning a  
26 provider for failing to properly evaluate a patient's medical condition.

27 X. An alternative treatment center shall not be subject to prosecution under state or  
28 municipal law; search or inspection, except by the department pursuant to RSA 126-W:7, XI; seizure;  
29 or penalty in any manner under state or municipal law for acting pursuant to this chapter and  
30 department rules to:

31 (a) Acquire or purchase marijuana seeds, seedlings, plants, or marijuana from other  
32 alternative treatment centers;

33 (b) Accept marijuana seeds from individuals and entities from jurisdictions outside of  
34 New Hampshire that are authorized to cultivate medical marijuana in their home state;

35 (c) Accept marijuana seeds from qualifying patients or designated caregivers;

36 (d) Sell or donate marijuana seeds to similar entities that are registered to dispense  
37 marijuana for medical use in other jurisdictions;

(e) Possess, cultivate, manufacture, or transport marijuana and seedlings; and/or

(f) Deliver, transfer, supply, sell, or dispense marijuana and related supplies and educational materials to qualifying patients and visiting qualifying patients who have designated the alternative treatment center to provide for them, to designated caregivers on behalf of the qualifying patients who have designated the alternative treatment center, and/or to other alternative treatment centers.

XI. An alternative treatment center agent shall not be subject to arrest by state or local law enforcement, prosecution or penalty in any manner under state or municipal law, search, or be denied any right or privilege for working for an alternative treatment center pursuant to this chapter and department rules to engage in any of the actions listed in paragraph X.

XII. Visiting qualifying patients, qualifying patients, designated caregivers, and entities that are authorized to cultivate medical marijuana in their home state shall not be subject to arrest by state or local law enforcement, prosecution or penalty under state or municipal law, or be denied any right or privilege for donating marijuana seeds to alternative treatment centers in New Hampshire.

XIII. Any marijuana, marijuana paraphernalia, licit property, or interest in licit property that is possessed, owned, or used in connection with the medical use of marijuana as allowed under this chapter, or acts incidental to such use, shall not be seized or forfeited if the basis for the seizure or forfeiture is activity related to marijuana that is exempt from state criminal penalties under this chapter.

XIV. An individual shall not be subject to arrest by state or local law enforcement, prosecution or penalty under state or municipal law, or be denied any right or privilege, including but not limited to a civil penalty or disciplinary action by a court or occupational or professional licensing entity, simply for being in the presence or vicinity of the medical use of marijuana as allowed under this chapter.

XV. If a state or local law enforcement agency or agent encounters an alternative treatment center or an individual who the agent or agency knows is an alternative treatment center agent, a designated caregiver, or a qualifying patient, or who credibly asserts he or she is an alternative treatment center agent, a designated caregiver, or a qualifying patient, the law enforcement agency or agent shall not provide any information from any marijuana-related investigation of the individual or entity to any law enforcement agency that does not recognize the protection of this chapter, and any prosecution of the individual or entity for a violation of this chapter shall be conducted pursuant to the laws of this state. This paragraph shall not apply in cases where the state or local law enforcement agency has probable cause to believe the person is distributing marijuana to a person who is not allowed to possess it under this chapter.

XVI. A person who ceases to be a qualifying patient or designated caregiver shall have 10 days after notification by the department to dispose of marijuana in one of the following ways:

1 (a) If the person was a designated caregiver and the qualifying patient who designated  
2 the caregiver is still a qualifying patient, but has designated a new caregiver or will cultivate plants  
3 himself or herself, the designated caregiver may transfer marijuana to the new person who will  
4 cultivate for the qualifying patient;

5 (b) The person may notify local law enforcement and request that they dispose of the  
6 marijuana;

7 (c) The person may dispose of marijuana, after mixing marijuana with other ingredients  
8 such as soil to render it unusable; or

9 (d) The person may donate usable marijuana to a qualifying patient.

10 126-W:3 Prohibitions and Limitations on the Use of Medical Marijuana.

11 I. A qualifying patient may use medical marijuana on privately owned real property only  
12 with the permission of the property owner or in the case of leased property with the permission of  
13 the tenant in possession of the property, except that a tenant shall not allow a qualifying patient to  
14 smoke medical marijuana on rented property if smoking on the property violates the lease or the  
15 lessor's rental policies that apply to all tenants at the property. However, a tenant may permit a  
16 qualifying patient to use medical marijuana on leased property by ingestion or inhalation through  
17 vaporization even if smoking is prohibited by the lease or rental policies. For purposes of this  
18 chapter, vaporization shall mean the inhalation of marijuana without the combustion of the  
19 marijuana.

20 II. Nothing in this chapter shall exempt any person from arrest or prosecution for:

21 (a) Being under the influence of marijuana while:

22 (1) Operating a motor vehicle, commercial vehicle, boat, or vessel, or any other  
23 vehicle propelled or drawn by power other than muscular power; or

24 (2) In his or her place of employment, without the written permission of the  
25 employer; or

26 (3) Operating heavy machinery or handling a dangerous instrumentality.

27 (b) The use or possession of marijuana by a qualifying patient or designated caregiver for  
28 purposes other than for medical use as permitted by this chapter;

29 (c) The smoking of marijuana in any public place, including:

30 (1) A school bus, public bus, or other public vehicle; or

31 (2) A place of employment, without the written permission of the employer; or

32 (3) The grounds of any preschool, elementary, or secondary school; or

33 (4) Any correctional facility; or

34 (5) Any public park, public beach, public recreation center, public field, or youth  
35 center; or

36 (6) Any law enforcement facility.

37 III. Nothing in this chapter shall be construed to require:

1 (a) Any health insurance provider, health care plan, or medical assistance program to be  
2 liable for any claim for reimbursement for the medical use of marijuana; or

3 (b) Any individual or entity in lawful possession of property to allow a guest, client,  
4 customer, or other visitor to use marijuana on or in that property; or

5 (c) Any accommodation of the medical use of marijuana on the property or premises of  
6 any place of employment or on the property or premises of any jail, correctional facility, or other type  
7 of penal institution where prisoners reside or persons under arrest are detained. This chapter shall  
8 in no way limit an employer's ability to discipline an employee for ingesting marijuana in the  
9 workplace or for working while under the influence of marijuana.

10 IV. Fraudulent representation to a law enforcement official of any fact or circumstance  
11 relating to the medical use of marijuana to avoid arrest or prosecution shall be punishable by a fine  
12 of \$500, which shall be in addition to any other penalties that may apply for making a false  
13 statement or for the use of marijuana other than use undertaken pursuant to this chapter.

14 V. A qualifying patient or designated caregiver who is found to be in possession of marijuana  
15 outside of his or her home and is not in possession of his or her registry identification card may be  
16 subject to a \$100 fine.

17 VI. Any qualifying patient or designated caregiver who sells marijuana to another person  
18 who is not a qualifying patient or designated caregiver under this chapter shall be subject to the  
19 penalties specified in RSA 318-B:26, IX-a, shall have his or her registry identification card revoked,  
20 and shall be subject to other penalties as provided in RSA 318-B:26.

21 VII. The department may revoke the registry identification card of a qualifying patient or  
22 designated caregiver who violates any other provision of this chapter, and the qualifying patient or  
23 designated caregiver shall be subject to any other penalties established in law for the violation.

24 126-W:4 Departmental Administration, Registry Identification Cards.

25 I. Except as provided in paragraph V, the department shall issue a registry identification  
26 card to a person applying as a qualifying patient who submits all of the following information:

27 (a) Written certification as defined in RSA 126-W:1.

28 (b) An application or a renewal application accompanied by the application or renewal  
29 fee.

30 (c) Name, residential and mailing address, and date of birth of the applicant, except that  
31 if the applicant is homeless, no residential address is required.

32 (d) Name, address, and telephone number of the applicant's provider.

33 (e) Name, address, and date of birth of the applicant's designated caregiver, if any. A  
34 qualifying patient shall have only one designated caregiver.

35 (f) Name of the alternative treatment center that the qualifying patient designates. A  
36 qualifying patient may designate no more than one alternative treatment center at any time.

37 (g) Street address of the cultivation location, if any, if the qualifying patient does not

1 have a designated caregiver.

2 (h) A statement signed by the applicant, pledging not to divert marijuana to anyone who  
3 is not allowed to possess marijuana pursuant to this chapter and acknowledging that his or her  
4 diversion of marijuana is punishable as a class B felony and revocation of his or her registry  
5 identification card, in addition to other penalties for the illegal sale of marijuana.

6 II.(a) Except as provided in paragraph V, the department shall issue a registry identification  
7 card to a person applying as a designated caregiver who submits all of the following information:

8 (1) An application or a renewal application accompanied by a medicinal use  
9 certificate.

10 (2) Name, residential and mailing address, and date of birth of the applicant.

11 (3) Name, residential and mailing address, and date of birth of the qualifying patient  
12 for whom the applicant will act as designated caregiver, except that if the qualifying patient is  
13 homeless, no residential address is required. A designated caregiver shall act on behalf of only one  
14 qualifying patient.

15 (4) A complete set of fingerprints.

16 (5) Street address of the cultivation location, except that the designated caregiver  
17 may not include a cultivation location if the designated caregiver's qualifying patient has designated  
18 an alternative treatment center.

19 (6) A statement indicating the applicant's preference as to whether the applicant  
20 requests the department to retain his or her fingerprints on file for any renewal application or  
21 whether the applicant requests the department to destroy his or her fingerprints and acknowledges  
22 that the applicant shall resubmit fingerprints if the applicant applies for renewal as a designated  
23 caregiver.

24 (7) A signed statement from the applicant agreeing to act as the designated  
25 caregiver for the qualifying patient named in the application and pledging not to divert marijuana to  
26 anyone who is not allowed to possess marijuana pursuant to this chapter and acknowledging that  
27 the diversion of marijuana is punishable as a class B felony and revocation of one's registry  
28 identification card, in addition to other penalties for the illegal sale of marijuana.

29 (b) A person who is applying to be a designated caregiver shall submit to a state and  
30 federal criminal records check. The department shall request the department of safety to perform  
31 the state and federal criminal records check and the department of safety shall complete such  
32 records checks and convey the findings of such checks to the department within 30 days of the  
33 request. The department and the department of safety may exchange necessary data including  
34 fingerprint data with the Federal Bureau of Investigation without disclosing that the records check  
35 is related to the provisions of this chapter and acts permitted by it. Unless the applicant stated that  
36 he or she prefers his or her fingerprints to be kept on file for any renewal, the department and the  
37 department of safety shall destroy each set of fingerprints obtained pursuant to this chapter after

1 the criminal records check is complete.

2 III. The department shall verify the information contained in an application or renewal  
3 submitted pursuant to this section. The department shall approve or deny an application or renewal  
4 for a qualifying patient within 15 days of receipt of the application. The department shall approve or  
5 deny an application or renewal to serve as a designated caregiver within 45 days of receipt of the  
6 application. The department may deny an application or renewal only if the applicant did not  
7 provide the information required pursuant to this section, or if the applicant previously had a  
8 registry identification card revoked for violating the provisions of this chapter, or if the department  
9 determines that the information provided was falsified. The department shall notify an applicant of  
10 the denial of an application. An applicant who is aggrieved by a department decision may request an  
11 administrative hearing at the department.

12 IV. The department shall issue registry identification cards to persons applying as a  
13 qualifying patient or designated caregiver within 5 days of approving an application or renewal.  
14 Each registry identification card shall expire one year after the date of issuance, unless the provider  
15 states in the written certification that he or she believes the qualifying patient would benefit from  
16 medical marijuana only until a specified earlier date, then the registry identification card shall  
17 expire on that date. Registry identification cards shall contain all of the following:

18 (a) Name, mailing address, and date of birth of the qualifying patient or designated  
19 caregiver.

20 (b) The date of issuance and expiration date of the registry identification card.

21 (c) A random 10-digit identification number, containing at least 4 numbers and at least 4  
22 letters, that is unique to the qualifying patient or the designated caregiver.

23 (d) A designation that the person is either a "qualifying patient" or a "designated  
24 caregiver." If the person is a designated caregiver, the identification card shall include the random  
25 10-digit identification number of the qualifying patient for whom he or she is providing care.

26 (e) The registry identification number corresponding with the alternative treatment  
27 center the qualifying patient designated, if any.

28 (f) A photograph of the qualifying patient or designated caregiver.

29 (g) A statement that the qualifying patient or designated caregiver is permitted under  
30 state law to possess marijuana pursuant to this chapter for the medical use of the qualifying patient.

31 (h) A statement noting whether or not the cardholder is exempt from state penalties for  
32 cultivating marijuana. The statement shall be determined as follows:

33 (1) A qualifying patient is exempt from state penalties for cultivating marijuana in  
34 accordance with this chapter if he or she does not have a designated caregiver. If a qualifying  
35 patient has selected a designated caregiver, he or she is not exempt from state penalties for  
36 cultivating marijuana.

37 (2) A designated caregiver is exempt from state penalties for cultivating marijuana

1 in accordance with this chapter if the designated caregiver's qualifying patient has not also  
2 designated an alternative treatment center. If the designated caregiver's qualifying patient has also  
3 designated an alternative treatment center, the designated caregiver is not exempt from state  
4 penalties for cultivating marijuana.

5 V. The department shall not issue a registry identification card to an applicant under 18  
6 years of age who is applying as a qualifying patient unless:

7 (a) The applicant's provider has explained the potential risks and benefits of the medical  
8 use of marijuana to the custodial parent or legal guardian with responsibility for health care  
9 decisions for the applicant; and

10 (b) The custodial parent or legal guardian with responsibility for health care decisions  
11 for the applicant consents in writing to:

12 (1) Allow the applicant's medical use of marijuana; and

13 (2) Control the acquisition of the marijuana and the frequency of the medical use of  
14 marijuana by the applicant; and

15 (3) The custodial parent or legal guardian completes an application in accordance  
16 with the requirements of paragraph I on behalf of the applicant.

17 VI. The department shall provide each approved qualifying patient and caregiver a  
18 statement with the registry identification card explaining federal law on the possession of marijuana  
19 and that possession of a state registry identification card does not protect a person from federal  
20 criminal penalties.

21 VII. The department shall track the number of qualifying patients who have designated  
22 each alternative treatment center and issue a monthly written statement to the alternative  
23 treatment center identifying the number of qualifying patients who have designated that alternative  
24 treatment center along with the registry identification numbers of each patient and each patient's  
25 designated caregiver.

26 VIII. In addition to the monthly reports, the department shall also provide written notice to  
27 an alternative treatment center which identifies the names and registration identification numbers  
28 of a qualifying patient and his or her designated caregiver whenever any of the following events  
29 occur:

30 (a) A qualifying patient designates the alternative treatment center to serve his or her  
31 needs under this chapter; or

32 (b) An existing qualifying patient revokes the designation of the alternative treatment  
33 center; or

34 (c) A qualifying patient who has designated the alternative treatment center loses his or  
35 her status as a qualifying patient under this chapter.

36 IX.(a) A qualifying patient shall notify the department before changing his or her designated  
37 caregiver or alternative treatment center.



1 (b) A qualifying patient and designated caregiver shall notify the department before  
2 changing his or her cultivation location.

3 (c) A qualifying patient shall notify the department of any change in his or her name or  
4 address within 10 days of such change. If the qualifying patient's certifying provider notifies the  
5 department in writing that either the qualifying patient no longer suffers from a qualifying medical  
6 condition or that the provider no longer believes the qualifying patient would receive benefit from  
7 the medical use of marijuana, the registry identification card shall become void upon notification by  
8 the department to the qualifying patient.

9 (d) When a qualifying patient or a designated caregiver notifies the department of any  
10 change to a name, address, or alternative treatment center, the department shall issue the  
11 qualifying patient or designated caregiver a new registry identification card with a new random 10-  
12 digit identification number within 15 days of receiving the updated information.

13 (e) If a qualifying patient notifies the department of a change in his or her designated  
14 caregiver and the prospective designated caregiver meets the requirements of this chapter, the  
15 department shall issue the designated caregiver a registry identification card with a new random 10-  
16 digit identification number within 45 days of receiving the designated caregiver's application.

17 (f) A qualifying patient or designated caregiver who fails to notify the department of any  
18 changes to his or her name, address, designated caregiver, or cultivation location shall be guilty of a  
19 violation and may be subject to a fine not to exceed \$150.

20 (g) If a qualifying patient or designated caregiver loses his or her registry identification  
21 card, he or she shall notify the department within 10 days of losing the card. Within 5 days after  
22 such notification, the department shall issue a new registry identification card with a new random  
23 10-digit identification number.

24 X. Mere possession of, or application for, a registry identification card shall not constitute  
25 probable cause or reasonable suspicion, nor shall it be used to support the search of the individual or  
26 property of the individual possessing or applying for the registry identification card. The possession  
27 of, or application for, a registry identification card shall not preclude the existence of probable cause  
28 if probable cause exists on other grounds.

29 XI.(a) The department shall create and maintain a confidential registry of each individual  
30 who has applied for and received a registry identification card as a qualifying patient or a designated  
31 caregiver in accordance with the provisions of this chapter. Each entry in the registry shall contain  
32 the qualifying patient's or designated caregiver's name, mailing address, date of birth, date of  
33 registry identification card issuance, date of registry identification card expiration, random 10-digit  
34 identification number, street address at which the marijuana plants will be cultivated or possessed,  
35 effective date of any change of cultivation location, and registry identification number of the  
36 qualifying patient's designated alternative treatment center, if any. The confidential registry and  
37 the information contained in it shall be exempt from disclosure under RSA 91-A.

(b)(1) Except as specifically provided in this chapter, no person shall have access to any information about qualifying patients or designated caregivers in the department's confidential registry, or any information otherwise maintained by the department about providers and alternative treatment centers, except for authorized employees of the department in the course of their official duties and local and state law enforcement personnel who have detained or arrested an individual who claims to be engaged in the medical use of marijuana.

(2) If a local or state law enforcement officer submits a sworn affidavit to the department affirming that he or she has probable cause to believe marijuana is possessed or cultivated at a specific address, an authorized employee for the department may disclose whether the location is associated with a qualifying patient, designated caregiver, cultivation location, or alternative treatment center location.

(3) If a local or state law enforcement officer submits a sworn affidavit to the department affirming that he or she has probable cause to believe a specific individual possesses or cultivates marijuana, an authorized employee for the department may disclose whether the person is a qualifying patient or a designated caregiver, provided that the law enforcement officer provides the person's name and address or name and date of birth.

(4) Counsel for the department may notify law enforcement officials about falsified or fraudulent information submitted to the department where counsel has made a legal determination that there is probable cause to believe the information is false or falsified.

XII. Within 5 days of learning of the death of a qualifying patient, a surviving family member, caretaker, executor, or the patient's designated caregiver shall notify the department that the qualifying patient has died. Within 5 days of learning of the death of a qualifying patient, the surviving family member, caretaker, executor, or the patient's designated caregiver shall either request that the local law enforcement agency remove any remaining marijuana or shall dispose of the marijuana in a manner that is specified by the department by rule.

126-W:5 Affirmative Defense.

I. Except as provided in RSA 126-W:3, it shall be an affirmative defense to any prosecution for an offense involving marijuana or marijuana paraphernalia intended for medical use if:

(a) The defendant is a qualifying patient in possession of a valid registry identification card and at the time of arrest or prosecution was in possession of a quantity of marijuana that was not more than allowed under this chapter, and the qualifying patient was engaged in the medical use of marijuana in accordance with the provisions of this chapter; or

(b)(1) The defendant is a designated caregiver in possession of a valid registry identification card and at the time of arrest or prosecution was in possession of a quantity of marijuana that was not more than allowed under this chapter; and

(2) The designated caregiver was engaged in the medical use of marijuana on behalf of a qualifying patient in accordance with the provisions of this chapter.

1 (c) If a defendant proves the elements of the affirmative defense listed in subparagraph  
2 (I)(a) or (b), the charges shall be dismissed with prejudice.

3 II. A person who is arrested or cited for possession, cultivation, or transportation of  
4 marijuana, or possession of marijuana paraphernalia, may raise as an affirmative defense that he or  
5 she is person with a qualifying medical condition who is not yet in possession of a valid registry  
6 identification card if:

7 (a) Prior to the arrest, the person submitted to the department a valid application to  
8 become a qualifying patient, complete with a written certification, but the person had not yet  
9 received a registry identification card from the department; and

10 (1) The person does not possess more than 2 ounces of usable marijuana and any  
11 amount of unusable marijuana, if the marijuana is not on the person's property; or

12 (2) If the marijuana is on the person's property, the person does not possess more  
13 than 6 ounces of usable marijuana and any amount of unusable marijuana and does not possess or is  
14 not cultivating more than 4 mature marijuana plants and 12 seedlings, which shall be in a locked  
15 and enclosed location on the person's property.

16 (b) The affirmative defense under this section shall not be available to a person who has  
17 violated any of the provisions of RSA 126-W:3, I-IV.

18 (c) If a defendant proves the elements of the affirmative defense listed in this paragraph,  
19 the defendant shall be acquitted of any charge to which the defendant proved the affirmative  
20 defense.

21 III. A person who is arrested or cited for possession, cultivation, or transportation of  
22 marijuana, or possession of marijuana paraphernalia, prior to the date on which the department  
23 begins accepting registry identification card applications may raise as an affirmative defense that he  
24 or she is a person with a qualifying medical condition who is not yet in possession of a valid registry  
25 identification card if:

26 (a) The person produces a written statement signed by a provider stating that in the  
27 provider's professional opinion, after having completed a full assessment of the person's medical  
28 history and current medical condition made in the course of a provider-patient relationship of at  
29 least 3 months duration, unless the person's qualifying medical condition is of recent or sudden onset  
30 in which case the 3-month time requirement shall not apply, the person has a qualifying medical  
31 condition and the potential benefits of the medical use of marijuana would likely outweigh the health  
32 risks for the person; and

33 (1) The person does not possess more than 2 ounces of usable marijuana and any  
34 amount of unusable marijuana, if the marijuana is not on the person's property; and

35 (2) If the marijuana is on the person's property, the person does not possess more  
36 than 6 ounces of usable marijuana and any amount of unusable marijuana and does not possess or is  
37 not cultivating more than 4 mature marijuana plants and 12 seedlings which shall be in a locked and

1 enclosed location.

2 (b) The affirmative defense under this section shall not be available to a person who has  
3 violated any of the provisions of RSA 126-W:3, I-IV.

4 (c) If a defendant proves the elements of the affirmative defense listed in this paragraph,  
5 the defendant shall be acquitted of any charge to which the defendant proved the affirmative  
6 defense.

7 126-W:6 Departmental Rules.

8 I. Not later than 90 days after the effective date of this chapter, the department shall adopt  
9 rules, pursuant to RSA 541-A, governing the manner in which it shall consider applications for  
10 issuance and renewals of registry identification cards for qualifying patients and designated  
11 caregivers.

12 II. The department's rules shall establish application and renewal fees for registry  
13 identification cards in accordance with the following:

14 (a) The fee structure by the department for alternative treatment centers and registry  
15 identification cards shall generate revenues sufficient to offset all state expenses of implementing  
16 and administering this chapter; however,

17 (b) The department may accept donations from private sources without the approval of  
18 the governor and council in order to reduce the application and renewal fees.

19 III.(a) Not later than one year after the effective date of this section, the department shall  
20 adopt rules, pursuant to RSA 541-A, governing alternative treatment centers and the manner in  
21 which it shall consider applications for registration certificates for alternative treatment centers,  
22 including, but not necessarily limited to, rules governing:

23 (1) The form and content of registration and renewal applications.

24 (2) Oversight requirements.

25 (3) Security requirements, which shall include at a minimum, lighting, physical  
26 security, video security, alarm requirements, measures to prevent loitering, and on-site parking.

27 (4) Sanitary requirements.

28 (5) Electrical safety requirements.

29 (6) The specification of acceptable forms of picture identification that an alternative  
30 treatment center may accept when verifying a sale.

31 (7) Personnel requirements including how many volunteers an alternative treatment  
32 center is permitted to have and requirements for supervision.

33 (8) Labeling standards.

34 (9) Procedures for suspending or terminating the registration of alternative  
35 treatment centers that violate the provisions of this section or the rules adopted pursuant to this  
36 section, procedures for appealing penalties, and a schedule of penalties.

37 (10) Procedures for inspections and investigations.

(11) Advertising restrictions, including a prohibition of misrepresentation and unfair practices.

(12) Permissible hours of operation.

(13) The fees for the processing and review of applications for registration as an alternative treatment center and regulation of an alternative treatment center after it has been approved by the department. Such fees shall be established in an amount that covers all costs of the department and other state agencies, as applicable, for the review, registration, and regulation of alternative treatment centers.

(14) Such other matters as are necessary for the fair, impartial, stringent, and comprehensive administration of this chapter.

(b) The department shall adopt rules with the goal of protecting against diversion and theft, without imposing an undue burden on the alternative treatment centers or compromising the confidentiality of qualifying patients and their designated caregivers.

126-W:7 Departmental Administration, Alternative Treatment Centers.

I. Within 30 days of the adoption of rules pursuant to RSA 126-W:6, the department shall begin accepting applications for the operation of alternative treatment centers.

II. Within 18 months of the effective date of this section, provided that at least 5 applications have been submitted that score sufficiently high to receive a certificate, the department shall issue alternative treatment center registration certificates to the 5 highest-scoring applicants. Each registration certificate shall include a registry number that is unique to the alternative treatment center.

III. Any time an alternative treatment center registration certificate is revoked, relinquished, or expires, the department shall accept applications for a new alternative treatment center and issue registration certificates to the applicant who scores the highest.

IV. If at any time after one year after the effective date of this section, fewer than 5 alternative treatment centers hold valid registration certificates in New Hampshire, the department shall accept applications for a new alternative treatment center. Except as provided in paragraph V, no more than 5 alternative treatment centers may hold valid registration certificates at one time.

V.(a) An alternative treatment center applicant must submit a completed department-approved application form with all required documentation and a non-refundable fee in an amount set by department rule. The alternative treatment center application and supporting materials must include, at a minimum:

(1) The legal name, articles of incorporation, and bylaws of the alternative treatment center.

(2) The proposed physical address of the alternative treatment center, if a precise address has been determined, or, if not, the general location where it would be located. This may include a second location for the cultivation of medical marijuana.

1 (3) A description of the enclosed, locked facility that would be used in the cultivation  
2 of marijuana by the alternative treatment center.

3 (4) The name, address, and date of birth of each principal officer and board member  
4 of the alternative treatment center and a complete set of fingerprints for each of them. The board of  
5 directors for the non-profit must include at least one physician, nurse, or pharmacist licensed to  
6 practice in New Hampshire and at least 3 patients qualified to register as qualifying patients.

7 (5) Proposed security and safety measures that comply with the rules issued  
8 pursuant to RSA 126-W:6, including a description of interior and exterior lighting and security  
9 systems.

10 (6) The distance from any pre-existing private or public school.

11 (7) A copy of the proposed policy regarding services to qualifying patients who cannot  
12 afford to purchase marijuana for medical purposes.

13 (8) Information demonstrating the applicant's knowledge of organic growing  
14 methods to be used in their growing and cultivation of marijuana.

15 (9) Steps that will be taken to ensure the quality of the marijuana, including purity  
16 and consistency of dose.

17 (10) A start-up timetable which provides an estimated time from registration of the  
18 dispensary to full operation and the assumptions used for the basis of those estimates.

19 (11) Information showing the applicant's experience running a non-profit or other  
20 business.

21 (12) A description of any additional services that will be available to patients.

22 (13) The applicant's plans for record keeping and inventory control.

23 (b) Any time one or more alternative treatment center registration applications are  
24 being considered, the department shall solicit input from qualifying patients, designated caregivers,  
25 and the towns or cities where the applicants would be located.

26 (c) Each time an alternative treatment center certificate is granted, the decision shall be  
27 based on the overall health needs of qualifying patients and the safety of the public. The department  
28 shall evaluate applications for alternative treatment center registration certificates using an  
29 impartial and numerically scored competitive bidding process developed by the department in  
30 accordance with this chapter. The department shall require applicants to meet a minimum score to  
31 be considered. The registration considerations shall include the following criteria:

32 (1) The suitability of the proposed location or locations, including compliance with  
33 any local zoning laws and geographic convenience to patients from throughout the state of  
34 New Hampshire to alternative treatment centers if the applicant were approved.

35 (2) The proposed alternative treatment center's plan for operations and services,  
36 whether it has sufficient capital to operate, and ability to provide a steady supply of marijuana to the  
37 qualifying patients in the state.

(3) The principal officer and board members' character and relevant experience, including any training or professional licensing related to medicine, pharmaceuticals, natural treatments, botany, or marijuana cultivation and preparation and their experience running a non-profit organization or business.

(4) The applicant's plan for making medical marijuana available on an affordable basis to qualifying patients enrolled in Medicaid or receiving Supplemental Security Income or Social Security Disability Insurance.

(5) The applicant's plan for safe and accurate packaging and labeling of medical marijuana, including the applicant's plan for ensuring that all medical marijuana is free of contaminants.

(6) The sufficiency of the applicant's plans for record keeping and inventory control. Records shall be considered confidential health care information under New Hampshire law and are intended to be deemed protected health care information for purposes of the federal Health Insurance Portability and Accountability Act of 1996, as amended. Any dispensing records that an alternative treatment center is required to keep shall keep track of transactions according to qualifying patients' and designated caregivers' registry identification numbers, rather than their names, to protect their confidentiality.

(7) The sufficiency of the applicant's plans for safety and security, including proposed location and security devices employed.

(8) Whether the entity possesses or has the right to use sufficient land, buildings, and equipment to properly carry out its duties as an alternative treatment center.

VI. After an alternative treatment center is approved, but before it begins operations, it shall submit the registration and regulation fee paid to the department in accordance with the rules adopted by the department.

VII. Notwithstanding any other provision of law, information required to be submitted to the department on an application for an alternative treatment center identifying the locations where marijuana is proposed to be grown, cultivated, harvested, and otherwise prepared for distribution to qualifying patients, designated caregivers, and alternative treatment centers, and any other department records identifying such location, shall be considered to be confidential information and not subject to disclosure pursuant to RSA 91-A, except that:

(a) Such information may be disclosed to a law enforcement agency upon request for purposes of enforcement under this chapter;

(b) The location may be disclosed to towns and cities when seeking input on locations, provided that the towns and cities' representatives keep the information confidential; and

(c) The name, address, and phone number of alternative treatment centers may be disclosed to qualifying patients.

VIII. The alternative treatment center's certificate may be revoked at any time it commits a

1 serious violation of these rules, including if it negligently or knowingly allows marijuana to be  
2 distributed to someone who is not exempt from penalties pursuant to this act.

3 IX. By April 10 of every odd year, beginning no sooner than one year after an alternative  
4 treatment center receives its first registry certificate, each alternative treatment center shall pay a  
5 fee in an amount determined by the department.

6 X. By April 10 of every odd year, beginning no sooner than one year after an alternative  
7 treatment center receives its first registry certificate, the department shall evaluate each alternative  
8 treatment center's operations. A registration certificate may be revoked if the alternative treatment  
9 center:

10 (a) Committed multiple or serious violations of this act or department rules; or

11 (b) Is not operational.

12 XI. Alternative treatment centers shall be subject to reasonable inspection by the  
13 department of health and human services. During an inspection, the department may review the  
14 alternative treatment center's records, including its confidential dispensing records, which shall  
15 track transactions according to qualifying patients' registry identification numbers to protect their  
16 confidentiality.

17 126-W:8 Alternative Treatment Centers; Requirements.

18 I. An alternative treatment center shall be operated on a not-for-profit basis for the benefit  
19 of its patients. An alternative treatment center need not be recognized as a tax-exempt organization  
20 by the Internal Revenue Service.

21 II. An alternative treatment center may not be located in a residential district or within  
22 1,000 feet of the property line of a pre-existing public or private primary or secondary school.

23 III. An alternative treatment center shall implement appropriate security measures to deter  
24 and prevent the unauthorized entrance into areas containing marijuana and the theft of marijuana  
25 and shall ensure that each location has an operational security alarm system.

26 IV.(a) An alternative treatment center shall conduct a background check into the criminal  
27 history of every person seeking to become a principal officer, board member, agent, volunteer, or  
28 employee before the person begins working at the alternative treatment center. An alternative  
29 treatment center may not allow any person to be an alternative treatment center agent who:

30 (1) Was convicted of a drug-related offense; or

31 (2) Is under 21 years of age.

32 (b) An alternative treatment center shall create an identification badge for each  
33 alternative treatment center agent before the alternative treatment center agent possesses,  
34 cultivates, or transports marijuana on behalf of the alternative treatment center. The badges may  
35 include the alternative treatment center's registration certificate number and either a unique  
36 number for each agent or his or her name.

37 (c) An alternative treatment center agent must wear his or her badge at all times when



1 working at an alternative treatment center, including at any cultivation location.

2 V. No person who has been convicted of a drug-related offense shall be an alternative  
3 treatment center agent. A person who is employed by or is an agent, volunteer, principal officer, or  
4 board member of an alternative treatment center who violates this paragraph shall be guilty of a  
5 violation punishable by a fine of up to \$1,000. A subsequent violation of this paragraph shall be a  
6 misdemeanor.

7 VI. The operating documents of an alternative treatment center shall include procedures for  
8 the oversight of the alternative treatment center and procedures to ensure accurate record keeping.

9 VII. Each alternative treatment center shall keep the following records, dating back at least  
10 6 months:

11 (a) Records of the disposal of marijuana that is not distributed by the alternative  
12 treatment center to qualifying patients who have designated the alternative treatment center to  
13 cultivate for them.

14 (b) A record of each transaction, including the amount of marijuana dispensed, the  
15 amount of consideration, and the registry identification number of the qualifying patient, designated  
16 caregiver, or alternative treatment center.

17 VIII. Each alternative treatment center shall:

18 (a) Conduct an initial comprehensive inventory of all medical marijuana, including  
19 usable marijuana available for dispensing and mature marijuana plants at each authorized location  
20 on the date the alternative treatment center first dispenses medical marijuana.

21 (b) Conduct a monthly comprehensive inventory of all medical marijuana, including  
22 usable marijuana available for dispensing, mature marijuana plants, and seedlings at each  
23 authorized location.

24 IX. An alternative treatment center shall submit a department-approved incident report  
25 form on the next business day after it discovers a reportable incident. The report shall indicate the  
26 nature of the breach and the corrective actions taken by the alternative treatment center. For  
27 purposes of reporting, an incident includes:

28 (a) Confidential information accessed or disclosed in violation of department rules;

29 (b) Loss of inventory by theft or diversion;

30 (c) Unauthorized intrusion into the alternative treatment center or the one permitted  
31 additional location, if any;

32 (d) Any known violation of this chapter or department rules by an alternative treatment  
33 center agent; and

34 (e) Any other incident that the department by rule requires to be reported.

35 X. Alternative treatment centers cannot use pesticides in marijuana cultivation unless  
36 pesticides become authorized for application on marijuana.

37 XI. No marijuana or paraphernalia at an alternative treatment center may be visible from

1 outside the property of the alternative treatment center.

2 XII. An alternative treatment center shall submit an annual report to the department that  
3 shall provide information required by the department in order to allow the department to evaluate  
4 the effectiveness and operations of the alternative treatment center.

5 XIII.(a) Each time an alternative treatment center agent dispenses marijuana to a  
6 qualifying patient directly or through the qualifying patient's designated caregiver, he or she shall  
7 consult the alternative treatment center's records to verify that the records do not indicate that the  
8 dispensing of the marijuana would cause the qualifying patient to receive more marijuana than is  
9 permitted in a 10-day period. Each time marijuana is dispensed, the alternative treatment center  
10 agent shall record the date the marijuana was dispensed and the amount dispensed. All records  
11 shall be kept according to the registry identification number of the qualifying patient and designated  
12 caregiver, if any.

13 (b) Except as provided in subparagraph (c), a qualifying patient is not allowed to obtain  
14 more than two ounces of usable marijuana directly or through the qualifying patient's designated  
15 caregiver during a 10-day period.

16 (c) After providing an opportunity for patients, experts, researchers, and physicians to be  
17 heard, the department may issue a rule adjusting the limit specified in subparagraph (a) to an  
18 amount that is reasonably necessary for a 10-day supply.

19 XIV.(a) Except when transporting marijuana in accordance with subparagraphs (b) or (c),  
20 alternative treatment center agents are only allowed to possess and manufacture marijuana at the  
21 alternative treatment center location or locations at which the alternative treatment center agents  
22 are employed. Volunteers are only allowed to possess and manufacture marijuana at an alternative  
23 treatment center location. Volunteers cannot dispense marijuana.

24 (b) Distributions of marijuana for medical use to a qualifying patient or a designated  
25 caregiver for use by a qualifying patient shall be labeled with a trip ticket to identify the alternative  
26 treatment center, the patient's registry number, or the caregiver's number, the amount and form, the  
27 time and date of origin, and destination of the product.

28 (c) An alternative treatment center with a growing location in addition to the location of  
29 the alternative treatment center shall label the marijuana that is being moved between the growing  
30 location and the alternative treatment center with a trip ticket that identifies the alternative  
31 treatment center by registry number, the time, date, origin, and destination of the material being  
32 transported, and the amount and form of marijuana and marijuana material that is being  
33 transported. Marijuana shall be transported only by an alternative treatment center agent who is  
34 not a volunteer.

35 XV.(a) An alternative treatment center shall not possess or cultivate marijuana in excess of  
36 the greater of the following quantities:

37 (1) 80 marijuana plants, 160 seedlings, and 80 ounces of usable marijuana; or

(2)(A) Six ounces of usable marijuana; and

(B) Four mature marijuana plants, 12 seedlings, and 6 ounces for each qualifying patient who has designated the alternative treatment center to provide him or her with marijuana for medical use. An alternative treatment center may also possess marijuana seeds, stalks, and unusable roots.

(b) An alternative treatment center may possess marijuana seeds, stalks, and unusable roots.

(c) An alternative treatment center or alternative treatment center agent shall not dispense, deliver, or otherwise transfer marijuana to a person other than:

(1) A qualifying patient who has designated the relevant alternative treatment center; or

(2) Such patient's designated caregiver; or

(3) A visiting qualifying patient who has designated the relevant alternative treatment center.

(d) All cultivation of marijuana shall take place in an enclosed, locked facility registered with the department and which can only be accessed by alternative treatment center agents.

XVI.(a) All marijuana dispensed by an alternative treatment center shall include a label specifying the weight of the marijuana and any other information the department requires to appear on the label. The label shall also specify that the marijuana is for medical use and that diversion is a class B felony requiring revocation of one's registry identification card.

(b) An alternative treatment center must provide educational materials about marijuana to qualifying patients and their registered primary caregivers. Each alternative treatment center shall have an adequate supply of up-to-date educational material available for distribution. Educational materials shall be available for inspection by the department upon request. The educational material shall at least include information about the following:

(1) Strains of marijuana, routes of administration, and their different effects. Alternative treatment centers shall have educational materials available to assist in the selection of prepared marijuana. Alternative treatment centers shall provide tracking sheets to qualifying patients and registered primary caregivers who request them to keep track of the strains used and their effects.

(2) How to achieve proper dosage for different modes of administration. Emphasis shall be on using the smallest amount possible to achieve the desired effect. The impact of potency must also be explained.

(3) Information on tolerance, dependence, and withdrawal must be provided.

(4) Information regarding substance abuse signs and symptoms must be available, as well as referral information.

(5) Information on whether the alternative treatment center's marijuana and

1 associated products meet organic certification standards.

2 (6) Information about possible side effects from the use of marijuana for medical  
3 purposes.

4 XV.(a) Each alternative treatment center shall develop, implement, and maintain on the  
5 premises employee and agent policies and procedures to address the following requirements:

6 (1) A job description or employment contract developed for all employees and a  
7 volunteer agreement for all volunteers, which includes duties, authority, responsibilities,  
8 qualifications, and supervision.

9 (2) Training in and adherence to confidentiality laws.

10 (3) The proper use of security measures and controls that have been adopted.

11 (4) Specific procedural instructions on how to respond to an emergency.

12 (b) All alternative treatment centers shall prepare training documentation for each  
13 employee and have employees sign a statement indicating the date, time, and place the employee  
14 received said training and topics discussed, to include name and title of presenters. The alternative  
15 treatment center shall maintain documentation of an employee's and a volunteer's training for a  
16 period of at least 6 months after termination of an employee's period of employment or the  
17 volunteer's period of voluntary service.

18 (c) Each alternative treatment center shall maintain a personnel record for each  
19 alternative treatment center agent that includes an application for employment or to volunteer and a  
20 record of any disciplinary action taken.

21 XVI. A provider shall not:

22 (a) Accept, solicit, or offer any form of pecuniary remuneration from or to an alternative  
23 treatment center, except if the provider is employed by an alternative treatment center.

24 (b) Offer a discount or other thing of value to a patient who uses or agrees to use a  
25 particular alternative treatment center.

26 (c) Examine a patient in relation to issuing a written certification at a location where  
27 medical marijuana is sold or distributed.

28 (d) Hold an economic interest in an alternative treatment center if the provider issues  
29 written certifications to patients.

30 126-W:9 Annual Report.

31 I. The commissioner of the department of health and human services shall report annually  
32 on the medical marijuana program established under this chapter to the health and human services  
33 oversight committee established under RSA 126-A:13. The initial report shall be filed with the  
34 chairman of the committee no later than December 1, 2014. The commissioner's report shall include  
35 the following information:

36 (a) The ability of qualifying patients and designated caregivers in all areas of the state to  
37 obtain timely access to medical marijuana.

Amendment to HB 573-FN

- Page 24 -

1 (b) The effectiveness of alternative treatment centers individually and together in  
2 serving the needs of qualifying patients and designated caregivers, including the provision of  
3 educational and support services.

4 (c) Provider participation in the medical marijuana program.

5 (d) The number of designated caregivers and the number of qualifying patients, by  
6 county.

7 (e) Sufficiency of the regulatory and security safeguards contained in this chapter to  
8 ensure that access to and use of marijuana cultivated is provided only to alternative treatment  
9 centers, qualifying patients, visiting qualifying patients, and designated caregivers.

10 (f) Any illegal distribution or diversion of marijuana cultivated pursuant to this chapter  
11 to individuals who are not alternative treatment center agents, qualifying patients, visiting  
12 qualifying patients, or designated caregivers.

13 (g) Any other issues related to the implementation of the medical use of marijuana  
14 permitted under this chapter that the committee shall request.

15 (h) A summary of the reports submitted by alternative treatment centers as required  
16 under RSA 126-W:8, XII.

17 126-W:10 Registry Identification Card and Certificate Fund. There is hereby established in the  
18 office of the state treasurer a fund to be known as the registry identification card and certificate fund  
19 which shall be kept separate and distinct from all other funds. The fund is established to pay for the  
20 operational expenses of the program for permitting the use of marijuana for medicinal purposes as  
21 established in this chapter. The moneys in this fund shall be nonlapsing and continually  
22 appropriated to the department. Interest on fund balances shall accrue to the fund. All fines and  
23 other income received by the department and all monetary fees, gifts, grants, and donations received  
24 by the department pursuant to this chapter shall be deposited in the fund.

25 2 New Subparagraph; Application of Receipts; Registry Identification Card and Certificate  
26 Fund. Amend RSA 6:12, I(b) by inserting after subparagraph (310) the following new subparagraph:

27 (311) Moneys deposited in the registry identification card and certificate fund established in  
28 RSA 126-W:7.

29 3 New Paragraph; Controlled Drug Act; Acts Prohibited. Amend RSA 318-B:2 by inserting after  
30 paragraph I-a the following new paragraph:

31 I-b. It shall be unlawful for a qualifying patient or designated caregiver as defined under  
32 RSA 126-W:1 to sell marijuana to another person who is not a qualifying patient or designated  
33 caregiver. A conviction for the sale of marijuana to a person who is not a qualifying patient or  
34 designated caregiver shall not preclude or limit a prosecution or conviction of any person for sale of  
35 marijuana or any other offense defined in this chapter.

36 4 New Paragraph; Controlled Drug Act; Penalties. Amend RSA 318-B:26 by inserting after  
37 paragraph IX the following new paragraph:

Amendment to HB 573-FN

- Page 25 -

1 IX-a. A qualifying patient or designated caregiver as defined in RSA 126-W:1 who is  
2 convicted of selling marijuana to a person who is not a qualifying patient or designated caregiver  
3 shall be guilty of a class B felony and shall be sentenced to a maximum term of imprisonment of not  
4 more than 7 years, a fine of not more than \$300,000, or both.

5 5 Effective Date. This act shall take effect upon its passage.

AMENDED ANALYSIS

Amendment to HB 573-FN

1 Amend the bill by replacing all after the enacting clause with the following:

2  
3 1 New Chapter; Use of Cannabis for Therapeutic Purposes. Amend RSA by inserting after  
4 chapter 126-V the following new chapter:

Deleted: Marijuana

Deleted: Medicinal

5 CHAPTER 126-W

6 USE OF CANNABIS FOR THERAPEUTIC PURPOSES

Deleted: MARIJUANA

Deleted: MEDICINAL

7 126-W:1 Definitions. In this chapter:

8 I. "Alternative treatment center" means a not-for-profit entity registered under RSA  
9 126-W:7 that acquires, possesses, cultivates, manufactures, delivers, transfers, transports,  
10 sells, supplies, and dispenses cannabis, and related supplies and educational materials, to  
11 qualifying patients.

Deleted: marijuana

12 II. "Alternative treatment center agent" means a principal officer, board member,  
13 employee, manager, or volunteer of an alternative treatment center who is 21 years of age or  
14 older and has not been convicted of a felony or any drug-related offense.

15 III. "Cultivation location" means a locked and enclosed site, under the control of the  
16 qualifying patient or designated caregiver who has reported the location of the site to the  
17 department, where cannabis is cultivated in accordance with the provisions of this chapter. A  
18 cultivation location may be a closet, a room, a greenhouse, a building, or another enclosed area  
19 that is secured with one or more locks or other security devices.

Deleted: marijuana

20 IV. "Department" means the department of health and human services.

21 V. "Designated caregiver" means an individual:

22 (a) Who is at least 21 years of age;

23 (b) Who has agreed to assist with a qualifying patient's therapeutic use of cannabis;

Deleted: medical

24 (c) Who has never been convicted of a felony or any drug-related offense; and

Deleted: marijuana

25 (d) Who possesses a valid registry identification card issued pursuant to RSA 126-

26 W:4.

27 VI. "Cannabis" means all parts of any plant of the Cannabis genus of plants, whether  
28 growing or not; the seeds thereof; the resin extracted from any part of such plant; and every  
29 compound, salt, derivative, mixture, or preparation of such plant, its seeds, or resin. Such  
30 term shall not include the mature stalks of such plants, fiber produced from such stalks, oil, or  
31 cake made from the seeds of such plants, any other compound, salt, derivative, mixture, or  
32 preparation of such mature stalks (except the resin extracted therefrom), fiber, oil or cake, or

Deleted: Marijuana



the sterilized seeds of such plants which are incapable of germination.

VII. "Therapeutic use" means the acquisition, possession, cultivation, preparation, use, delivery, transfer, or transportation of cannabis or paraphernalia relating to the administration of cannabis to treat or alleviate a qualifying patient's qualifying medical condition or symptoms or results of treatment associated with the qualifying patient's qualifying medical condition. It does not include:

- (a) The use of cannabis by a designated caregiver who is not a qualifying patient; or
- (b) Cultivation by a visiting qualifying patient; or
- (c) Cultivation by a designated caregiver or qualifying patient who is not designated

as being allowed to cultivate.

VIII.(a) Except as provided in this chapter, "provider" means a physician licensed to prescribe drugs to humans under RSA 329 and who possesses certification from the United States Drug Enforcement Administration to prescribe controlled substances. "Provider" shall also mean an advanced practice registered nurse licensed pursuant to RSA 326-B:18.

(b) If the qualifying patient's qualifying medical condition is post-traumatic stress disorder, the provider shall also be a licensed psychiatrist.

(c) For a visiting qualifying patient, "provider" means an individual licensed to prescribe drugs to humans in the state of the patient's residence and who possesses certification from the United States Drug Enforcement Administration to prescribe controlled substances.

IX. "Provider-patient relationship" means a medical connection between a licensed provider and a patient that includes an in-person exam, a history, a diagnosis, a treatment plan appropriate for the licensee's medical specialty, and documentation of all prescription drugs including name and dosage.

X. "Qualifying medical condition" means the presence of either:

(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, agitation of Alzheimer's disease, multiple sclerosis, or post-traumatic stress disorder; or

(b) A severely debilitating or terminal medical condition or its treatment that produces at least one of the following: wasting syndrome, severe 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, severe nausea, severe vomiting, seizures, or severe, persistent muscle spasms.

XI. "Qualifying patient" means a resident of New Hampshire, who has been diagnosed by a provider as having a qualifying medical condition and who possesses a valid registry identification card issued pursuant to RSA 126-W:4.

XII. "Registry identification card" means a document issued by the department

Deleted: Medical

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Comment [MS1]: CRNAs are included in the definition of APRNs

Deleted: and a certified registered nurse anesthetist

Deleted:

Deleted: means a relationship between a provider and a patient that includes:¶

... (a) Taking a medical history; ¶

... (b) Performing a relevant physical examination; ¶

... (c) Reviewing prior treatment and treatment response; ¶

... (d) Obtaining and reviewing relevant diagnostic test results; ¶

... (e) The provider being available for and offering follow-up care and treatment to the patient, including but not limited to patient examinations; ¶

... (f) Creating and maintaining patient records; and ¶

... (g) Notifying the patient's primary care provider when appropriate. ¶

Deleted: n individual

pursuant to RSA 126-W:4 that identifies an individual as a qualifying patient or a designated caregiver.

XIII. "Seedling" means a ~~cannabis plant that has no flowers and is less than 12 inches in height and less than 12 inches in diameter.~~

Deleted: marijuana

XIV. "Unusable ~~cannabis~~" means any ~~cannabis~~, other than usable ~~cannabis~~, including the seeds, stalks, and roots of the plant.

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

XV. "Usable ~~cannabis~~" means the dried leaves and flowers of the ~~cannabis~~ plant and any mixture or preparation thereof, but does not include the seeds, stalks, and roots of the plant and does not include the weight of any non-~~cannabis~~ ingredients combined with ~~cannabis~~ and prepared for consumption as food or drink.

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

XVI. "Visiting qualifying patient" means a patient with a qualifying medical condition who is not a resident of New Hampshire or who has been a resident of New Hampshire for fewer than 30 days.

XVII. "Written certification" means a document signed by a provider stating that in the provider's professional opinion, after having completed a full assessment of the patient's medical history and current medical condition made in the course of a provider-patient relationship of at least three months in duration, the patient has a qualifying medical condition. The three-month requirement for the provider-patient relationship required in this paragraph shall not apply if the provider issuing the written certification certifies that 1) the onset of the patient's qualifying medical condition occurred within the past three months; and 2) the certifying provider is primarily responsible for the patient's care related to his or her qualifying medical condition. The date of issuance and the patient's qualifying medical condition shall be specified on the written certification.

Deleted: 3

Deleted: , and the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient

Deleted: If the patient's qualifying medical condition is of recent or sudden onset and the certifying provider is primarily responsible for the patient's care related to his or her qualifying medical condition, the 3-month requirement for the provider-patient relationship required in this paragraph shall not apply.

126-W:2 Therapeutic Use of Cannabis Protections.

I. A qualifying patient shall not be subject to arrest by state or local law enforcement, prosecution or penalty under state or municipal law, or be denied any right or privilege for the therapeutic use of cannabis in accordance with this chapter, if the qualifying patient possesses, cultivates, or possesses and cultivates, an amount of cannabis that does not exceed the following:

Deleted: Medical Marijuana

Deleted: medical

Deleted: marijuana

(a) If the qualifying patient does not have a designated caregiver, for the possession and cultivation of ~~cannabis that occurs at the cultivation location reported to the department, or while transporting cannabis and cannabis plants and seedlings to a new cultivation location that has been reported to the department within the prior 21 days:~~

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: Six

(1) ~~Six ounces of usable cannabis;~~

Deleted: marijuana

(2) Any amount of unusable ~~cannabis~~; and

Deleted: marijuana

(3) ~~Three mature cannabis plants and 12 seedlings, with a total canopy of no more than 50 square feet.~~

Deleted: Four

Deleted: marijuana

(b) If the qualifying patient is not at a cultivation location reported to the

Deleted: 2

Deleted: 10

department:

(1) Two ounces of usable cannabis; and

Deleted: marijuana

(2) Any amount of unusable cannabis.

Deleted: marijuana

II. A designated caregiver shall not be subject to arrest by state or local law enforcement, prosecution or penalty under state or municipal law, or denied any right or privilege for the therapeutic use of cannabis in accordance with this chapter on behalf of a qualifying patient if the designated caregiver possesses or cultivates, or both, an amount of cannabis that does not exceed the following:

Deleted: medical

Deleted: marijuana

Deleted: marijuana

(a) If at the cultivation location reported to the department, or while transporting cannabis and cannabis plants and seedlings to a new cultivation location that has been reported to the department within the prior 21 days:

Deleted: marijuana

Deleted: marijuana

(1) Six ounces of usable cannabis; and

Deleted: marijuana

(2) Any amount of unusable cannabis; and

Deleted: marijuana

(3) Three mature cannabis plants and 12 seedlings, with a total canopy of no more than 50 square feet.

Deleted: Four

Deleted: marijuana

Deleted: 10

(b) If not at a cultivation location reported to the department:

(1) Two ounces of usable cannabis; and

Deleted: marijuana

(2) Any amount of unusable cannabis.

Deleted: marijuana

III. A qualifying patient or designated caregiver shall not be subject to arrest by state or local law enforcement or prosecution or penalty under state or municipal law for giving cannabis to a qualifying patient or a visiting qualifying patient where nothing of value is transferred in return, or for offering to do the same, if the person giving the cannabis does not knowingly cause the recipient to possess more cannabis than is permitted by this section.

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

IV. Notwithstanding paragraph III, a designated caregiver may receive compensation for costs, not including labor, associated with assisting a qualifying patient who has designated the designated caregiver to assist him or her with the therapeutic use of cannabis. Such compensation shall not constitute the sale of controlled substances.

Deleted: medical

Deleted: marijuana

V.(a) A qualifying patient is presumed to be lawfully engaged in the therapeutic use of cannabis in accordance with this chapter if the qualifying patient possesses a valid registry identification card and possesses an amount of cannabis that does not exceed the amount allowed under this chapter.

Deleted: medical

Deleted: marijuana

Deleted: marijuana

(b) A designated caregiver is presumed to be lawfully engaged in assisting with the medical use of cannabis in accordance with this chapter if the designated caregiver possesses a valid registry identification card and possesses an amount of cannabis that does not exceed the amount allowed under this chapter.

Deleted: marijuana

Deleted: marijuana

(c) The presumptions made in subparagraphs (a) and (b) may be rebutted by evidence that conduct related to cannabis was not for the purpose of treating or alleviating the qualifying patient's qualifying medical condition or symptoms or effects of the treatment

Deleted: marijuana

1 associated with the qualifying medical condition, in accordance with this chapter.

2 VI. A valid registry identification card, or its equivalent, that is issued under the laws of  
3 another state, district, territory, commonwealth, or insular possession of the United States that  
4 allows, in the jurisdiction of issuance, a visiting qualifying patient to possess cannabis for  
5 therapeutic purposes, shall have the same force and effect as a valid registry identification card  
6 issued by the department in this state, provided that:

Deleted: marijuana

Deleted: medical

7 (a) The visiting qualifying patient shall also produce a statement from his or her  
8 provider stating that the visiting qualifying patient has a qualifying medical condition as  
9 defined in RSA 126-W:1, X; and

10 (b) A visiting qualifying patient shall not cultivate cannabis in New Hampshire or  
11 obtain cannabis from alternative treatment centers.

Deleted: marijuana

12 VII. A person otherwise entitled to custody of, or visitation or parenting time with, a  
13 minor shall not be denied such a right solely for conduct allowed under this chapter, and there  
14 shall be no presumption of neglect or child endangerment.

15 VIII. For the purposes of medical care, including organ transplants, a qualifying  
16 patient's authorized use of cannabis in accordance with this chapter shall be considered the  
17 equivalent of the authorized use of any other medication used at the direction of a provider,  
18 and shall not constitute the use of an illicit substance.

Deleted: marijuana

19 IX. A provider shall not be subject to arrest by state or local law enforcement,  
20 prosecution or penalty under state or municipal law, or be denied any right or privilege,  
21 including but not limited to a civil penalty or disciplinary action by the New Hampshire board  
22 of medicine or any other occupational or professional licensing entity, solely for providing  
23 written certifications, provided that nothing shall prevent a professional licensing entity from  
24 sanctioning a provider for failing to properly evaluate a patient's medical condition.

Deleted: or for otherwise  
stating that, in the provider's  
professional opinion, and in  
the context of a provider-  
patient relationship, a patient  
is likely to receive therapeutic  
or palliative benefit from the  
medical use of marijuana

25 X. An alternative treatment center shall not be subject to prosecution under state or  
26 municipal law; search or inspection, except by the department pursuant to RSA 126-W:7, XI;  
27 seizure; or penalty in any manner under state or municipal law for acting pursuant to this  
28 chapter and department rules to:

29 (a) Acquire or purchase cannabis seeds, seedlings, plants, or cannabis from other  
30 alternative treatment centers;

Deleted: marijuana

Deleted: marijuana

31 (b) Accept cannabis seeds from individuals and entities from jurisdictions outside of  
32 New Hampshire that are authorized to cultivate cannabis in their home state;

Deleted: marijuana

Deleted: medical marijuana

33 (c) Accept cannabis seeds from qualifying patients or designated caregivers;

Deleted: marijuana

34 (d) Sell or donate cannabis seeds to similar entities that are registered to dispense  
35 cannabis for therapeutic use in other jurisdictions;

Deleted: marijuana

Deleted: marijuana

Deleted: medical

36 (e) Possess, cultivate, manufacture, or transport cannabis and seedlings; and/or

Deleted: marijuana

37 (f) Deliver, transfer, supply, sell, or dispense cannabis and related supplies and  
38 educational materials to qualifying patients and visiting qualifying patients who have

Deleted: marijuana

1 designated the alternative treatment center to provide for them, to designated caregivers on  
2 behalf of the qualifying patients who have designated the alternative treatment center, and/or  
3 to other alternative treatment centers.

4 XI. An alternative treatment center agent shall not be subject to arrest by state or local  
5 law enforcement, prosecution or penalty in any manner under state or municipal law, search,  
6 or be denied any right or privilege for working for an alternative treatment center pursuant to  
7 this chapter and department rules to engage in any of the actions listed in paragraph X.

8 XII. Visiting qualifying patients, qualifying patients, designated caregivers, and entities  
9 that are authorized to cultivate cannabis in their home state shall not be subject to arrest by  
10 state or local law enforcement, prosecution or penalty under state or municipal law, or be  
11 denied any right or privilege for donating cannabis seeds to alternative treatment centers in  
12 New Hampshire.

13 XIII. Any cannabis, cannabis paraphernalia, licit property, or interest in licit property  
14 that is possessed, owned, or used in connection with the therapeutic use of cannabis as  
15 allowed under this chapter, or acts incidental to such use, shall not be seized or forfeited if the  
16 basis for the seizure or forfeiture is activity related to cannabis that is exempt from state  
17 criminal penalties under this chapter.

18 XIV. An individual shall not be subject to arrest by state or local law enforcement,  
19 prosecution or penalty under state or municipal law, or be denied any right or privilege,  
20 including but not limited to a civil penalty or disciplinary action by a court or occupational or  
21 professional licensing entity, simply for being in the presence or vicinity of the therapeutic use  
22 of cannabis as allowed under this chapter.

23 XV. If a state or local law enforcement agency or agent encounters an alternative  
24 treatment center or an individual who the agent or agency knows is an alternative treatment  
25 center agent, a designated caregiver, or a qualifying patient, or who credibly asserts he or she  
26 is an alternative treatment center agent, a designated caregiver, or a qualifying patient, the law  
27 enforcement agency or agent shall not provide any information from any cannabis-related  
28 investigation of the individual or entity to any law enforcement agency that does not recognize  
29 the protection of this chapter, and any prosecution of the individual or entity for a violation of  
30 this chapter shall be conducted pursuant to the laws of this state. This paragraph shall not  
31 apply in cases where the state or local law enforcement agency has probable cause to believe  
32 the person is distributing cannabis to a person who is not allowed to possess it under this  
33 chapter.

34 XVI. A person who ceases to be a qualifying patient or designated caregiver shall have  
35 10 days after notification by the department to dispose of cannabis in one of the following  
36 ways:

37 (a) If the person was a designated caregiver and the qualifying patient who  
38 designated the caregiver is still a qualifying patient, but has designated a new caregiver or will

Deleted: medical marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: medical

Deleted: marijuana

Deleted: marijuana

Deleted: medical

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

1 cultivate plants himself or herself, the designated caregiver may transfer cannabis to the new  
2 person who will cultivate for the qualifying patient;

Deleted: marijuana

3 (b) The person may notify local law enforcement and request that they dispose of  
4 the cannabis; or

Deleted: marijuana

5 (c) The person may dispose of cannabis, after mixing cannabis with other  
6 ingredients such as soil to render it unusable; or

Deleted: marijuana

Deleted: marijuana

7 (d) The person may donate usable cannabis to a qualifying patient.

Deleted: .

Deleted: marijuana

8 126-W:3 Prohibitions and Limitations on the Therapeutic Use of Cannabis.

Deleted: Medical Marijuana

9 I. A qualifying patient may use cannabis on privately owned real property only with the  
10 permission of the property owner or in the case of leased property with the permission of the  
11 tenant in possession of the property, except that a tenant shall not allow a qualifying patient to  
12 smoke cannabis on rented property if smoking on the property violates the lease or the lessor's  
13 rental policies that apply to all tenants at the property. However, a tenant may permit a  
14 qualifying patient to use cannabis on leased property by ingestion or inhalation through  
15 vaporization even if smoking is prohibited by the lease or rental policies. For purposes of this  
16 chapter, vaporization shall mean the inhalation of cannabis without the combustion of the  
17 cannabis.

Deleted: medical marijuana

Deleted: medical marijuana

Deleted: medical marijuana

Deleted: marijuana

Deleted: marijuana

18 II. Nothing in this chapter shall exempt any person from arrest or prosecution for:

19 (a) Being under the influence of cannabis while:

Deleted: marijuana

20 (1) Operating a motor vehicle, commercial vehicle, boat, or vessel, or any other  
21 vehicle propelled or drawn by power other than muscular power; or

22 (2) In his or her place of employment, without the written permission of the  
23 employer; or

24 (3) Operating heavy machinery or handling a dangerous instrumentality.

25 (b) The use or possession of cannabis by a qualifying patient or designated  
26 caregiver for purposes other than for therapeutic use as permitted by this chapter;

Deleted: marijuana

Deleted: medical

27 (c) The smoking or vaporization of cannabis in any public place, including:

Deleted: marijuana

28 (1) A school bus, public bus, or other public vehicle; or

29 (2) A place of employment, without the written permission of the employer; or

30 (3) The grounds of any preschool, elementary, or secondary school; or

31 (4) Any correctional facility; or

32 (5) Any public park, public beach, public recreation center, public field, or  
33 youth center; or

34 (6) Any law enforcement facility.

35 III. Nothing in this chapter shall be construed to require:

36 (a) Any health insurance provider, health care plan, or medical assistance program  
37 to be liable for any claim for reimbursement for the therapeutic use of cannabis; or

Deleted: medical

38 (b) Any individual or entity in lawful possession of property to allow a guest, client,

Deleted: marijuana

customer, or other visitor to use cannabis on or in that property; or

Deleted: marijuana

(c) Any accommodation of the therapeutic use of cannabis on the property or premises of any place of employment or on the property or premises of any jail, correctional facility, or other type of penal institution where prisoners reside or persons under arrest are detained. This chapter shall in no way limit an employer's ability to discipline an employee for ingesting cannabis in the workplace or for working while under the influence of cannabis.

Deleted: medical

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

IV. Fraudulent representation to a law enforcement official of any fact or circumstance relating to the therapeutic use of cannabis to avoid arrest or prosecution shall be guilty of a violation punishable by a fine of \$500, which shall be in addition to any other penalties that may apply for making a false statement or for the use of cannabis other than use undertaken pursuant to this chapter.

Deleted: medical

Deleted: marijuana

Deleted: marijuana

V. A qualifying patient or designated caregiver who is found to be in possession of cannabis outside of his or her home and is not in possession of his or her registry identification card may be subject to a \$100 fine.

Deleted: marijuana

VI. Any qualifying patient or designated caregiver who sells cannabis to another person who is not a qualifying patient or designated caregiver under this chapter shall be subject to the penalties specified in RSA 318-B:26, IX-a, shall have his or her registry identification card revoked, and shall be subject to other penalties as provided in RSA 318-B:26.

Deleted: marijuana

VII. The department may revoke the registry identification card of a qualifying patient or designated caregiver for violation of rules adopted by the department or for violation of any other provision of this chapter, and the qualifying patient or designated caregiver shall be subject to any other penalties established in law for the violation.

Deleted: who

Deleted: violates

126-W:4 Departmental Administration, Registry Identification Cards.

I. Except as provided in paragraph V, the department shall issue a registry identification card to a person applying as a qualifying patient who submits all of the following information:

(a) Written certification as defined in RSA 126-W:1.

(b) An application or a renewal application accompanied by the application or renewal fee.

(c) A recent passport-sized photograph of the applicant's face.

(d) Name, residential and mailing address, and date of birth of the applicant, except that if the applicant is homeless, no residential address is required.

Deleted: c

(e) Name, address, and telephone number of the applicant's provider.

Deleted: d

(f) Name, address, and date of birth of the applicant's designated caregiver, if any.

Deleted: c

A qualifying patient shall have only one designated caregiver.

(g) Name of the alternative treatment center that the qualifying patient designates.

Deleted: f

A qualifying patient may designate no more than one alternative treatment center at any time.

(h) Street address of the cultivation location, if any, if the qualifying patient does

Deleted: g

not have a designated caregiver.

(i) A statement signed by the applicant, pledging not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to this chapter and acknowledging that his or her diversion of cannabis is punishable as a class B felony and revocation of his or her registry identification card, in addition to other penalties for the illegal sale of cannabis.

Deleted: h

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

II.(a) Except as provided in paragraph V, the department shall issue a registry identification card to a person applying as a designated caregiver who submits all of the following information:

(1) An application or a renewal application accompanied by a therapeutic use certificate.

Deleted: medicinal

(2) A recent passport-sized photograph of the applicant's face.

Deleted:

(3) Name, residential and mailing address, and date of birth of the applicant.

(4) Name, residential and mailing address, and date of birth of the qualifying

Deleted: 3

patient for whom the applicant will act as designated caregiver, except that if the qualifying patient is homeless, no residential address is required. A designated caregiver shall act on behalf of only one qualifying patient.

(5) Street address of the cultivation location, except that the designated caregiver may not include a cultivation location if the designated caregiver's qualifying patient has designated an alternative treatment center.

Deleted: 1

(4) A complete set of fingerprints.

Deleted: 5

(6) A statement indicating the applicant's preference as to whether the applicant requests the department to retain his or her fingerprints on file for any renewal application or whether the applicant requests the department to destroy his or her fingerprints and acknowledges that the applicant shall resubmit fingerprints if the applicant applies for renewal as a designated caregiver.

Deleted: 6

(7) A signed statement from the applicant agreeing to act as the designated caregiver for the qualifying patient named in the application and pledging not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to this chapter and acknowledging that the diversion of cannabis is punishable as a class B felony and revocation of one's registry identification card, in addition to other penalties for the illegal sale of cannabis.

Deleted: 7

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: b

Deleted: to a state

Deleted: nd

(8) A person who is applying to be a designated caregiver shall submit the results of a state and federal criminal records check obtained through the department of safety. The department of safety may exchange necessary data including fingerprint data with the Federal Bureau of Investigation without disclosing that the records check is related to the provisions of this chapter and acts permitted by it. Unless the applicant stated that he or she prefers his or her fingerprints to be kept on file for any renewal, the department and the department of safety shall destroy each set of fingerprints obtained pursuant to this chapter after the criminal records check is complete.

Deleted: The department shall request the department of safety to perform the state and federal criminal records check and the department of safety shall complete such records checks and convey the findings of such checks to the department within 30 days of the request.

Deleted: department and the



1 III. The department shall verify the information contained in an application or renewal  
2 submitted pursuant to this section. The department shall approve or deny an application or  
3 renewal for a qualifying patient within 15 days of receipt of the application. The department  
4 shall approve or deny an application or renewal to serve as a designated caregiver within 45  
5 days of receipt of the application. The department may deny an application or renewal only if  
6 the applicant did not provide the information required pursuant to this section, or if the  
7 applicant previously had a registry identification card revoked for violating the provisions of  
8 this chapter, or rules adopted by the department, or if the department determines that the  
9 information provided was falsified. The department shall notify an applicant of the denial of an  
10 application. An applicant who is aggrieved by a department decision may request an  
11 administrative hearing at the department.

Deleted: ,

12 IV. The department shall issue registry identification cards to persons applying as a  
13 qualifying patient or designated caregiver within five days of approving an application or  
14 renewal. Each registry identification card shall expire one year after the date of issuance,  
15 unless the provider states in the written certification that the certification should expire at an  
16 earlier specified date, then the registry identification card shall expire on that date. Registry  
17 identification cards shall contain all of the following:

Deleted: 5

Deleted: he or she believes the  
qualifying patient would  
benefit from medical  
marijuana only until a  
specified

18 (a) Name, mailing address, and date of birth of the qualifying patient or designated  
19 caregiver.

20 (b) The date of issuance and expiration date of the registry identification card.

21 (c) A random 10-digit identification number, containing at least four numbers and  
22 at least four letters, that is unique to the qualifying patient or the designated caregiver.

Deleted: 4

Deleted: 4

23 (d) A designation that the person is either a "qualifying patient" or a "designated  
24 caregiver." If the person is a designated caregiver, the identification card shall include the  
25 random 10-digit identification number of the qualifying patient for whom he or she is providing  
26 care.

27 (e) The registry identification number corresponding with the alternative treatment  
28 center the qualifying patient designated, if any.

29 (f) A photograph of the qualifying patient or designated caregiver.

30 (g) A statement that the qualifying patient or designated caregiver is permitted  
31 under state law to possess cannabis pursuant to this chapter for the medical use of the  
32 qualifying patient.

Deleted: marijuana

33 (h) A statement noting whether or not the cardholder is exempt from state penalties  
34 for cultivating cannabis. The statement shall be determined as follows:

Deleted: marijuana

Deleted: marijuana

35 (1) A qualifying patient is exempt from state penalties for cultivating cannabis in  
36 accordance with this chapter if he or she does not have a designated caregiver. If a qualifying  
37 patient has selected a designated caregiver, he or she is not exempt from state penalties for  
38 cultivating cannabis.

Deleted: marijuana

1 (2) A designated caregiver is exempt from state penalties for cultivating  
2 cannabis in accordance with this chapter if the designated caregiver's qualifying patient has  
3 not also designated an alternative treatment center. If the designated caregiver's qualifying  
4 patient has also designated an alternative treatment center, the designated caregiver is not  
5 exempt from state penalties for cultivating cannabis.

Deleted: marijuana

6 V. The department shall not issue a registry identification card to an applicant under  
7 18 years of age who is applying as a qualifying patient unless:

Deleted: marijuana

8 (a) A custodial parent or legal guardian responsible for health care decisions for the  
9 qualifying patient submits a written certification from two providers, one of whom must be a  
10 pediatrician.

11 (b) The applicant's provider has explained the potential risks and benefits of the  
12 therapeutic use of cannabis to the custodial parent or legal guardian with responsibility for  
13 health care decisions for the applicant; and

Deleted: medical

Deleted: marijuana

14 (c) The custodial parent or legal guardian with responsibility for health care  
15 decisions for the applicant consents in writing to:

Deleted: b

16 (1) Allow the applicant's therapeutic use of cannabis; and

Deleted: medical

17 (2) Serve as the applicant's designated caregiver, and control the acquisition of  
18 the cannabis, and the frequency of the therapeutic use of cannabis by the applicant; and

Deleted: marijuana

Deleted: Control

19 (3) The custodial parent or legal guardian completes an application in  
20 accordance with the requirements of paragraph I on behalf of the applicant.

Deleted: marijuana

Deleted: medical

Deleted: marijuana

21 VI. The department shall provide each approved qualifying patient and caregiver a  
22 statement with the registry identification card explaining federal law on the possession of  
23 cannabis, and that possession of a state registry identification card does not protect a person  
24 from federal criminal penalties.

Deleted: marijuana

25 VII. The department shall track the number of qualifying patients who have designated  
26 each alternative treatment center and issue a monthly written statement to the alternative  
27 treatment center identifying the number of qualifying patients who have designated that  
28 alternative treatment center along with the registry identification numbers of each patient and  
29 each patient's designated caregiver.

30 VIII. In addition to the monthly reports, the department shall also provide written  
31 notice to an alternative treatment center which identifies the names and registration  
32 identification numbers of a qualifying patient and his or her designated caregiver whenever any  
33 of the following events occur:

34 (a) A qualifying patient designates the alternative treatment center to serve his or  
35 her needs under this chapter; or

36 (b) An existing qualifying patient revokes the designation of the alternative  
37 treatment center; or

38 (c) A qualifying patient who has designated the alternative treatment center loses

1 his or her status as a qualifying patient under this chapter.

2 IX.(a) A qualifying patient shall notify the department before changing his or her  
3 designated caregiver or alternative treatment center.

4 (b) A qualifying patient and designated caregiver shall notify the department before  
5 changing his or her cultivation location.

6 (c) A qualifying patient shall notify the department of any change in his or her name  
7 or address within 10 days of such change. If the qualifying patient's certifying provider notifies  
8 the department in writing that the qualifying patient no longer suffers from a qualifying  
9 medical condition or should discontinue using cannabis for another compelling reason, the  
10 registry identification card shall become void upon notification by the department to the  
11 qualifying patient.

Deleted: either

Deleted: or that the provider  
no longer believes the  
qualifying patient would  
receive benefit from the  
medical use of marijuana

12 (d) When a qualifying patient or a designated caregiver notifies the department of  
13 any change to a name, address, or alternative treatment center, the department shall issue the  
14 qualifying patient or designated caregiver a new registry identification card with a new random  
15 10-digit identification number within 20 days of receiving the updated information.

Deleted: 15

16 (e) If a qualifying patient notifies the department of a change in his or her  
17 designated caregiver and the prospective designated caregiver meets the requirements of this  
18 chapter, the department shall issue the designated caregiver a registry identification card with  
19 a new random 10-digit identification number within 50 days of receiving the designated  
20 caregiver's application.

Deleted: 45

21 (f) A qualifying patient or designated caregiver who fails to notify the department of  
22 any changes to his or her name, address, designated caregiver, or cultivation location shall be  
23 guilty of a violation and may be subject to a fine not to exceed \$150 under rules adopted by the  
24 department.

25 (g) If a qualifying patient or designated caregiver loses his or her registry  
26 identification card, he or she shall notify the department within 10 days of losing the card.  
27 Within 5 days after such notification, the department shall issue a new registry identification  
28 card with a new random 10-digit identification number.

29 (2) The fee for new registry cards shall be established in rules set by the department  
30 under RSA 541-A.

31 X. Mere possession of, or application for, a registry identification card shall not  
32 constitute probable cause or reasonable suspicion, nor shall it be used to support the search of  
33 the individual or property of the individual possessing or applying for the registry identification  
34 card. The possession of, or application for, a registry identification card shall not preclude the  
35 existence of probable cause if probable cause exists on other grounds.

36 XI.(a) The department shall create and maintain a confidential registry of each  
37 individual who has applied for and received a registry identification card as a qualifying patient  
38 or a designated caregiver in accordance with the provisions of this chapter. Each entry in the

1 registry shall contain the qualifying patient's or designated caregiver's name, mailing address,  
2 date of birth, date of registry identification card issuance, date of registry identification card  
3 expiration, random 10-digit identification number, street address at which the cannabis plants  
4 will be cultivated or possessed, effective date of any change of cultivation location, and registry  
5 identification number of the qualifying patient's designated alternative treatment center, if any.  
6 The confidential registry and the information contained in it shall be exempt from disclosure  
7 under RSA 91-A.

Deleted: marijuana

8 (b)(1) Except as specifically provided in this chapter, no person shall have access to  
9 any information about qualifying patients or designated caregivers in the department's  
10 confidential registry, or any information otherwise maintained by the department about  
11 providers and alternative treatment centers, except for authorized employees of the department  
12 in the course of their official duties and local and state law enforcement personnel who have  
13 detained or arrested an individual who claims to be engaged in the therapeutic use of  
14 cannabis.

Deleted: medical

Deleted: marijuana

15 (2) If a local or state law enforcement officer submits a sworn affidavit to the  
16 department affirming that he or she has probable cause to believe cannabis is possessed or  
17 cultivated at a specific address, an authorized employee for the department may disclose  
18 whether the location is associated with a qualifying patient, designated caregiver, cultivation  
19 location, or alternative treatment center location.

Deleted: marijuana

20 (3) If a local or state law enforcement officer submits a sworn affidavit to the  
21 department affirming that he or she has probable cause to believe a specific individual  
22 possesses or cultivates cannabis, an authorized employee for the department may disclose  
23 whether the person is a qualifying patient or a designated caregiver, provided that the law  
24 enforcement officer provides the person's name and address or name and date of birth.

Deleted: marijuana

25 (4) Counsel for the department may notify law enforcement officials about  
26 falsified or fraudulent information submitted to the department where counsel has made a  
27 legal determination that there is probable cause to believe the information is false or falsified.

28 XII. Within five days of learning of the death of a qualifying patient, a surviving family  
29 member, caretaker, executor, or the patient's designated caregiver shall notify the department  
30 that the qualifying patient has died. Within five days of learning of the death of a qualifying  
31 patient, the surviving family member, caretaker, executor, or the patient's designated caregiver  
32 shall either request that the local law enforcement agency remove any remaining cannabis or  
33 shall dispose of the cannabis in a manner that is specified by the department by rule.

Deleted: 5

Deleted: 5

Deleted: marijuana

Deleted: marijuana

34 126-W:5 Affirmative Defense.

35 I. Except as provided in RSA 126-W:3, it shall be an affirmative defense to any  
36 prosecution for an offense involving cannabis or cannabis paraphernalia intended for  
37 therapeutic use if:

Deleted: marijuana

Deleted: medical

38 (a) The defendant is a qualifying patient in possession of a valid registry

1 identification card and at the time of arrest or prosecution was in possession of a quantity of  
2 cannabis that was not more than allowed under this chapter, and the qualifying patient was  
3 engaged in the therapeutic use of cannabis in accordance with the provisions of this chapter;  
4 or

Deleted: marijuana

Deleted: medical

Deleted: marijuana

5 (b)(1) The defendant is a designated caregiver in possession of a valid registry  
6 identification card and at the time of arrest or prosecution was in possession of a quantity of  
7 cannabis that was not more than allowed under this chapter; and

Deleted: marijuana

Deleted: medical

Deleted: marijuana

8 (2) The designated caregiver was engaged in the therapeutic use of cannabis on  
9 behalf of a qualifying patient in accordance with the provisions of this chapter.

10 (c) If a defendant proves the elements of the affirmative defense listed in  
11 subparagraph (I)(a) or (b), the charges shall be dismissed with prejudice.

12 II. A person who is arrested or cited for possession, cultivation, or transportation of  
13 cannabis, or possession of cannabis paraphernalia, may raise as an affirmative defense that he  
14 or she is person with a qualifying medical condition who is not yet in possession of a valid  
15 registry identification card if:

Deleted: marijuana

Deleted: marijuana

16 (a) Prior to the arrest, the person submitted to the department a valid application to  
17 become a qualifying patient, complete with a written certification, but the person had not yet  
18 received a registry identification card from the department; and

19 (1) The person does not possess more than two ounces of usable cannabis and  
20 any amount of unusable cannabis, if the cannabis is not on the person's property; or

Deleted: 2

Deleted: marijuan

Deleted: a

21 (2) If the cannabis is on the person's property, the person does not possess  
22 more than six ounces of usable cannabis and any amount of unusable cannabis and does not  
23 possess or is not cultivating more than three mature cannabis plants and 12 seedlings, which  
24 shall be in a locked and enclosed location on the person's property.

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: 6

25 (b) The affirmative defense under this section shall not be available to a person who  
26 has violated any of the provisions of RSA 126-W:3, I-IV.

Deleted: marijuana

Deleted: marijuana

27 (c) If a defendant proves the elements of the affirmative defense listed in this  
28 paragraph, the defendant shall be acquitted of any charge to which the defendant proved the  
29 affirmative defense.

Deleted: 4

Deleted: marijuana

30 III. A person who is arrested or cited for possession, cultivation, or transportation of  
31 cannabis, or possession of cannabis paraphernalia, prior to the date on which the department  
32 begins accepting registry identification card applications may raise as an affirmative defense  
33 that he or she is a person with a qualifying medical condition who is not yet in possession of a  
34 valid registry identification card if:

Deleted: marijuana

Deleted: marijuana

35 (a) The person produces a written statement signed by a provider stating that in the  
36 provider's professional opinion, after having completed a full assessment made in the course of  
37 a provider-patient relationship of at least three months duration, the person has a qualifying  
38 medical condition. The three-month requirement for the provider-patient relationship required

Deleted: of the person's  
medical history and current  
medical condition

Deleted: 3

Deleted: ,

1 in this paragraph shall not apply if the provider issuing the written certification certifies that 1)  
2 the onset of the patient's qualifying medical condition occurred within the past three months;  
3 and 2) the certifying provider is primarily responsible for the patient's care related to his or her  
4 qualifying medical condition.; and

5 (1) The person does not possess more than three ounces of usable cannabis and  
6 any amount of unusable cannabis, if the cannabis is not on the person's property; and

7 (2) If the cannabis is on the person's property, the person does not possess  
8 more than six ounces of usable cannabis and any amount of unusable cannabis and does not  
9 possess or is not cultivating more than three mature cannabis plants and 12 seedlings which  
10 shall be in a locked and enclosed location.

11 (b) The affirmative defense under this section shall not be available to a person who  
12 has violated any of the provisions of RSA 126-W:3, I-IV.

13 (c) If a defendant proves the elements of the affirmative defense listed in this  
14 paragraph, the defendant shall be acquitted of any charge to which the defendant proved the  
15 affirmative defense.

16 126-W:6 Departmental Rules.

17 I. Not later than six months after the effective date of this chapter, the department  
18 shall adopt rules, pursuant to RSA 541-A, governing the manner in which it shall consider  
19 applications for issuance and renewals of registry identification cards for qualifying patients  
20 and designated caregivers.

21 II. The department's rules shall establish application and renewal fees for registry  
22 identification cards in accordance with the following:

23 (a) The fee structure by the department for alternative treatment centers and  
24 registry identification cards shall generate revenues sufficient to offset all state expenses of  
25 implementing and administering this chapter; however,

26 (b) The department may accept donations from private sources without the  
27 approval of the governor and council in order to reduce the application and renewal fees for  
28 individual qualifying patients.

29 III.(a) Not later than one year after the effective date of this section, the department  
30 shall adopt rules, pursuant to RSA 541-A, governing alternative treatment centers and the  
31 manner in which it shall consider applications for registration certificates for alternative  
32 treatment centers, including, but not necessarily limited to, rules governing:

33 (1) The form and content of registration and renewal applications.

34 (2) Oversight requirements.

35 (3) Security requirements, which shall include at a minimum, lighting, physical  
36 security, video security, alarm requirements, measures to prevent loitering, and on-site  
37 parking.

38 (4) Sanitary requirements.

Deleted: unless the person's  
qualifying medical condition is  
of recent or sudden onset in  
which case the 3-month time  
requirement shall not apply,  
the person has a qualifying  
medical condition and the  
potential benefits of the  
medical use of marijuana  
would likely outweigh the  
health risks for the person

Deleted: 2

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: 6

Deleted: marijuana

Deleted: marijuana

Deleted: 4

Deleted: marijuana

Deleted: 90 days

(5) Electrical safety requirements.

(6) The specification of acceptable forms of picture identification that an alternative treatment center may accept when verifying a sale.

(7) Personnel requirements including how many volunteers an alternative treatment center is permitted to have and requirements for supervision.

(8) Labeling standards.

(9) ~~Procedures for suspending or terminating the registration of alternative treatment centers that violate the provisions of this section or the rules adopted pursuant to this section, procedures for appealing fines, and a schedule of fines.~~

Deleted:

Deleted: penalties

Deleted: penalties

(10) Procedures for inspections and investigations.

(11) Advertising restrictions, including a prohibition of misrepresentation and unfair practices.

(12) Permissible hours of operation.

(13) The fees for the processing and review of applications for registration as an alternative treatment center and regulation of an alternative treatment center after it has been approved by the department. Such fees shall be established in an amount that covers all costs of the department for the review, registration, and regulation of alternative treatment centers.

Deleted: and other state agencies, as applicable,

(14) Such other matters as are necessary for the fair, impartial, stringent, and comprehensive administration of this chapter.

(b) The department shall adopt rules with the goal of protecting against diversion and theft, without imposing an undue burden on the alternative treatment centers or compromising the confidentiality of qualifying patients and their designated caregivers.

126-W:7 Departmental Administration, Alternative Treatment Centers.

I. Within 30 days of the adoption of rules pursuant to RSA 126-W:6, the department shall begin accepting applications for the operation of alternative treatment centers.

II. Within 18 months of the effective date of this section, provided that at least three applications have been submitted that score sufficiently high to receive a certificate, the department shall issue alternative treatment center registration certificates to the three highest-scoring applicants. Each registration certificate shall include a registry number that is unique to the alternative treatment center.

Deleted: 5

Deleted: 5

III. Any time an alternative treatment center registration certificate is revoked, relinquished, or expires without a renewal application being submitted, the department shall accept applications for a new alternative treatment center and issue registration certificates to the applicant who scores the highest.

IV. If at any time after one year after the effective date of this section, fewer than three alternative treatment centers hold valid registration certificates in New Hampshire, the department shall accept applications for a new alternative treatment center. Except as provided in paragraph V, no more than 5 alternative treatment centers may hold valid

Deleted: 5

1 registration certificates at one time.

2 V.(a) An alternative treatment center applicant must submit a completed department-  
3 approved application form with all required documentation and a non-refundable fee in an  
4 amount set by department rule. The alternative treatment center application and supporting  
5 materials must include, at a minimum:

6 (1) The legal name, articles of incorporation, and bylaws of the alternative  
7 treatment center.

8 (2) The proposed physical address of the alternative treatment center, if a  
9 precise address has been determined, or, if not, the general location where it would be located.

10 This may include a second location for the cultivation of cannabis.

Deleted: medical marijuana

11 (3) A description of the enclosed, locked facility that would be used in the  
12 cultivation of cannabis by the alternative treatment center.

Deleted: marijuana

13 (4) The name, address, and date of birth of each principal officer and board  
14 member of the alternative treatment center and a complete set of fingerprints for each of them.

15 The board of directors for the non-profit must include at least one physician, nurse, or  
16 pharmacist licensed to practice in New Hampshire and at least three patients qualified to  
17 register as qualifying patients.

Deleted: 3

18 (5) Proposed security and safety measures that comply with the rules issued  
19 pursuant to RSA 126-W:6, including a description of interior and exterior lighting and security  
20 systems.

21 (6) The distance from any pre-existing private or public school.

22 (7) A copy of the proposed policy regarding services to qualifying patients who  
23 cannot afford to purchase cannabis for therapeutic use.

Deleted: marijuana

24 (8) Information demonstrating the applicant's knowledge of organic growing  
25 methods to be used in their growing and cultivation of cannabis.

Deleted: medical

Deleted: purposes

26 (9) Steps that will be taken to ensure the quality of the cannabis, including  
27 purity and consistency of dose.

Deleted: marijuana

Deleted: marijuana

28 (10) A start-up timetable that provides an estimated time from registration of  
29 the alternative treatment center to full operation and the assumptions used for the basis of  
30 those estimates.

Deleted: which

Deleted: dispensary

31 (11) Information showing the applicant's experience running a non-profit or  
32 other business.

33 (12) A description of any additional services that will be available to patients.

34 (13) The applicant's plans for record keeping and inventory control.

35 (b) Any time one or more alternative treatment center registration applications are  
36 being considered, the department shall, in partnership with the local governing body of the  
37 town or city where the applicants would be located, solicit input from the qualifying patients,  
38 designated caregivers, and the residents of the towns or cities.

Deleted: where the applicants  
would be located



(c) Each time an alternative treatment center certificate is granted, the decision shall be based on the overall health needs of qualifying patients and the safety of the public. The department shall evaluate applications for alternative treatment center registration certificates using an impartial and numerically scored competitive bidding process developed by the department in accordance with this chapter. The department shall require applicants to meet a minimum score to be considered. The registration considerations shall include the following criteria:

(1) The suitability of the proposed location or locations, including compliance with any local zoning laws and geographic convenience to patients from throughout the state of New Hampshire to alternative treatment centers if the applicant were approved.

(2) The proposed alternative treatment center's plan for operations and services, whether it has sufficient capital to operate, and ability to provide a steady supply of cannabis to the qualifying patients in the state.

Deleted: marijuana

(3) The principal officer and board members' character and relevant experience, including any training or professional licensing related to medicine, pharmaceuticals, natural treatments, botany, or cannabis cultivation and preparation and their experience running a non-profit organization or business.

Deleted: marijuana

(4) The applicant's plan for making cannabis available on an affordable basis to qualifying patients enrolled in Medicaid or receiving Supplemental Security Income or Social Security Disability Insurance.

Deleted: medical marijuana

(5) The applicant's plan for safe and accurate packaging and labeling of cannabis, including the applicant's plan for ensuring that all cannabis is free of contaminants.

Deleted: medical

(6) The sufficiency of the applicant's plans for record keeping and inventory control. Records shall be considered confidential health care information under New Hampshire law and are intended to be deemed protected health care information for purposes of the federal Health Insurance Portability and Accountability Act of 1996, as amended. Any dispensing records that an alternative treatment center is required to keep shall keep track of transactions according to qualifying patients' and designated caregivers' registry identification numbers, rather than their names, to protect their confidentiality.

Deleted: marijuana

Deleted: medical marijuana

(7) The sufficiency of the applicant's plans for safety and security, including proposed location and security devices employed.

(8) Whether the entity possesses or has the right to use sufficient land, buildings, and equipment to properly carry out its duties as an alternative treatment center.

VI. After an alternative treatment center is approved, but before it begins operations, it shall submit the registration and regulation fee paid to the department in accordance with the rules adopted by the department.

VII. Notwithstanding any other provision of law, information required to be submitted to the department on an application for an alternative treatment center identifying the

1 locations where ~~cannabis~~ is proposed to be grown, cultivated, harvested, and otherwise  
2 prepared for distribution to qualifying patients, designated caregivers, and alternative  
3 treatment centers, and any other department records identifying such location, shall be  
4 considered to be confidential information and not subject to disclosure pursuant to RSA 91-A,  
5 except that:

Deleted: marijuana

6 (a) Such information may be disclosed to a law enforcement agency upon request  
7 for purposes of enforcement under this chapter;

8 (b) The location may be disclosed to towns and cities when seeking input on  
9 locations, provided that the towns and cities' representatives keep the information confidential;  
10 and

11 (c) The name, address, and phone number of alternative treatment centers may be  
12 disclosed to qualifying patients.

13 VIII. The alternative treatment center's certificate may be revoked at any time it  
14 commits a violation of these rules, including if it negligently or knowingly allows ~~cannabis~~ to be  
15 distributed to someone who is not exempt from penalties pursuant to this act.

Deleted: serious

Deleted: marijuana

16 IX. ~~Beginning no sooner than one year after an alternative treatment center receives its~~  
17 first registry certificate, each alternative treatment center shall pay a fee in an amount  
18 determined by the department.

Deleted: By April 10 of every  
odd year, b

19 X. ~~Beginning no sooner than one year after an alternative treatment center receives its~~  
20 first registry certificate, the department shall evaluate each alternative treatment center's  
21 operations. A registration certificate may be revoked if the alternative treatment center:

Deleted: By April 10 of every  
odd year, b

22 (a) Committed violations of this act or department rules; or

Deleted: multiple or serious

23 (b) Is not operational.

24 XI. Alternative treatment centers shall be subject to inspection by the department of  
25 health and human services. During an inspection, the department may review the alternative  
26 treatment center's records, including its confidential dispensing records, which shall track  
27 transactions according to qualifying patients' registry identification numbers to protect their  
28 confidentiality.

Deleted: reasonable

29 126-W:8 Alternative Treatment Centers; Requirements.

30 I. An alternative treatment center shall be operated on a not-for-profit basis for the  
31 benefit of its patients. An alternative treatment center need not be recognized as a tax-exempt  
32 organization by the Internal Revenue Service.

33 II. An alternative treatment center may not be located in a residential district or within  
34 1,000 feet of the property line of a pre-existing public or private primary or secondary school.

35 III. An alternative treatment center shall implement appropriate security measures to  
36 deter and prevent the unauthorized entrance into areas containing ~~cannabis~~ and the theft of  
37 ~~cannabis~~, and shall ensure that each location has an operational security alarm system.

Deleted: marijuana

Deleted: marijuana

38 IV.(a) An alternative treatment center shall conduct a ~~state and federal criminal records~~

Deleted: background check  
into the criminal history of

1 | check for every person seeking to become a principal officer, board member, agent, volunteer,  
2 | or employee before the person begins working at the alternative treatment center. An  
3 | alternative treatment center may not allow any person to be an alternative treatment center  
4 | agent who:

5 |       (1) Was convicted of a felony or any drug-related offense; or

6 |       (2) Is under 21 years of age.

7 |       (b) An alternative treatment center shall create an identification badge for each  
8 | alternative treatment center agent before the alternative treatment center agent possesses,  
9 | cultivates, or transports cannabis on behalf of the alternative treatment center. The badges  
10 | may include the alternative treatment center's registration certificate number and either a  
11 | unique number for each agent or his or her name.

Deleted: marijuana

12 |       (c) An alternative treatment center agent must wear his or her badge at all times  
13 | when working at an alternative treatment center, including at any cultivation location.

14 |       V. No person who has been convicted of a drug-related offense shall be an alternative  
15 | treatment center agent. A person who is employed by or is an agent, volunteer, principal  
16 | officer, or board member of an alternative treatment center who violates this paragraph shall  
17 | be guilty of a violation punishable by a fine of up to \$1,000. A subsequent violation of this  
18 | paragraph shall be a misdemeanor.

19 |       VI. The operating documents of an alternative treatment center shall include  
20 | procedures for the oversight of the alternative treatment center and procedures to ensure  
21 | accurate record keeping.

22 |       VII. Each alternative treatment center shall keep the following records, dating back at  
23 | least six months:

Deleted: 6

24 |       (a) Records of the disposal of cannabis that is not distributed by the alternative  
25 | treatment center to qualifying patients who have designated the alternative treatment center to  
26 | cultivate for them.

Deleted: marijuana

27 |       (b) A record of each transaction, including the amount of cannabis dispensed, the  
28 | amount of consideration, and the registry identification number of the qualifying patient,  
29 | designated caregiver, or alternative treatment center.

Deleted: marijuana

30 |       VIII. Each alternative treatment center shall:

31 |       (a) Conduct an initial comprehensive inventory of all cannabis, including usable  
32 | cannabis available for dispensing and mature cannabis plants at each authorized location on  
33 | the date the alternative treatment center first dispenses cannabis.

Deleted: medical marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: medical marijuana

34 |       (b) Conduct a monthly comprehensive inventory of all cannabis, including usable  
35 | cannabis available for dispensing, mature cannabis plants, and seedlings at each authorized  
36 | location.

Deleted: medical marijuana

Deleted: marijuana

Deleted: marijuana

37 |       IX. An alternative treatment center shall submit a department-approved incident report  
38 | form on the next business day after it discovers a reportable incident. The report shall indicate

1 the nature of the breach and the corrective actions taken by the alternative treatment center.

2 For purposes of reporting, an incident includes:

3 (a) Confidential information accessed or disclosed in violation of department rules;

4 (b) Loss of inventory by theft or diversion;

5 (c) Unauthorized intrusion into the alternative treatment center or the one  
6 permitted additional location, if any;

7 (d) Any known violation of this chapter or department rules by an alternative  
8 treatment center agent; and

9 (e) Any other incident that the department by rule requires to be reported.

10 X. Alternative treatment centers cannot use pesticides in cannabis cultivation unless  
11 pesticides become authorized for application on cannabis.

Deleted: marijuana

Deleted: marijuana

12 XI. No cannabis or paraphernalia at an alternative treatment center may be visible  
13 from outside the property of the alternative treatment center.

Deleted: marijuana

14 XII. An alternative treatment center shall submit an annual report to the department  
15 that shall provide information required by the department in order to allow the department to  
16 evaluate the effectiveness and operations of the alternative treatment center.

17 XIII.(a) Each time an alternative treatment center agent dispenses cannabis to a  
18 qualifying patient directly or through the qualifying patient's designated caregiver, he or she  
19 shall consult the alternative treatment center's records to verify that the records do not  
20 indicate that the dispensing of the cannabis would cause the qualifying patient to receive more  
21 cannabis than is permitted in a 10-day period. Each time cannabis is dispensed, the  
22 alternative treatment center agent shall record the date the cannabis was dispensed and the  
23 amount dispensed. All records shall be kept according to the registry identification number of  
24 the qualifying patient and designated caregiver, if any.

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

25 (b) Except as provided in subparagraph (c), a qualifying patient is not allowed to  
26 obtain more than two ounces of usable cannabis directly or through the qualifying patient's  
27 designated caregiver during a 10-day period.

Deleted: marijuana

28 (c) After providing an opportunity for patients, experts, researchers, and physicians  
29 to be heard, the department may issue a rule adjusting the limit specified in subparagraph (a)  
30 to an amount that is reasonably necessary for a 10-day supply.

31 XIV.(a) Except when transporting cannabis in accordance with subparagraphs (b) or  
32 (c), alternative treatment center agents are only allowed to possess and manufacture cannabis  
33 at the alternative treatment center location or locations at which the alternative treatment  
34 center agents are employed. Volunteers are only allowed to possess and manufacture cannabis  
35 at an alternative treatment center location. Volunteers cannot dispense cannabis.

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

36 (b) Distributions of cannabis to a qualifying patient or a designated caregiver for  
37 use by a qualifying patient shall be labeled with a trip ticket to identify the alternative  
38 treatment center, the patient's registry number, or the caregiver's number, the amount and

Deleted: marijuana for  
medical use

form, the time and date of origin, and destination of the product.

(c) An alternative treatment center with a growing location in addition to the location of the alternative treatment center shall label the cannabis that is being moved between the growing location and the alternative treatment center with a trip ticket that identifies the alternative treatment center by registry number, the time, date, origin, and destination of the material being transported, and the amount and form of cannabis and cannabis material that is being transported. Cannabis shall be transported only by an alternative treatment center agent who is not a volunteer.

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

Deleted: Marijuana

XV.(a) An alternative treatment center shall not possess or cultivate cannabis in excess of the greater of the following quantities:

Deleted: marijuana

(1) 80 cannabis plants, 160 seedlings, and 80 ounces of usable cannabis; or

Deleted: marijuana

(2)(A) Six ounces of usable cannabis; and

Deleted: marijuana

Deleted: marijuana

(B) Three, mature cannabis plants, 12 seedlings, and six ounces for each qualifying patient who has designated the alternative treatment center to provide him or her with cannabis for medical use. An alternative treatment center may also possess cannabis seeds, stalks, and unusable roots.

Deleted: Four

Deleted: marijuana

Deleted: 6

Deleted: marijuana

(b) An alternative treatment center may possess cannabis seeds, stalks, and unusable roots.

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

(c) An alternative treatment center or alternative treatment center agent shall not dispense, deliver, or otherwise transfer cannabis to a person other than:

Deleted: marijuana

(1) A qualifying patient who has designated the relevant alternative treatment center; or

(2) Such patient's designated caregiver; or

(3) A visiting qualifying patient who has designated the relevant alternative treatment center.

(d) All cultivation of cannabis shall take place in an enclosed, locked facility registered with the department and which can only be accessed by alternative treatment center agents.

Deleted: marijuana

XVI.(a) All cannabis dispensed by an alternative treatment center shall include a label specifying the weight of the cannabis and any other information the department requires to appear on the label. The label shall also specify that the cannabis is for therapeutic use and that diversion is a class B felony requiring revocation of one's registry identification card.

Deleted: m

Deleted: arijuana

Deleted: marijuana

Deleted: marijuana

Deleted: medical

(b) An alternative treatment center must provide educational materials about cannabis to qualifying patients and their registered primary caregivers. Each alternative treatment center shall have an adequate supply of up-to-date educational material available for distribution. Educational materials shall be available for inspection by the department upon request. The educational material shall at least include information about the following:

Deleted: marijuana

(1) Strains of cannabis, routes of administration, and their different effects.

Deleted: marijuana

1 Alternative treatment centers shall have educational materials available to assist in the  
2 selection of prepared cannabis. Alternative treatment centers shall provide tracking sheets to  
3 qualifying patients and registered primary caregivers who request them to keep track of the  
4 strains used and their effects.

Deleted: marijuana

5 (2) How to achieve proper dosage for different modes of administration.  
6 Emphasis shall be on using the smallest amount possible to achieve the desired effect. The  
7 impact of potency must also be explained.

8 (3) Information on tolerance, dependence, and withdrawal must be provided.

9 (4) Information regarding substance abuse signs and symptoms must be  
10 available, as well as referral information.

11 (5) Information on whether the alternative treatment center's cannabis and  
12 associated products meet organic certification standards.

Deleted: marijuana

13 (6) Information about possible side effects from the use of cannabis for medical  
14 purposes.

Deleted: marijuana

15 XVII.(a) Each alternative treatment center shall develop, implement, and maintain on  
16 the premises employee and agent policies and procedures to address the following  
17 requirements:

18 (1) A job description or employment contract developed for all employees and a  
19 volunteer agreement for all volunteers, which includes duties, authority, responsibilities,  
20 qualifications, and supervision.

21 (2) Training in and adherence to confidentiality laws.

22 (3) The proper use of security measures and controls that have been adopted.

23 (4) Specific procedural instructions on how to respond to an emergency.

24 (b) All alternative treatment centers shall prepare training documentation for each  
25 employee and have employees sign a statement indicating the date, time, and place the  
26 employee received said training and topics discussed, to include name and title of presenters.  
27 The alternative treatment center shall maintain documentation of an employee's and a  
28 volunteer's training for a period of at least six months after termination of an employee's period  
29 of employment or the volunteer's period of voluntary service.

Deleted: 6

30 (c) Each alternative treatment center shall maintain a personnel record for each  
31 alternative treatment center agent that includes an application for employment or to volunteer  
32 and a record of any disciplinary action taken.

33 XVIII. A provider shall not:

34 (a) Accept, solicit, or offer any form of pecuniary remuneration from or to an  
35 alternative treatment center, except if the provider is employed by an alternative treatment  
36 center.

37 (b) Offer a discount or other thing of value to a patient who uses or agrees to use a  
38 particular alternative treatment center.

1 (c) Examine a patient in relation to issuing a written certification at a location  
2 where ~~cannabis~~ is sold or distributed.

Deleted: medical marijuana

3 (d) Hold an economic interest in an alternative treatment center if the provider  
4 issues written certifications to patients.

5 126-W:9 Therapeutic Use of Cannabis Advisory Council.

6 I. There is hereby established a ~~therapeutic use of cannabis~~ advisory council comprised  
7 of:

Deleted: therapeutic cannabis

8 (a) ~~Two members of the House of Representatives appointed by the speaker of the~~  
9 ~~House;~~

Deleted: One

10 (b) One member of the Senate appointed by the Senate president;

11 (c) The commissioner of the department of health and human services, or a  
12 designee;

13 (d) The commissioner of the department of safety, or a designee;

14 (d) ~~One physician with experience in therapeutic use of cannabis issues appointed~~  
15 ~~by the governor;~~

Deleted: therapeutic cannabis

16 (e) One nurse practitioner appointed by the New Hampshire Nurse Practitioner  
17 Association;

Deleted: 1

18 (h) ~~One qualifying patient appointed by the governor;~~

Deleted: . . . (f) One individual with experience in policy development or implementation in the field of therapeutic cannabis appointed by the governor; 1  
... (g) One representative of the New Hampshire Medical Society appointed by the society; 1

19 (i) One member of the public appointed by the governor; and

Deleted: Two

20 II. The advisory council shall:

Deleted: s

21 (a) Assist the department in adopting and revising rules to implement this chapter.

22 (b) Collect information, including regarding:

Deleted: 1

23 (1) Satisfaction of qualifying patients with the ~~therapeutic use of cannabis~~ program;

... (i) One representative of law enforcement appointed by the governor.

24 (2) Any impact the ~~therapeutic use of cannabis~~ law has had on referrals to  
25 regulatory boards.

Deleted: therapeutic cannabis

26 (3) Best practices in other states that allow the ~~therapeutic use of cannabis~~.

Deleted: therapeutic cannabis

27 (4) The ability of qualifying patients in all areas of the State to obtain timely access  
28 to high-quality ~~cannabis~~.

Deleted: use of therapeutic cannabis

29 (5) Any research studies regarding health effects of ~~cannabis~~ for patients.

Deleted: therapeutic

30 (6) The effectiveness of New Hampshire's ~~therapeutic use of cannabis~~ program.

Deleted: therapeutic cannabis

31 (7) Efforts to educate New Hampshire physicians about research relating to the  
32 ~~therapeutic use of cannabis~~.

Deleted: therapeutic cannabis

33 (8) The effectiveness of the registered alternative treatment centers, individually and  
34 together, in serving the needs of qualifying patients, including the provision of educational and  
35 support services, the reasonableness of their fees, whether they are generating any complaints  
36 or security problems, and the sufficiency of the number operating to serve the registered  
37 qualifying patients of New Hampshire.

Deleted: therapeutic cannabis

38 (9) The sufficiency of the regulatory and security safeguards contained in this

chapter and adopted by the department to ensure that access to and use of cannabis cultivated is provided only to cardholders authorized for such purposes.

(10) Any illegal distribution or diversion of cannabis cultivated pursuant to this chapter to individuals who are not alternative treatment center agents, qualifying patients, visiting qualifying patients, or designated caregivers.

(c) Make recommendations to the legislature and the department for any additions or revisions to the department regulations or this chapter, including relating to security, safe handling, and labeling.

III. The advisory council may meet as often as is necessary to effectuate its goals. The first meeting shall be called by the department within 45 days of the effective date of this chapter. At the first meeting, a chairman shall be elected by the members.

IV. On or before January 1 of each year, the advisory council shall provide a report to the department of health and human services and the health and human services oversight committee established under RSA 126-A:13 on its findings.

126-W:10 Annual Report. The commissioner of the department of health and human services shall report annually on the therapeutic use of cannabis program established under this chapter to the health and human services oversight committee established under RSA 126-A:13. The initial report shall be filed with the chairman of the committee no later than December 1, 2014. The commissioner's report shall include the following information:

I. Provider participation in the program.

II. The number of designated caregivers and the number of qualifying patients, by county.

III. Any other issues related to the implementation of the therapeutic use of cannabis permitted under this chapter that the committee shall request.

IV. A summary of the reports submitted by alternative treatment centers as required under RSA 126-W:8, XII.

126-W:11, Registry Identification Card and Certificate Fund. There is hereby established in the office of the state treasurer a fund to be known as the registry identification card and certificate fund which shall be kept separate and distinct from all other funds. The fund is established to pay for the operational expenses of the program for permitting the therapeutic use of cannabis as established in this chapter. The moneys in this fund shall be non-lapsing and continually appropriated to the department. Interest on fund balances shall accrue to the fund. All fines and other income received by the department and all monetary fees, gifts, grants, and donations received by the department pursuant to this chapter shall be deposited in the fund.

2 New Subparagraph; Application of Receipts; Registry Identification Card and Certificate Fund. Amend RSA 6:12, I(b) by inserting after subparagraph (310) the following new subparagraph:

Deleted: D

Deleted: D

Deleted: medical marijuana

Deleted: The ability of qualifying patients and designated caregivers in all areas of the state to obtain timely access to cannabismedical marijuana.¶

... II. The effectiveness of alternative treatment centers individually and together in serving the needs of qualifying patients and designated caregivers, including the provision of educational and support services.¶

... III.

Deleted: medical marijuana

Deleted: V

Deleted: V

Deleted: Sufficiency of the regulatory and security safeguards contained in this chapter to ensure that access to and use of cannabismarijuana cultivated is provided only to alternative treatment centers, qualifying patients, visiting qualifying patients, and designated caregivers.¶

... VI. Any illegal distribution or diversion of cannabismarijuana cultivated pursuant to this chapter to individuals who are not alternative treatment center agents, qualifying patients, visiting qualifying patients, or designated caregivers.¶

... VII.

Deleted: medical

Deleted: marijuana

Deleted: III

Deleted: O

Deleted: marijuana

Deleted: for medicinal purposes



(311) Moneys deposited in the registry identification card and certificate fund established in RSA 126-W:7.

3 New Paragraph; Controlled Drug Act; Acts Prohibited. Amend RSA 318-B:2 by inserting after paragraph I-a the following new paragraph:

I-b. It shall be unlawful for a qualifying patient or designated caregiver as defined under RSA 126-W:1 to sell ~~cannabis to another person who is not a qualifying patient or designated caregiver. A conviction for the sale of cannabis to a person who is not a qualifying patient or designated caregiver shall not preclude or limit a prosecution or conviction of any person for sale of cannabis or any other offense defined in this chapter.~~

Deleted: marijuana

Deleted: marijuana

Deleted: marijuana

4 New Paragraph; Controlled Drug Act; Penalties. Amend RSA 318-B:26 by inserting after paragraph IX the following new paragraph:

IX-a. A qualifying patient or designated caregiver as defined in RSA 126-W:1 who is convicted of selling ~~cannabis to a person who is not a qualifying patient or designated caregiver~~ shall be guilty of a class B felony and shall be sentenced to a maximum term of imprisonment of not more than ~~seven years, a fine of not more than \$300,000, or both.~~

Deleted: marijuana

Deleted: 7

5 Effective Date. This act shall take effect upon its passage.

Amendment to HB 573-FN

1 Amend the bill by replacing all after the enacting clause with the following:

2  
3 1 New Chapter; Use of Marijuana for Medicinal Purposes. Amend RSA by inserting after  
4 chapter 126-V the following new chapter:

5 CHAPTER 126-W

6 USE OF MARIJUANA FOR MEDICINAL PURPOSES

7 126-W:1 Definitions. In this chapter:

8 I. "Alternative treatment center" means a not-for-profit entity registered under RSA 126-  
9 W:7 that acquires, possesses, cultivates, manufactures, delivers, transfers, transports, sells, supplies,  
10 and dispenses marijuana, and related supplies and educational materials, to qualifying patients.

11 II. "Alternative treatment center agent" means a principal officer, board member, employee,  
12 manager, or volunteer of an alternative treatment center who is 21 years of age or older and has not  
13 been convicted of a drug-related offense.

14 III. "Cultivation location" means a locked and enclosed site, under the control of the  
15 qualifying patient or designated caregiver who has reported the location of the site to the  
16 department, where marijuana is cultivated in accordance with the provisions of this chapter. A  
17 cultivation location may be a closet, a room, a greenhouse, a building, or another enclosed area that  
18 is secured with one or more locks or other security devices.

19 IV. "Department" means the department of health and human services.

20 V. "Designated caregiver" means an individual:

21 (a) Who is at least 21 years of age;

22 (b) Who has agreed to assist with a qualifying patient's medical use of marijuana;

23 (c) Who has never been convicted of any drug-related offense; and

24 (d) Who possesses a valid registry identification card issued pursuant to RSA 126-W:4.

25 VI. "Marijuana" means all parts of any plant of the Cannabis genus of plants, whether  
26 growing or not; the seeds thereof; the resin extracted from any part of such plant; and every  
27 compound, salt, derivative, mixture, or preparation of such plant, its seeds, or resin. Such term shall  
28 not include the mature stalks of such plants, fiber produced from such stalks, oil, or cake made from  
29 the seeds of such plants, any other compound, salt, derivative, mixture, or preparation of such  
30 mature stalks (except the resin extracted therefrom), fiber, oil or cake, or the sterilized seeds of such  
31 plants which are incapable of germination.

32 VII. "Medical use" means the acquisition, possession, cultivation, preparation, use, delivery,

*Not adopted*



transfer, or transportation of marijuana or paraphernalia relating to the administration of marijuana to treat or alleviate a qualifying patient's qualifying medical condition or symptoms or results of treatment associated with the qualifying patient's qualifying medical condition. It does not include:

- (a) The use of marijuana by a designated caregiver who is not a qualifying patient; or
- (b) Cultivation by a visiting qualifying patient; or
- (c) Cultivation by a designated caregiver or qualifying patient who is not designated as being allowed to cultivate.

VIII.(a) Except as provided in this chapter, "provider" means a physician licensed to prescribe drugs to humans under RSA 329 and who possesses certification from the United States Drug Enforcement Administration to prescribe controlled substances. "Provider" shall also mean an advanced practice registered nurse licensed pursuant to RSA 326-B:18 and a certified registered nurse anesthetist.

(b) If the qualifying patient's qualifying medical condition is post-traumatic stress disorder, the provider shall also be a licensed psychiatrist.

(c) For a visiting qualifying patient, "provider" means an individual licensed to prescribe drugs to humans in the state of the patient's residence and who possesses certification from the United States Drug Enforcement Administration to prescribe controlled substances.

IX. "Provider-patient relationship" means a relationship between a provider and a patient that includes:

- (a) Taking a medical history;
- (b) Performing a relevant physical examination;
- (c) Reviewing prior treatment and treatment response;
- (d) Obtaining and reviewing relevant diagnostic test results;
- (e) The provider being available for and offering follow-up care and treatment to the patient, including but not limited to patient examinations;
- (f) Creating and maintaining patient records; and
- (g) Notifying the patient's primary care provider when appropriate.

X. "Qualifying medical condition" means the presence of either:

(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, agitation of Alzheimer's disease, multiple sclerosis, or post-traumatic stress disorder; or

(b) A severely debilitating or terminal medical condition or its treatment that produces at least one of the following: wasting syndrome, severe 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, severe nausea, severe vomiting, seizures, or severe, persistent



1 muscle spasms.

2 XI. "Qualifying patient" means an individual who has been diagnosed by a provider as  
3 having a qualifying medical condition and who possesses a valid registry identification card issued  
4 pursuant to RSA 126-W:4.

5 XII. "Registry identification card" means a document issued by the department pursuant to  
6 RSA 126-W:4 that identifies an individual as a qualifying patient or a designated caregiver.

7 XIII. "Seedling" means a marijuana plant that has no flowers and is less than 12 inches in  
8 height and less than 12 inches in diameter.

9 XIV. "Unusable marijuana" means any marijuana, other than usable marijuana, including  
10 the seeds, stalks, and roots of the plant.

11 XV. "Usable marijuana" means the dried leaves and flowers of the marijuana plant and any  
12 mixture or preparation thereof, but does not include the seeds, stalks, and roots of the plant and does  
13 not include the weight of any non-marijuana ingredients combined with marijuana and prepared for  
14 consumption as food or drink.

15 XVI. "Visiting qualifying patient" means a patient with a qualifying medical condition who  
16 is not a resident of New Hampshire or who has been a resident of New Hampshire for fewer than 30  
17 days.

18 XVII. "Written certification" means a document signed by a provider stating that in the  
19 provider's professional opinion, after having completed a full assessment of the patient's medical  
20 history and current medical condition made in the course of a provider-patient relationship of at  
21 least 3 months in duration, the patient has a qualifying medical condition, and the potential benefits  
22 of the medical use of marijuana would likely outweigh the health risks for the qualifying patient. If  
23 the patient's qualifying medical condition is of recent or sudden onset and the certifying provider is  
24 primarily responsible for the patient's care related to his or her qualifying medical condition, the 3-  
25 month requirement for the provider-patient relationship required in this paragraph shall not apply.  
26 The date of issuance and the patient's qualifying medical condition shall be specified on the written  
27 certification.

28 126-W:2 Medical Marijuana Protections.

29 I. A qualifying patient shall not be subject to arrest by state or local law enforcement,  
30 prosecution or penalty under state or municipal law, or be denied any right or privilege for the  
31 medical use of marijuana in accordance with this chapter, if the qualifying patient possesses,  
32 cultivates, or possesses and cultivates, an amount of marijuana that does not exceed the following:

33 (a) If the qualifying patient does not have a designated caregiver, for the possession and  
34 cultivation of marijuana that occurs at the cultivation location reported to the department, or while  
35 transporting marijuana and marijuana plants and seedlings to a new cultivation location that has  
36 been reported to the department within the prior 21 days:

37 (1) Six ounces of usable marijuana;



(2) Any amount of unusable marijuana; and  
(3) Four mature marijuana plants and 12 seedlings, with a total canopy of no more than 100 square feet.

(b) If the qualifying patient is not at a cultivation location reported to the department:

(1) Two ounces of usable marijuana; and

(2) Any amount of unusable marijuana.

II. A designated caregiver shall not be subject to arrest by state or local law enforcement, prosecution or penalty under state or municipal law, or denied any right or privilege for the medical use of marijuana in accordance with this chapter on behalf of a qualifying patient if the designated caregiver possesses or cultivates, or both, an amount of marijuana that does not exceed the following:

(a) If at the cultivation location reported to the department, or while transporting marijuana and marijuana plants and seedlings to a new cultivation location that has been reported to the department within the prior 21 days:

(1) Six ounces of usable marijuana; and

(2) Any amount of unusable marijuana; and

(3) Four mature marijuana plants and 12 seedlings, with a total canopy of no more than 100 square feet.

(b) If not at a cultivation location reported to the department:

(1) Two ounces of usable marijuana; and

(2) Any amount of unusable marijuana.

III. A qualifying patient or designated caregiver shall not be subject to arrest by state or local law enforcement or prosecution or penalty under state or municipal law for giving marijuana to a qualifying patient or a visiting qualifying patient where nothing of value is transferred in return, or for offering to do the same, if the person giving the marijuana does not knowingly cause the recipient to possess more marijuana than is permitted by this section.

IV. Notwithstanding paragraph III, a designated caregiver may receive compensation for costs, not including labor, associated with assisting a qualifying patient who has designated the designated caregiver to assist him or her with the medical use of marijuana. Such compensation shall not constitute the sale of controlled substances.

V.(a) A qualifying patient is presumed to be lawfully engaged in the medical use of marijuana in accordance with this chapter if the qualifying patient possesses a valid registry identification card and possesses an amount of marijuana that does not exceed the amount allowed under this chapter.

(b) A designated caregiver is presumed to be lawfully engaged in assisting with the medical use of marijuana in accordance with this chapter if the designated caregiver possesses a valid registry identification card and possesses an amount of marijuana that does not exceed the amount allowed under this chapter.



(c) The presumptions made in subparagraphs (a) and (b) may be rebutted by evidence that conduct related to marijuana was not for the purpose of treating or alleviating the qualifying patient's qualifying medical condition or symptoms or effects of the treatment associated with the qualifying medical condition, in accordance with this chapter.

VI. A valid registry identification card, or its equivalent, that is issued under the laws of another state, district, territory, commonwealth, or insular possession of the United States that allows, in the jurisdiction of issuance, a visiting qualifying patient to possess marijuana for medical purposes, shall have the same force and effect as a valid registry identification card issued by the department in this state, provided that:

(a) The visiting qualifying patient shall also produce a statement from his or her provider stating that the visiting qualifying patient has a qualifying medical condition as defined in RSA 126-W:1, X; and

(b) A visiting qualifying patient shall not cultivate marijuana in New Hampshire.

VII. A person otherwise entitled to custody of, or visitation or parenting time with, a minor shall not be denied such a right solely for conduct allowed under this chapter, and there shall be no presumption of neglect or child endangerment.

VIII. For the purposes of medical care, including organ transplants, a qualifying patient's authorized use of marijuana in accordance with this chapter shall be considered the equivalent of the authorized use of any other medication used at the direction of a provider, and shall not constitute the use of an illicit substance.

IX. A provider shall not be subject to arrest by state or local law enforcement, prosecution or penalty under state or municipal law, or be denied any right or privilege, including but not limited to a civil penalty or disciplinary action by the New Hampshire board of medicine or any other occupational or professional licensing entity, solely for providing written certifications or for otherwise stating that, in the provider's professional opinion, and in the context of a provider-patient relationship, a patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana, provided that nothing shall prevent a professional licensing entity from sanctioning a provider for failing to properly evaluate a patient's medical condition.

X. An alternative treatment center shall not be subject to prosecution under state or municipal law; search or inspection, except by the department pursuant to RSA 126-W:7, XI; seizure; or penalty in any manner under state or municipal law for acting pursuant to this chapter and department rules to:

(a) Acquire or purchase marijuana seeds, seedlings, plants, or marijuana from other alternative treatment centers;

(b) Accept marijuana seeds from individuals and entities from jurisdictions outside of New Hampshire that are authorized to cultivate medical marijuana in their home state;

(c) Accept marijuana seeds from qualifying patients or designated caregivers;



(d) Sell or donate marijuana seeds to similar entities that are registered to dispense marijuana for medical use in other jurisdictions;

(e) Possess, cultivate, manufacture, or transport marijuana and seedlings; and/or

(f) Deliver, transfer, supply, sell, or dispense marijuana and related supplies and educational materials to qualifying patients and visiting qualifying patients who have designated the alternative treatment center to provide for them, to designated caregivers on behalf of the qualifying patients who have designated the alternative treatment center, and/or to other alternative treatment centers.

XI. An alternative treatment center agent shall not be subject to arrest by state or local law enforcement, prosecution or penalty in any manner under state or municipal law, search, or be denied any right or privilege for working for an alternative treatment center pursuant to this chapter and department rules to engage in any of the actions listed in paragraph X.

XII. Visiting qualifying patients, qualifying patients, designated caregivers, and entities that are authorized to cultivate medical marijuana in their home state shall not be subject to arrest by state or local law enforcement, prosecution or penalty under state or municipal law, or be denied any right or privilege for donating marijuana seeds to alternative treatment centers in New Hampshire.

XIII. Any marijuana, marijuana paraphernalia, licit property, or interest in licit property that is possessed, owned, or used in connection with the medical use of marijuana as allowed under this chapter, or acts incidental to such use, shall not be seized or forfeited if the basis for the seizure or forfeiture is activity related to marijuana that is exempt from state criminal penalties under this chapter.

XIV. An individual shall not be subject to arrest by state or local law enforcement, prosecution or penalty under state or municipal law, or be denied any right or privilege, including but not limited to a civil penalty or disciplinary action by a court or occupational or professional licensing entity, simply for being in the presence or vicinity of the medical use of marijuana as allowed under this chapter.

XV. If a state or local law enforcement agency or agent encounters an alternative treatment center or an individual who the agent or agency knows is an alternative treatment center agent, a designated caregiver, or a qualifying patient, or who credibly asserts he or she is an alternative treatment center agent, a designated caregiver, or a qualifying patient, the law enforcement agency or agent shall not provide any information from any marijuana-related investigation of the individual or entity to any law enforcement agency that does not recognize the protection of this chapter, and any prosecution of the individual or entity for a violation of this chapter shall be conducted pursuant to the laws of this state. This paragraph shall not apply in cases where the state or local law enforcement agency has probable cause to believe the person is distributing marijuana to a person who is not allowed to possess it under this chapter.



Amendment to HB 573-FN

- Page 7 -

XVI. A person who ceases to be a qualifying patient or designated caregiver shall have 10 days after notification by the department to dispose of marijuana in one of the following ways:

(a) If the person was a designated caregiver and the qualifying patient who designated the caregiver is still a qualifying patient, but has designated a new caregiver or will cultivate plants himself or herself, the designated caregiver may transfer marijuana to the new person who will cultivate for the qualifying patient;

(b) The person may notify local law enforcement and request that they dispose of the marijuana;

(c) The person may dispose of marijuana, after mixing marijuana with other ingredients such as soil to render it unusable; or

(d) The person may donate usable marijuana to a qualifying patient.

126-W:3 Prohibitions and Limitations on the Use of Medical Marijuana.

I. A qualifying patient may use medical marijuana on privately owned real property only with the permission of the property owner or in the case of leased property with the permission of the tenant in possession of the property, except that a tenant shall not allow a qualifying patient to smoke medical marijuana on rented property if smoking on the property violates the lease or the lessor's rental policies that apply to all tenants at the property. However, a tenant may permit a qualifying patient to use medical marijuana on leased property by ingestion or inhalation through vaporization even if smoking is prohibited by the lease or rental policies. For purposes of this chapter, vaporization shall mean the inhalation of marijuana without the combustion of the marijuana.

II. Nothing in this chapter shall exempt any person from arrest or prosecution for:

(a) Being under the influence of marijuana while:

(1) Operating a motor vehicle, commercial vehicle, boat, or vessel, or any other vehicle propelled or drawn by power other than muscular power; or

(2) In his or her place of employment, without the written permission of the employer; or

(3) Operating heavy machinery or handling a dangerous instrumentality.

(b) The use or possession of marijuana by a qualifying patient or designated caregiver for purposes other than for medical use as permitted by this chapter;

(c) The smoking of marijuana in any public place, including:

(1) A school bus, public bus, or other public vehicle; or

(2) A place of employment, without the written permission of the employer; or

(3) The grounds of any preschool, elementary, or secondary school; or

(4) Any correctional facility; or

(5) Any public park, public beach, public recreation center, public field, or youth center; or





1 (6) Any law enforcement facility.

2 III. Nothing in this chapter shall be construed to require:

3 (a) Any health insurance provider, health care plan, or medical assistance program to be  
4 liable for any claim for reimbursement for the medical use of marijuana; or

5 (b) Any individual or entity in lawful possession of property to allow a guest, client,  
6 customer, or other visitor to use marijuana on or in that property; or

7 (c) Any accommodation of the medical use of marijuana on the property or premises of  
8 any place of employment or on the property or premises of any jail, correctional facility, or other type  
9 of penal institution where prisoners reside or persons under arrest are detained. This chapter shall  
10 in no way limit an employer's ability to discipline an employee for ingesting marijuana in the  
11 workplace or for working while under the influence of marijuana.

12 IV. Fraudulent representation to a law enforcement official of any fact or circumstance  
13 relating to the medical use of marijuana to avoid arrest or prosecution shall be punishable by a fine  
14 of \$500, which shall be in addition to any other penalties that may apply for making a false  
15 statement or for the use of marijuana other than use undertaken pursuant to this chapter.

16 V. A qualifying patient or designated caregiver who is found to be in possession of marijuana  
17 outside of his or her home and is not in possession of his or her registry identification card may be  
18 subject to a \$100 fine.

19 VI. Any qualifying patient or designated caregiver who sells marijuana to another person  
20 who is not a qualifying patient or designated caregiver under this chapter shall be subject to the  
21 penalties specified in RSA 318-B:26, IX-a, shall have his or her registry identification card revoked,  
22 and shall be subject to other penalties as provided in RSA 318-B:26.

23 VII. The department may revoke the registry identification card of a qualifying patient or  
24 designated caregiver who violates any other provision of this chapter, and the qualifying patient or  
25 designated caregiver shall be subject to any other penalties established in law for the violation.

26 126-W:4 Departmental Administration, Registry Identification Cards.

27 I. Except as provided in paragraph V, the department shall issue a registry identification  
28 card to a person applying as a qualifying patient who submits all of the following information:

29 (a) Written certification as defined in RSA 126-W:1.

30 (b) An application or a renewal application accompanied by the application or renewal  
31 fee.

32 (c) Name, residential and mailing address, and date of birth of the applicant, except that  
33 if the applicant is homeless, no residential address is required.

34 (d) Name, address, and telephone number of the applicant's provider.

35 (e) Name, address, and date of birth of the applicant's designated caregiver, if any. A  
36 qualifying patient shall have only one designated caregiver.

37 (f) Name of the alternative treatment center that the qualifying patient designates. A



Amendment to HB 573-FN

- Page 9 -

1 qualifying patient may designate no more than one alternative treatment center at any time.

2 (g) Street address of the cultivation location, if any, if the qualifying patient does not  
3 have a designated caregiver.

4 (h) A statement signed by the applicant, pledging not to divert marijuana to anyone who  
5 is not allowed to possess marijuana pursuant to this chapter and acknowledging that his or her  
6 diversion of marijuana is punishable as a class B felony and revocation of his or her registry  
7 identification card, in addition to other penalties for the illegal sale of marijuana.

8 II.(a) Except as provided in paragraph V, the department shall issue a registry identification  
9 card to a person applying as a designated caregiver who submits all of the following information:

10 (1) An application or a renewal application accompanied by a medicinal use  
11 certificate.

12 (2) Name, residential and mailing address, and date of birth of the applicant.

13 (3) Name, residential and mailing address, and date of birth of the qualifying patient  
14 for whom the applicant will act as designated caregiver, except that if the qualifying patient is  
15 homeless, no residential address is required. A designated caregiver shall act on behalf of only one  
16 qualifying patient.

17 (4) A complete set of fingerprints.

18 (5) Street address of the cultivation location, except that the designated caregiver  
19 may not include a cultivation location if the designated caregiver's qualifying patient has designated  
20 an alternative treatment center.

21 (6) A statement indicating the applicant's preference as to whether the applicant  
22 requests the department to retain his or her fingerprints on file for any renewal application or  
23 whether the applicant requests the department to destroy his or her fingerprints and acknowledges  
24 that the applicant shall resubmit fingerprints if the applicant applies for renewal as a designated  
25 caregiver.

26 (7) A signed statement from the applicant agreeing to act as the designated  
27 caregiver for the qualifying patient named in the application and pledging not to divert marijuana to  
28 anyone who is not allowed to possess marijuana pursuant to this chapter and acknowledging that  
29 the diversion of marijuana is punishable as a class B felony and revocation of one's registry  
30 identification card, in addition to other penalties for the illegal sale of marijuana.

31 (b) A person who is applying to be a designated caregiver shall submit to a state and  
32 federal criminal records check. The department shall request the department of safety to perform  
33 the state and federal criminal records check and the department of safety shall complete such  
34 records checks and convey the findings of such checks to the department within 30 days of the  
35 request. The department and the department of safety may exchange necessary data including  
36 fingerprint data with the Federal Bureau of Investigation without disclosing that the records check  
37 is related to the provisions of this chapter and acts permitted by it. Unless the applicant stated that



1 he or she prefers his or her fingerprints to be kept on file for any renewal, the department and the  
2 department of safety shall destroy each set of fingerprints obtained pursuant to this chapter after  
3 the criminal records check is complete.

4 III. The department shall verify the information contained in an application or renewal  
5 submitted pursuant to this section. The department shall approve or deny an application or renewal  
6 for a qualifying patient within 15 days of receipt of the application. The department shall approve or  
7 deny an application or renewal to serve as a designated caregiver within 45 days of receipt of the  
8 application. The department may deny an application or renewal only if the applicant did not  
9 provide the information required pursuant to this section, or if the applicant previously had a  
10 registry identification card revoked for violating the provisions of this chapter, or if the department  
11 determines that the information provided was falsified. The department shall notify an applicant of  
12 the denial of an application. An applicant who is aggrieved by a department decision may request an  
13 administrative hearing at the department.

14 IV. The department shall issue registry identification cards to persons applying as a  
15 qualifying patient or designated caregiver within 5 days of approving an application or renewal.  
16 Each registry identification card shall expire one year after the date of issuance, unless the provider  
17 states in the written certification that he or she believes the qualifying patient would benefit from  
18 medical marijuana only until a specified earlier date, then the registry identification card shall  
19 expire on that date. Registry identification cards shall contain all of the following:

20 (a) Name, mailing address, and date of birth of the qualifying patient or designated  
21 caregiver.

22 (b) The date of issuance and expiration date of the registry identification card.

23 (c) A random 10-digit identification number, containing at least 4 numbers and at least 4  
24 letters, that is unique to the qualifying patient or the designated caregiver.

25 (d) A designation that the person is either a "qualifying patient" or a "designated  
26 caregiver." If the person is a designated caregiver, the identification card shall include the random  
27 10-digit identification number of the qualifying patient for whom he or she is providing care.

28 (e) The registry identification number corresponding with the alternative treatment  
29 center the qualifying patient designated, if any.

30 (f) A photograph of the qualifying patient or designated caregiver.

31 (g) A statement that the qualifying patient or designated caregiver is permitted under  
32 state law to possess marijuana pursuant to this chapter for the medical use of the qualifying patient.

33 (h) A statement noting whether or not the cardholder is exempt from state penalties for  
34 cultivating marijuana. The statement shall be determined as follows:

35 (1) A qualifying patient is exempt from state penalties for cultivating marijuana in  
36 accordance with this chapter if he or she does not have a designated caregiver. If a qualifying  
37 patient has selected a designated caregiver, he or she is not exempt from state penalties for



Amendment to HB 573-FN

- Page 11 -

1 cultivating marijuana.

2 (2) A designated caregiver is exempt from state penalties for cultivating marijuana  
3 in accordance with this chapter if the designated caregiver's qualifying patient has not also  
4 designated an alternative treatment center. If the designated caregiver's qualifying patient has also  
5 designated an alternative treatment center, the designated caregiver is not exempt from state  
6 penalties for cultivating marijuana.

7 V. The department shall not issue a registry identification card to an applicant under 18  
8 years of age who is applying as a qualifying patient unless:

9 (a) The applicant's provider has explained the potential risks and benefits of the medical  
10 use of marijuana to the custodial parent or legal guardian with responsibility for health care  
11 decisions for the applicant; and

12 (b) The custodial parent or legal guardian with responsibility for health care decisions  
13 for the applicant consents in writing to:

14 (1) Allow the applicant's medical use of marijuana; and

15 (2) Control the acquisition of the marijuana and the frequency of the medical use of  
16 marijuana by the applicant; and

17 (3) The custodial parent or legal guardian completes an application in accordance  
18 with the requirements of paragraph I on behalf of the applicant.

19 VI. The department shall provide each approved qualifying patient and caregiver a  
20 statement with the registry identification card explaining federal law on the possession of marijuana  
21 and that possession of a state registry identification card does not protect a person from federal  
22 criminal penalties.

23 VII. The department shall track the number of qualifying patients who have designated  
24 each alternative treatment center and issue a monthly written statement to the alternative  
25 treatment center identifying the number of qualifying patients who have designated that alternative  
26 treatment center along with the registry identification numbers of each patient and each patient's  
27 designated caregiver.

28 VIII. In addition to the monthly reports, the department shall also provide written notice to  
29 an alternative treatment center which identifies the names and registration identification numbers  
30 of a qualifying patient and his or her designated caregiver whenever any of the following events  
31 occur:

32 (a) A qualifying patient designates the alternative treatment center to serve his or her  
33 needs under this chapter; or

34 (b) An existing qualifying patient revokes the designation of the alternative treatment  
35 center; or

36 (c) A qualifying patient who has designated the alternative treatment center loses his or  
37 her status as a qualifying patient under this chapter.



IX.(a) A qualifying patient shall notify the department before changing his or her designated caregiver or alternative treatment center.

(b) A qualifying patient and designated caregiver shall notify the department before changing his or her cultivation location.

(c) A qualifying patient shall notify the department of any change in his or her name or address within 10 days of such change. If the qualifying patient's certifying provider notifies the department in writing that either the qualifying patient no longer suffers from a qualifying medical condition or that the provider no longer believes the qualifying patient would receive benefit from the medical use of marijuana, the registry identification card shall become void upon notification by the department to the qualifying patient.

(d) When a qualifying patient or a designated caregiver notifies the department of any change to a name, address, or alternative treatment center, the department shall issue the qualifying patient or designated caregiver a new registry identification card with a new random 10-digit identification number within 15 days of receiving the updated information.

(e) If a qualifying patient notifies the department of a change in his or her designated caregiver and the prospective designated caregiver meets the requirements of this chapter, the department shall issue the designated caregiver a registry identification card with a new random 10-digit identification number within 45 days of receiving the designated caregiver's application.

(f) A qualifying patient or designated caregiver who fails to notify the department of any changes to his or her name, address, designated caregiver, or cultivation location shall be guilty of a violation and may be subject to a fine not to exceed \$150.

(g) If a qualifying patient or designated caregiver loses his or her registry identification card, he or she shall notify the department within 10 days of losing the card. Within 5 days after such notification, the department shall issue a new registry identification card with a new random 10-digit identification number.

X. Mere possession of, or application for, a registry identification card shall not constitute probable cause or reasonable suspicion, nor shall it be used to support the search of the individual or property of the individual possessing or applying for the registry identification card. The possession of, or application for, a registry identification card shall not preclude the existence of probable cause if probable cause exists on other grounds.

XI.(a) The department shall create and maintain a confidential registry of each individual who has applied for and received a registry identification card as a qualifying patient or a designated caregiver in accordance with the provisions of this chapter. Each entry in the registry shall contain the qualifying patient's or designated caregiver's name, mailing address, date of birth, date of registry identification card issuance, date of registry identification card expiration, random 10-digit identification number, street address at which the marijuana plants will be cultivated or possessed, effective date of any change of cultivation location, and registry identification number of the



qualifying patient's designated alternative treatment center, if any. The confidential registry and the information contained in it shall be exempt from disclosure under RSA 91-A.

(b)(1) Except as specifically provided in this chapter, no person shall have access to any information about qualifying patients or designated caregivers in the department's confidential registry, or any information otherwise maintained by the department about providers and alternative treatment centers, except for authorized employees of the department in the course of their official duties and local and state law enforcement personnel who have detained or arrested an individual who claims to be engaged in the medical use of marijuana.

(2) If a local or state law enforcement officer submits a sworn affidavit to the department affirming that he or she has probable cause to believe marijuana is possessed or cultivated at a specific address, an authorized employee for the department may disclose whether the location is associated with a qualifying patient, designated caregiver, cultivation location, or alternative treatment center location.

(3) If a local or state law enforcement officer submits a sworn affidavit to the department affirming that he or she has probable cause to believe a specific individual possesses or cultivates marijuana, an authorized employee for the department may disclose whether the person is a qualifying patient or a designated caregiver, provided that the law enforcement officer provides the person's name and address or name and date of birth.

(4) Counsel for the department may notify law enforcement officials about falsified or fraudulent information submitted to the department where counsel has made a legal determination that there is probable cause to believe the information is false or falsified.

XII. Within 5 days of learning of the death of a qualifying patient, a surviving family member, caretaker, executor, or the patient's designated caregiver shall notify the department that the qualifying patient has died. Within 5 days of learning of the death of a qualifying patient, the surviving family member, caretaker, executor, or the patient's designated caregiver shall either request that the local law enforcement agency remove any remaining marijuana or shall dispose of the marijuana in a manner that is specified by the department by rule.

#### 126-W:5 Affirmative Defense.

I. Except as provided in RSA 126-W:3, it shall be an affirmative defense to any prosecution for an offense involving marijuana or marijuana paraphernalia intended for medical use if:

(a) The defendant is a qualifying patient in possession of a valid registry identification card and at the time of arrest or prosecution was in possession of a quantity of marijuana that was not more than allowed under this chapter, and the qualifying patient was engaged in the medical use of marijuana in accordance with the provisions of this chapter; or

(b)(1) The defendant is a designated caregiver in possession of a valid registry identification card and at the time of arrest or prosecution was in possession of a quantity of marijuana that was not more than allowed under this chapter; and



(2) The designated caregiver was engaged in the medical use of marijuana on behalf of a qualifying patient in accordance with the provisions of this chapter.

(c) If a defendant proves the elements of the affirmative defense listed in subparagraph (I)(a) or (b), the charges shall be dismissed with prejudice.

II. A person who is arrested or cited for possession, cultivation, or transportation of marijuana, or possession of marijuana paraphernalia, may raise as an affirmative defense that he or she is person with a qualifying medical condition who is not yet in possession of a valid registry identification card if:

(a) Prior to the arrest, the person submitted to the department a valid application to become a qualifying patient, complete with a written certification, but the person had not yet received a registry identification card from the department; and

(1) The person does not possess more than 2 ounces of usable marijuana and any amount of unusable marijuana, if the marijuana is not on the person's property; or

(2) If the marijuana is on the person's property, the person does not possess more than 6 ounces of usable marijuana and any amount of unusable marijuana and does not possess or is not cultivating more than 4 mature marijuana plants and 12 seedlings, which shall be in a locked and enclosed location on the person's property.

(b) The affirmative defense under this section shall not be available to a person who has violated any of the provisions of RSA 126-W:3, I-IV.

(c) If a defendant proves the elements of the affirmative defense listed in this paragraph, the defendant shall be acquitted of any charge to which the defendant proved the affirmative defense.

III. A person who is arrested or cited for possession, cultivation, or transportation of marijuana, or possession of marijuana paraphernalia, prior to the date on which the department begins accepting registry identification card applications may raise as an affirmative defense that he or she is a person with a qualifying medical condition who is not yet in possession of a valid registry identification card if:

(a) The person produces a written statement signed by a provider stating that in the provider's professional opinion, after having completed a full assessment of the person's medical history and current medical condition made in the course of a provider-patient relationship of at least 3 months duration, unless the person's qualifying medical condition is of recent or sudden onset in which case the 3-month time requirement shall not apply, the person has a qualifying medical condition and the potential benefits of the medical use of marijuana would likely outweigh the health risks for the person; and

(1) The person does not possess more than 2 ounces of usable marijuana and any amount of unusable marijuana, if the marijuana is not on the person's property; and

(2) If the marijuana is on the person's property, the person does not possess more



Amendment to HB 573-FN

- Page 15 -

1 than 6 ounces of usable marijuana and any amount of unusable marijuana and does not possess or is  
2 not cultivating more than 4 mature marijuana plants and 12 seedlings which shall be in a locked and  
3 enclosed location.

4 (b) The affirmative defense under this section shall not be available to a person who has  
5 violated any of the provisions of RSA 126-W:3, I-IV.

6 (c) If a defendant proves the elements of the affirmative defense listed in this paragraph,  
7 the defendant shall be acquitted of any charge to which the defendant proved the affirmative  
8 defense.

9 126-W:6 Departmental Rules.

10 I. Not later than 90 days after the effective date of this chapter, the department shall adopt  
11 rules, pursuant to RSA 541-A, governing the manner in which it shall consider applications for  
12 issuance and renewals of registry identification cards for qualifying patients and designated  
13 caregivers.

14 II. The department's rules shall establish application and renewal fees for registry  
15 identification cards in accordance with the following:

16 (a) The fee structure by the department for alternative treatment centers and registry  
17 identification cards shall generate revenues sufficient to offset all state expenses of implementing  
18 and administering this chapter; however,

19 (b) The department may accept donations from private sources without the approval of  
20 the governor and council in order to reduce the application and renewal fees.

21 III.(a) Not later than one year after the effective date of this section, the department shall  
22 adopt rules, pursuant to RSA 541-A, governing alternative treatment centers and the manner in  
23 which it shall consider applications for registration certificates for alternative treatment centers,  
24 including, but not necessarily limited to, rules governing:

25 (1) The form and content of registration and renewal applications.

26 (2) Oversight requirements.

27 (3) Security requirements, which shall include at a minimum, lighting, physical  
28 security, video security, alarm requirements, measures to prevent loitering, and on-site parking.

29 (4) Sanitary requirements.

30 (5) Electrical safety requirements.

31 (6) The specification of acceptable forms of picture identification that an alternative  
32 treatment center may accept when verifying a sale.

33 (7) Personnel requirements including how many volunteers an alternative treatment  
34 center is permitted to have and requirements for supervision.

35 (8) Labeling standards.

36 (9) Procedures for suspending or terminating the registration of alternative  
37 treatment centers that violate the provisions of this section or the rules adopted pursuant to this





1 section, procedures for appealing penalties, and a schedule of penalties.

2 (10) Procedures for inspections and investigations.

3 (11) Advertising restrictions, including a prohibition of misrepresentation and unfair  
4 practices.

5 (12) Permissible hours of operation.

6 (13) The fees for the processing and review of applications for registration as an  
7 alternative treatment center and regulation of an alternative treatment center after it has been  
8 approved by the department. Such fees shall be established in an amount that covers all costs of the  
9 department and other state agencies, as applicable, for the review, registration, and regulation of  
10 alternative treatment centers.

11 (14) Such other matters as are necessary for the fair, impartial, stringent, and  
12 comprehensive administration of this chapter.

13 (b) The department shall adopt rules with the goal of protecting against diversion and  
14 theft, without imposing an undue burden on the alternative treatment centers or compromising the  
15 confidentiality of qualifying patients and their designated caregivers.

16 126-W:7 Departmental Administration, Alternative Treatment Centers.

17 I. Within 30 days of the adoption of rules pursuant to RSA 126-W:6, the department shall  
18 begin accepting applications for the operation of alternative treatment centers.

19 II. Within 18 months of the effective date of this section, provided that at least 5  
20 applications have been submitted that score sufficiently high to receive a certificate, the department  
21 shall issue alternative treatment center registration certificates to the 5 highest-scoring applicants.  
22 Each registration certificate shall include a registry number that is unique to the alternative  
23 treatment center.

24 III. Any time an alternative treatment center registration certificate is revoked,  
25 relinquished, or expires, the department shall accept applications for a new alternative treatment  
26 center and issue registration certificates to the applicant who scores the highest.

27 IV. If at any time after one year after the effective date of this section, fewer than 5  
28 alternative treatment centers hold valid registration certificates in New Hampshire, the department  
29 shall accept applications for a new alternative treatment center. Except as provided in paragraph V,  
30 no more than 5 alternative treatment centers may hold valid registration certificates at one time.

31 V.(a) An alternative treatment center applicant must submit a completed department-  
32 approved application form with all required documentation and a non-refundable fee in an amount  
33 set by department rule. The alternative treatment center application and supporting materials must  
34 include, at a minimum:

35 (1) The legal name, articles of incorporation, and bylaws of the alternative treatment  
36 center.

37 (2) The proposed physical address of the alternative treatment center, if a precise



1 address has been determined, or, if not, the general location where it would be located. This may  
2 include a second location for the cultivation of medical marijuana.

3 (3) A description of the enclosed, locked facility that would be used in the cultivation  
4 of marijuana by the alternative treatment center.

5 (4) The name, address, and date of birth of each principal officer and board member  
6 of the alternative treatment center and a complete set of fingerprints for each of them. The board of  
7 directors for the non-profit must include at least one physician, nurse, or pharmacist licensed to  
8 practice in New Hampshire and at least 3 patients qualified to register as qualifying patients.

9 (5) Proposed security and safety measures that comply with the rules issued  
10 pursuant to RSA 126-W:6, including a description of interior and exterior lighting and security  
11 systems.

12 (6) The distance from any pre-existing private or public school.

13 (7) A copy of the proposed policy regarding services to qualifying patients who cannot  
14 afford to purchase marijuana for medical purposes.

15 (8) Information demonstrating the applicant's knowledge of organic growing  
16 methods to be used in their growing and cultivation of marijuana.

17 (9) Steps that will be taken to ensure the quality of the marijuana, including purity  
18 and consistency of dose.

19 (10) A start-up timetable which provides an estimated time from registration of the  
20 dispensary to full operation and the assumptions used for the basis of those estimates.

21 (11) Information showing the applicant's experience running a non-profit or other  
22 business.

23 (12) A description of any additional services that will be available to patients.

24 (13) The applicant's plans for record keeping and inventory control.

25 (b) Any time one or more alternative treatment center registration applications are  
26 being considered, the department shall solicit input from qualifying patients, designated caregivers,  
27 and the towns or cities where the applicants would be located.

28 (c) Each time an alternative treatment center certificate is granted, the decision shall be  
29 based on the overall health needs of qualifying patients and the safety of the public. The department  
30 shall evaluate applications for alternative treatment center registration certificates using an  
31 impartial and numerically scored competitive bidding process developed by the department in  
32 accordance with this chapter. The department shall require applicants to meet a minimum score to  
33 be considered. The registration considerations shall include the following criteria:

34 (1) The suitability of the proposed location or locations, including compliance with  
35 any local zoning laws and geographic convenience to patients from throughout the state of  
36 New Hampshire to alternative treatment centers if the applicant were approved.

37 (2) The proposed alternative treatment center's plan for operations and services,



1 whether it has sufficient capital to operate, and ability to provide a steady supply of marijuana to the  
2 qualifying patients in the state.

3 (3) The principal officer and board members' character and relevant experience,  
4 including any training or professional licensing related to medicine, pharmaceuticals, natural  
5 treatments, botany, or marijuana cultivation and preparation and their experience running a non-  
6 profit organization or business.

7 (4) The applicant's plan for making medical marijuana available on an affordable  
8 basis to qualifying patients enrolled in Medicaid or receiving Supplemental Security Income or Social  
9 Security Disability Insurance.

10 (5) The applicant's plan for safe and accurate packaging and labeling of medical  
11 marijuana, including the applicant's plan for ensuring that all medical marijuana is free of  
12 contaminants.

13 (6) The sufficiency of the applicant's plans for record keeping and inventory control.  
14 Records shall be considered confidential health care information under New Hampshire law and are  
15 intended to be deemed protected health care information for purposes of the federal Health  
16 Insurance Portability and Accountability Act of 1996, as amended. Any dispensing records that an  
17 alternative treatment center is required to keep shall keep track of transactions according to  
18 qualifying patients' and designated caregivers' registry identification numbers, rather than their  
19 names, to protect their confidentiality.

20 (7) The sufficiency of the applicant's plans for safety and security, including  
21 proposed location and security devices employed.

22 (8) Whether the entity possesses or has the right to use sufficient land, buildings,  
23 and equipment to properly carry out its duties as an alternative treatment center.

24 VI. After an alternative treatment center is approved, but before it begins operations, it  
25 shall submit the registration and regulation fee paid to the department in accordance with the rules  
26 adopted by the department.

27 VII. Notwithstanding any other provision of law, information required to be submitted to the  
28 department on an application for an alternative treatment center identifying the locations where  
29 marijuana is proposed to be grown, cultivated, harvested, and otherwise prepared for distribution to  
30 qualifying patients, designated caregivers, and alternative treatment centers, and any other  
31 department records identifying such location, shall be considered to be confidential information and  
32 not subject to disclosure pursuant to RSA 91-A, except that:

33 (a) Such information may be disclosed to a law enforcement agency upon request for  
34 purposes of enforcement under this chapter;

35 (b) The location may be disclosed to towns and cities when seeking input on locations,  
36 provided that the towns and cities' representatives keep the information confidential; and

37 (c) The name, address, and phone number of alternative treatment centers may be



disclosed to qualifying patients.

VIII. The alternative treatment center's certificate may be revoked at any time it commits a serious violation of these rules, including if it negligently or knowingly allows marijuana to be distributed to someone who is not exempt from penalties pursuant to this act.

IX. By April 10 of every odd year, beginning no sooner than one year after an alternative treatment center receives its first registry certificate, each alternative treatment center shall pay a fee in an amount determined by the department.

X. By April 10 of every odd year, beginning no sooner than one year after an alternative treatment center receives its first registry certificate, the department shall evaluate each alternative treatment center's operations. A registration certificate may be revoked if the alternative treatment center:

(a) Committed multiple or serious violations of this act or department rules; or

(b) Is not operational.

XI. Alternative treatment centers shall be subject to reasonable inspection by the department of health and human services. During an inspection, the department may review the alternative treatment center's records, including its confidential dispensing records, which shall track transactions according to qualifying patients' registry identification numbers to protect their confidentiality.

126-W:8 Alternative Treatment Centers; Requirements.

I. An alternative treatment center shall be operated on a not-for-profit basis for the benefit of its patients. An alternative treatment center need not be recognized as a tax-exempt organization by the Internal Revenue Service.

II. An alternative treatment center may not be located in a residential district or within 1,000 feet of the property line of a pre-existing public or private primary or secondary school.

III. An alternative treatment center shall implement appropriate security measures to deter and prevent the unauthorized entrance into areas containing marijuana and the theft of marijuana and shall ensure that each location has an operational security alarm system.

IV.(a) An alternative treatment center shall conduct a background check into the criminal history of every person seeking to become a principal officer, board member, agent, volunteer, or employee before the person begins working at the alternative treatment center. An alternative treatment center may not allow any person to be an alternative treatment center agent who:

(1) Was convicted of a drug-related offense; or

(2) Is under 21 years of age.

(b) An alternative treatment center shall create an identification badge for each alternative treatment center agent before the alternative treatment center agent possesses, cultivates, or transports marijuana on behalf of the alternative treatment center. The badges may include the alternative treatment center's registration certificate number and either a unique



number for each agent or his or her name.

(c) An alternative treatment center agent must wear his or her badge at all times when working at an alternative treatment center, including at any cultivation location.

V. No person who has been convicted of a drug-related offense shall be an alternative treatment center agent. A person who is employed by or is an agent, volunteer, principal officer, or board member of an alternative treatment center who violates this paragraph shall be guilty of a violation punishable by a fine of up to \$1,000. A subsequent violation of this paragraph shall be a misdemeanor.

VI. The operating documents of an alternative treatment center shall include procedures for the oversight of the alternative treatment center and procedures to ensure accurate record keeping.

VII. Each alternative treatment center shall keep the following records, dating back at least 6 months:

(a) Records of the disposal of marijuana that is not distributed by the alternative treatment center to qualifying patients who have designated the alternative treatment center to cultivate for them.

(b) A record of each transaction, including the amount of marijuana dispensed, the amount of consideration, and the registry identification number of the qualifying patient, designated caregiver, or alternative treatment center.

VIII. Each alternative treatment center shall:

(a) Conduct an initial comprehensive inventory of all medical marijuana, including usable marijuana available for dispensing and mature marijuana plants at each authorized location on the date the alternative treatment center first dispenses medical marijuana.

(b) Conduct a monthly comprehensive inventory of all medical marijuana, including usable marijuana available for dispensing, mature marijuana plants, and seedlings at each authorized location.

IX. An alternative treatment center shall submit a department-approved incident report form on the next business day after it discovers a reportable incident. The report shall indicate the nature of the breach and the corrective actions taken by the alternative treatment center. For purposes of reporting, an incident includes:

(a) Confidential information accessed or disclosed in violation of department rules;

(b) Loss of inventory by theft or diversion;

(c) Unauthorized intrusion into the alternative treatment center or the one permitted additional location, if any;

(d) Any known violation of this chapter or department rules by an alternative treatment center agent; and

(e) Any other incident that the department by rule requires to be reported.

X. Alternative treatment centers cannot use pesticides in marijuana cultivation unless



pesticides become authorized for application on marijuana.

XI. No marijuana or paraphernalia at an alternative treatment center may be visible from outside the property of the alternative treatment center.

XII. An alternative treatment center shall submit an annual report to the department that shall provide information required by the department in order to allow the department to evaluate the effectiveness and operations of the alternative treatment center.

XIII.(a) Each time an alternative treatment center agent dispenses marijuana to a qualifying patient directly or through the qualifying patient's designated caregiver, he or she shall consult the alternative treatment center's records to verify that the records do not indicate that the dispensing of the marijuana would cause the qualifying patient to receive more marijuana than is permitted in a 10-day period. Each time marijuana is dispensed, the alternative treatment center agent shall record the date the marijuana was dispensed and the amount dispensed. All records shall be kept according to the registry identification number of the qualifying patient and designated caregiver, if any.

(b) Except as provided in subparagraph (c), a qualifying patient is not allowed to obtain more than two ounces of usable marijuana directly or through the qualifying patient's designated caregiver during a 10-day period.

(c) After providing an opportunity for patients, experts, researchers, and physicians to be heard, the department may issue a rule adjusting the limit specified in subparagraph (a) to an amount that is reasonably necessary for a 10-day supply.

XIV.(a) Except when transporting marijuana in accordance with subparagraphs (b) or (c), alternative treatment center agents are only allowed to possess and manufacture marijuana at the alternative treatment center location or locations at which the alternative treatment center agents are employed. Volunteers are only allowed to possess and manufacture marijuana at an alternative treatment center location. Volunteers cannot dispense marijuana.

(b) Distributions of marijuana for medical use to a qualifying patient or a designated caregiver for use by a qualifying patient shall be labeled with a trip ticket to identify the alternative treatment center, the patient's registry number, or the caregiver's number, the amount and form, the time and date of origin, and destination of the product.

(c) An alternative treatment center with a growing location in addition to the location of the alternative treatment center shall label the marijuana that is being moved between the growing location and the alternative treatment center with a trip ticket that identifies the alternative treatment center by registry number, the time, date, origin, and destination of the material being transported, and the amount and form of marijuana and marijuana material that is being transported. Marijuana shall be transported only by an alternative treatment center agent who is not a volunteer.

XV.(a) An alternative treatment center shall not possess or cultivate marijuana in excess of



Amendment to HB 573-FN

- Page 22 -

the greater of the following quantities:

(1) 80 marijuana plants, 160 seedlings, and 80 ounces of usable marijuana; or

(2)(A) Six ounces of usable marijuana; and

(B) Four mature marijuana plants, 12 seedlings, and 6 ounces for each qualifying patient who has designated the alternative treatment center to provide him or her with marijuana for medical use. An alternative treatment center may also possess marijuana seeds, stalks, and unusable roots.

(b) An alternative treatment center may possess marijuana seeds, stalks, and unusable roots.

(c) An alternative treatment center or alternative treatment center agent shall not dispense, deliver, or otherwise transfer marijuana to a person other than:

(1) A qualifying patient who has designated the relevant alternative treatment center; or

(2) Such patient's designated caregiver; or

(3) A visiting qualifying patient who has designated the relevant alternative treatment center.

(d) All cultivation of marijuana shall take place in an enclosed, locked facility registered with the department and which can only be accessed by alternative treatment center agents.

XVI.(a) All marijuana dispensed by an alternative treatment center shall include a label specifying the weight of the marijuana and any other information the department requires to appear on the label. The label shall also specify that the marijuana is for medical use and that diversion is a class B felony requiring revocation of one's registry identification card.

(b) An alternative treatment center must provide educational materials about marijuana to qualifying patients and their registered primary caregivers. Each alternative treatment center shall have an adequate supply of up-to-date educational material available for distribution. Educational materials shall be available for inspection by the department upon request. The educational material shall at least include information about the following:

(1) Strains of marijuana, routes of administration, and their different effects. Alternative treatment centers shall have educational materials available to assist in the selection of prepared marijuana. Alternative treatment centers shall provide tracking sheets to qualifying patients and registered primary caregivers who request them to keep track of the strains used and their effects.

(2) How to achieve proper dosage for different modes of administration. Emphasis shall be on using the smallest amount possible to achieve the desired effect. The impact of potency must also be explained.

(3) Information on tolerance, dependence, and withdrawal must be provided.

(4) Information regarding substance abuse signs and symptoms must be available,



as well as referral information.

(5) Information on whether the alternative treatment center's marijuana and associated products meet organic certification standards.

(6) Information about possible side effects from the use of marijuana for medical purposes.

XVII.(a) Each alternative treatment center shall develop, implement, and maintain on the premises employee and agent policies and procedures to address the following requirements:

(1) A job description or employment contract developed for all employees and a volunteer agreement for all volunteers, which includes duties, authority, responsibilities, qualifications, and supervision.

(2) Training in and adherence to confidentiality laws.

(3) The proper use of security measures and controls that have been adopted.

(4) Specific procedural instructions on how to respond to an emergency.

(b) All alternative treatment centers shall prepare training documentation for each employee and have employees sign a statement indicating the date, time, and place the employee received said training and topics discussed, to include name and title of presenters. The alternative treatment center shall maintain documentation of an employee's and a volunteer's training for a period of at least 6 months after termination of an employee's period of employment or the volunteer's period of voluntary service.

(c) Each alternative treatment center shall maintain a personnel record for each alternative treatment center agent that includes an application for employment or to volunteer and a record of any disciplinary action taken.

XVIII. A provider shall not:

(a) Accept, solicit, or offer any form of pecuniary remuneration from or to an alternative treatment center, except if the provider is employed by an alternative treatment center.

(b) Offer a discount or other thing of value to a patient who uses or agrees to use a particular alternative treatment center.

(c) Examine a patient in relation to issuing a written certification at a location where medical marijuana is sold or distributed.

(d) Hold an economic interest in an alternative treatment center if the provider issues written certifications to patients.

126-W:9 Annual Report. The commissioner of the department of health and human services shall report annually on the medical marijuana program established under this chapter to the health and human services oversight committee established under RSA 126-A:13. The initial report shall be filed with the chairman of the committee no later than December 1, 2014. The commissioner's report shall include the following information:

I. The ability of qualifying patients and designated caregivers in all areas of the state to





1 obtain timely access to medical marijuana.

2 II. The effectiveness of alternative treatment centers individually and together in serving  
3 the needs of qualifying patients and designated caregivers, including the provision of educational  
4 and support services.

5 III. Provider participation in the medical marijuana program.

6 IV. The number of designated caregivers and the number of qualifying patients, by county.

7 V. Sufficiency of the regulatory and security safeguards contained in this chapter to ensure  
8 that access to and use of marijuana cultivated is provided only to alternative treatment centers,  
9 qualifying patients, visiting qualifying patients, and designated caregivers.

10 VI. Any illegal distribution or diversion of marijuana cultivated pursuant to this chapter to  
11 individuals who are not alternative treatment center agents, qualifying patients, visiting qualifying  
12 patients, or designated caregivers.

13 VII. Any other issues related to the implementation of the medical use of marijuana  
14 permitted under this chapter that the committee shall request.

15 VIII. A summary of the reports submitted by alternative treatment centers as required  
16 under RSA 126-W:8, XII.

17 126-W:10 Registry Identification Card and Certificate Fund. There is hereby established in the  
18 office of the state treasurer a fund to be known as the registry identification card and certificate fund  
19 which shall be kept separate and distinct from all other funds. The fund is established to pay for the  
20 operational expenses of the program for permitting the use of marijuana for medicinal purposes as  
21 established in this chapter. The moneys in this fund shall be nonlapsing and continually  
22 appropriated to the department. Interest on fund balances shall accrue to the fund. All fines and  
23 other income received by the department and all monetary fees, gifts, grants, and donations received  
24 by the department pursuant to this chapter shall be deposited in the fund.

25 2 New Subparagraph; Application of Receipts; Registry Identification Card and Certificate  
26 Fund. Amend RSA 6:12, I(b) by inserting after subparagraph (310) the following new subparagraph:

27 (311) Moneys deposited in the registry identification card and certificate fund  
28 established in RSA 126-W:7.

29 3 New Paragraph; Controlled Drug Act; Acts Prohibited. Amend RSA 318-B:2 by inserting after  
30 paragraph I-a the following new paragraph:

31 I-b. It shall be unlawful for a qualifying patient or designated caregiver as defined under  
32 RSA 126-W:1 to sell marijuana to another person who is not a qualifying patient or designated  
33 caregiver. A conviction for the sale of marijuana to a person who is not a qualifying patient or  
34 designated caregiver shall not preclude or limit a prosecution or conviction of any person for sale of  
35 marijuana or any other offense defined in this chapter.

36 4 New Paragraph; Controlled Drug Act; Penalties. Amend RSA 318-B:26 by inserting after  
37 paragraph IX the following new paragraph:

Amendment to HB 573-FN

- Page 25 -



1 IX-a. A qualifying patient or designated caregiver as defined in RSA 126-W:1 who is  
2 convicted of selling marijuana to a person who is not a qualifying patient or designated caregiver  
3 shall be guilty of a class B felony and shall be sentenced to a maximum term of imprisonment of not  
4 more than 7 years, a fine of not more than \$300,000, or both.

5 5 Effective Date. This act shall take effect upon its passage.



Amendment to HB 573-FN

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

2  
3 AN ACT relative to the use of cannabis for therapeutic purposes.  
4

5 Amend the bill by replacing all after the enacting clause with the following:  
6

7 1 New Chapter; Use of Cannabis for Therapeutic Purposes. Amend RSA by inserting after  
8 chapter 126-V the following new chapter:

9 CHAPTER 126-W

10 USE OF CANNABIS FOR THERAPEUTIC PURPOSES

11 126-W:1 Definitions. In this chapter:

12 I. "Alternative treatment center" means a not-for-profit entity registered under RSA 126-  
13 W:7 that acquires, possesses, cultivates, manufactures, delivers, transfers, transports, sells, supplies,  
14 and dispenses cannabis, and related supplies and educational materials, to qualifying patients.

15 II. "Alternative treatment center agent" means a principal officer, board member, employee,  
16 manager, or volunteer of an alternative treatment center who is 21 years of age or older and has not  
17 been convicted of a felony or any drug-related offense.

18 III. "Cannabis" means all parts of any plant of the Cannabis genus of plants, whether  
19 growing or not; the seeds thereof; the resin extracted from any part of such plant; and every  
20 compound, salt, derivative, mixture, or preparation of such plant, its seeds, or resin. Such term shall  
21 not include the mature stalks of such plants, fiber produced from such stalks, oil, or cake made from  
22 the seeds of such plants, any other compound, salt, derivative, mixture, or preparation of such  
23 mature stalks (except the resin extracted therefrom), fiber, oil or cake, or the sterilized seeds of such  
24 plants which are incapable of germination.

25 IV. "Cultivation location" means a locked and enclosed site, under the control of the  
26 qualifying patient or designated caregiver who has reported the location of the site to the  
27 department, where cannabis is cultivated in accordance with the provisions of this chapter. A  
28 cultivation location may be a closet, a room, a greenhouse, a building, or another enclosed area that  
29 is secured with one or more locks or other security devices.

30 V. "Department" means the department of health and human services.

31 VI. "Designated caregiver" means an individual:

32 (a) Who is at least 21 years of age;



(b) Who has agreed to assist with a qualifying patient's therapeutic use of cannabis;

(c) Who has never been convicted of a felony or any drug-related offense; and

(d) Who possesses a valid registry identification card issued pursuant to RSA 126-W:4.

VII.(a) "Provider" means a physician licensed to prescribe drugs to humans under RSA 329 and who possesses certification from the United States Drug Enforcement Administration to prescribe controlled substances. "Provider" shall also mean an advanced practice registered nurse licensed pursuant to RSA 326-B:18.

(b) If the qualifying patient's qualifying medical condition is post-traumatic stress disorder, the provider shall also be a licensed psychiatrist.

(c) For a visiting qualifying patient, "provider" means an individual licensed to prescribe drugs to humans in the state of the patient's residence and who possesses certification from the United States Drug Enforcement Administration to prescribe controlled substances.

VIII. "Provider-patient relationship" means at least a 3-month medical relationship between a licensed provider and a patient that includes an in-person exam, a history, a diagnosis, a treatment plan appropriate for the licensee's medical specialty, and documentation of all prescription drugs including name and dosage.

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

(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, agitation of Alzheimer's disease, multiple sclerosis, chronic pancreatitis, or post-traumatic stress disorder; and

(2) A severely debilitating or terminal medical condition or its treatment that produces at least one of the following: cachexia, chemotherapy-induced anorexia, wasting syndrome, severe 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, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms.

(b) The commissioner may include a medical condition which is not listed in subparagraph (a) and which the commissioner determines, on a case by case basis, is severely debilitating or terminal, based upon the written request of a provider who furnishes written certification to the commissioner.

X. "Qualifying patient" means a resident of New Hampshire who has been diagnosed by a provider as having a qualifying medical condition and who possesses a valid registry identification card issued pursuant to RSA 126-W:4.

XI. "Registry identification card" means a document issued by the department pursuant to RSA 126-W:4 that identifies an individual as a qualifying patient or a designated caregiver.

XII. "Seedling" means a cannabis plant that has no flowers and is less than 12 inches in height and less than 12 inches in diameter.



1 XIII. "Therapeutic use" means the acquisition, possession, cultivation, preparation, use,  
2 delivery, transfer, or transportation of cannabis or paraphernalia relating to the administration of  
3 cannabis to treat or alleviate a qualifying patient's qualifying medical condition or symptoms or  
4 results of treatment associated with the qualifying patient's qualifying medical condition. It does not  
5 include:

- 6 (a) The use of cannabis by a designated caregiver who is not a qualifying patient; or  
7 (b) Cultivation or purchase by a visiting qualifying patient; or  
8 (c) Cultivation by a designated caregiver or qualifying patient who is not designated as  
9 being allowed to cultivate.

10 XIV. "Unusable cannabis" means any cannabis, other than usable cannabis, including the  
11 seeds, stalks, and roots of the plant.

12 XV. "Usable cannabis" means the dried leaves and flowers of the cannabis plant and any  
13 mixture or preparation thereof, but does not include the seeds, stalks, and roots of the plant and does  
14 not include the weight of any non-cannabis ingredients combined with cannabis and prepared for  
15 consumption as food or drink.

16 XVI. "Visiting qualifying patient" means a patient with a qualifying medical condition who  
17 is not a resident of New Hampshire or who has been a resident of New Hampshire for fewer than 30  
18 days.

19 XVII. "Written certification" means documentation of a qualifying medical condition by a  
20 provider pursuant to rules adopted by the department pursuant to RSA 541-A for the purpose of  
21 issuing registry identification cards, after having completed a full assessment of the patient's  
22 medical history and current medical condition made in the course of a provider-patient relationship  
23 of at least 3 months in duration. The 3-month requirement for the provider-patient relationship  
24 required in this paragraph shall not apply if the provider issuing the written certification certifies  
25 that the onset of the patient's qualifying medical condition occurred within the past 3 months; and  
26 the certifying provider is primarily responsible for the patient's care related to his or her qualifying  
27 medical condition. The date of issuance and the patient's qualifying medical condition shall be  
28 specified on the written certification.

29 126-W:2 Therapeutic Use of Cannabis Protections.

30 I. A qualifying patient shall not be subject to arrest by state or local law enforcement,  
31 prosecution or penalty under state or municipal law, or be denied any right or privilege for the  
32 therapeutic use of cannabis in accordance with this chapter, if the qualifying patient possesses,  
33 cultivates, or possesses and cultivates, an amount of cannabis that does not exceed the following:

- 34 (a) If the qualifying patient does not have a designated caregiver, for the possession and  
35 cultivation of cannabis that occurs at the cultivation location reported to the department, or while  
36 transporting cannabis and cannabis plants and seedlings to a new cultivation location that has been  
37 reported to the department within the prior 21 days:



(1) Six ounces of usable cannabis;  
(2) Any amount of unusable cannabis; and  
(3) Three mature cannabis plants and 12 seedlings, with a total canopy of no more than 50 square feet.

(b) If the qualifying patient is not at a cultivation location reported to the department:

(1) Two ounces of usable cannabis; and  
(2) Any amount of unusable cannabis.

II. A designated caregiver shall not be subject to arrest by state or local law enforcement, prosecution or penalty under state or municipal law, or denied any right or privilege for the therapeutic use of cannabis in accordance with this chapter on behalf of a qualifying patient if the designated caregiver possesses or cultivates, or both, an amount of cannabis that does not exceed the following:

(a) If at the cultivation location reported to the department, or while transporting cannabis and cannabis plants and seedlings to a new cultivation location that has been reported to the department within the prior 21 days:

(1) Six ounces of usable cannabis; and  
(2) Any amount of unusable cannabis; and  
(3) Three mature cannabis plants and 12 seedlings, with a total canopy of no more than 50 square feet.

(b) If not at a cultivation location reported to the department:

(1) Two ounces of usable cannabis; and  
(2) Any amount of unusable cannabis.

III. A designated caregiver may receive compensation for costs, not including labor, associated with assisting a qualifying patient who has designated the designated caregiver to assist him or her with the therapeutic use of cannabis. Such compensation shall not constitute the sale of controlled substances.

IV.(a) A qualifying patient is presumed to be lawfully engaged in the therapeutic use of cannabis in accordance with this chapter if the qualifying patient possesses a valid registry identification card and possesses an amount of cannabis that does not exceed the amount allowed under this chapter.

(b) A designated caregiver is presumed to be lawfully engaged in assisting with the medical use of cannabis in accordance with this chapter if the designated caregiver possesses a valid registry identification card and possesses an amount of cannabis that does not exceed the amount allowed under this chapter.

(c) The presumptions made in subparagraphs (a) and (b) may be rebutted by evidence that conduct related to cannabis was not for the purpose of treating or alleviating the qualifying patient's qualifying medical condition or symptoms or effects of the treatment associated with the



1 qualifying medical condition, in accordance with this chapter.

2 V. A valid registry identification card, or its equivalent, that is issued under the laws of  
3 another state, district, territory, commonwealth, or insular possession of the United States that  
4 allows, in the jurisdiction of issuance, a visiting qualifying patient to possess cannabis for  
5 therapeutic purposes, shall have the same force and effect as a valid registry identification card  
6 issued by the department in this state, provided that:

7 (a) The visiting qualifying patient shall also produce a statement from his or her  
8 provider stating that the visiting qualifying patient has a qualifying medical condition as defined in  
9 RSA 126-W:1, X; and

10 (b) A visiting qualifying patient shall not cultivate or purchase cannabis in New  
11 Hampshire or obtain cannabis from alternative treatment centers.

12 VI. A person otherwise entitled to custody of, or visitation or parenting time with, a minor  
13 shall not be denied such a right solely for conduct allowed under this chapter, and there shall be no  
14 presumption of neglect or child endangerment.

15 VII. For the purposes of medical care, including organ transplants, a qualifying patient's  
16 authorized use of cannabis in accordance with this chapter shall be considered the equivalent of the  
17 authorized use of any other medication used at the direction of a provider, and shall not constitute  
18 the use of an illicit substance.

19 VIII. A provider shall not be subject to arrest by state or local law enforcement, prosecution  
20 or penalty under state or municipal law, or be denied any right or privilege, including but not limited  
21 to a civil penalty or disciplinary action by the New Hampshire board of medicine or any other  
22 occupational or professional licensing entity, solely for providing written certifications, provided that  
23 nothing shall prevent a professional licensing entity from sanctioning a provider for failing to  
24 properly evaluate a patient's medical condition.

25 IX. An alternative treatment center shall not be subject to prosecution under state or  
26 municipal law; search or inspection, except by the department pursuant to RSA 126-W:7, XI; seizure;  
27 or penalty in any manner under state or municipal law for acting pursuant to this chapter and  
28 department rules to:

29 (a) Acquire or purchase cannabis seeds, seedlings, plants, or cannabis from other  
30 sources;

31 (b) Possess, cultivate, manufacture, or transport cannabis and seedlings; or

32 (c) Deliver, transfer, supply, sell, or dispense cannabis and related supplies and  
33 educational materials to qualifying patients and visiting qualifying patients who have designated  
34 the alternative treatment center to provide for them, to designated caregivers on behalf of the  
35 qualifying patients who have designated the alternative treatment center, or to other alternative  
36 treatment centers.

37 X. An alternative treatment center agent shall not be subject to arrest by state or local law



1 enforcement, prosecution or penalty in any manner under state or municipal law, search, or be  
2 denied any right or privilege for working for an alternative treatment center pursuant to this  
3 chapter and department rules to engage in any of the actions listed in paragraph IX.

4 XI. Any cannabis, cannabis paraphernalia, licit property, or interest in licit property that is  
5 possessed, owned, or used in connection with the therapeutic use of cannabis as allowed under this  
6 chapter, or acts incidental to such use, shall not be seized or forfeited if the basis for the seizure or  
7 forfeiture is activity related to cannabis that is exempt from state criminal penalties under this  
8 chapter.

9 XII. An individual shall not be subject to arrest by state or local law enforcement,  
10 prosecution or penalty under state or municipal law, or be denied any right or privilege, including  
11 but not limited to a civil penalty or disciplinary action by a court or occupational or professional  
12 licensing entity, simply for being in the presence or vicinity of the therapeutic use of cannabis as  
13 allowed under this chapter.

14 XIII. If a state or local law enforcement agency or agent encounters an alternative treatment  
15 center or an individual who the agent or agency knows is an alternative treatment center agent, a  
16 designated caregiver, or a qualifying patient, or who credibly asserts he or she is an alternative  
17 treatment center agent, a designated caregiver, or a qualifying patient, the law enforcement agency  
18 or agent shall not provide any information from any cannabis-related investigation of the individual  
19 or entity to any law enforcement agency that does not recognize the protection of this chapter, and  
20 any prosecution of the individual or entity for a violation of this chapter shall be conducted pursuant  
21 to the laws of this state. This paragraph shall not apply in cases where the state or local law  
22 enforcement agency has probable cause to believe the person is distributing cannabis to a person  
23 who is not allowed to possess it under this chapter.

24 XIV. A person who ceases to be a qualifying patient or designated caregiver shall have 10  
25 days after notification by the department to dispose of cannabis in one of the following ways:

26 (a) If the person was a designated caregiver and the qualifying patient who designated  
27 the caregiver is still a qualifying patient, but has designated a new caregiver or will cultivate plants  
28 himself or herself, the designated caregiver may transfer cannabis to the new person who will  
29 cultivate for the qualifying patient;

30 (b) The person may notify local law enforcement and request that they dispose of the  
31 cannabis; or

32 (c) The person may dispose of cannabis, after mixing cannabis with other ingredients  
33 such as soil to render it unusable.

34 126-W:3 Prohibitions and Limitations on the Therapeutic Use of Cannabis.

35 I. A qualifying patient may use cannabis on privately-owned real property only with the  
36 permission of the property owner or in the case of leased property with the permission of the tenant  
37 in possession of the property, except that a tenant shall not allow a qualifying patient to smoke





1 cannabis on rented property if smoking on the property violates the lease or the lessor's rental  
2 policies that apply to all tenants at the property. However, a tenant may permit a qualifying patient  
3 to use cannabis on leased property by ingestion or inhalation through vaporization even if smoking is  
4 prohibited by the lease or rental policies. For purposes of this chapter, vaporization shall mean the  
5 inhalation of cannabis without the combustion of the cannabis.

6 II. Nothing in this chapter shall exempt any person from arrest or prosecution for:

7 (a) Being under the influence of cannabis while:

8 (1) Operating a motor vehicle, commercial vehicle, boat, or vessel, or any other  
9 vehicle propelled or drawn by power other than muscular power; or

10 (2) In his or her place of employment, without the written permission of the  
11 employer; or

12 (3) Operating heavy machinery or handling a dangerous instrumentality.

13 (b) The use or possession of cannabis by a qualifying patient or designated caregiver for  
14 purposes other than for therapeutic use as permitted by this chapter;

15 (c) The smoking or vaporization of cannabis in any public place, including:

16 (1) A school bus, public bus, or other public vehicle; or

17 (2) A place of employment, without the written permission of the employer; or

18 (3) The grounds of any preschool, elementary, or secondary school; or

19 (4) Any correctional facility; or

20 (5) Any public park, public beach, public recreation center, public field, or youth  
21 center; or

22 (6) Any law enforcement facility.

23 III. Nothing in this chapter shall be construed to require:

24 (a) Any health insurance provider, health care plan, or medical assistance program to be  
25 liable for any claim for reimbursement for the therapeutic use of cannabis; or

26 (b) Any individual or entity in lawful possession of property to allow a guest, client,  
27 customer, or other visitor to use cannabis on or in that property; or

28 (c) Any accommodation of the therapeutic use of cannabis on the property or premises of  
29 any place of employment or on the property or premises of any jail, correctional facility, or other type  
30 of penal institution where prisoners reside or persons under arrest are detained. This chapter shall  
31 in no way limit an employer's ability to discipline an employee for ingesting cannabis in the  
32 workplace or for working while under the influence of cannabis.

33 IV. Any person who makes a fraudulent representation to a law enforcement official of any  
34 fact or circumstance relating to the therapeutic use of cannabis to avoid arrest or prosecution shall  
35 be guilty of a violation and shall be fined \$500, which shall be in addition to any other penalties that  
36 may apply for making a false statement or for the use of cannabis other than use undertaken  
37 pursuant to this chapter.



V. A qualifying patient or designated caregiver who is found to be in possession of cannabis outside of his or her home and is not in possession of his or her registry identification card may be subject to a \$100 fine.

VI. Any qualifying patient or designated caregiver who sells cannabis to another person who is not a qualifying patient or designated caregiver under this chapter shall be subject to the penalties specified in RSA 318-B:26, IX-a, shall have his or her registry identification card revoked, and shall be subject to other penalties as provided in RSA 318-B:26.

VII. The department may revoke the registry identification card of a qualifying patient or designated caregiver for violation of rules adopted by the department or for violation of any other provision of this chapter, and the qualifying patient or designated caregiver shall be subject to any other penalties established in law for the violation.

126-W:4 Departmental Administration; Registry Identification Cards.

I. Except as provided in paragraph V, the department shall issue a registry identification card to a person applying as a qualifying patient who submits all of the following information:

(a) Written certification as defined in RSA 126-W:1.

(b) An application or a renewal application accompanied by the application or renewal fee.

(c) A recent passport-sized photograph of the applicant's face.

(d) Name, residential and mailing address, and date of birth of the applicant, except that if the applicant is homeless, no residential address is required.

(e) Name, address, and telephone number of the applicant's provider.

(f) Name, address, and date of birth of the applicant's designated caregiver, if any. A qualifying patient shall have only one designated caregiver.

(g) Name of the alternative treatment center that the qualifying patient designates. A qualifying patient may designate no more than one alternative treatment center at any time.

(h) Street address of the cultivation location, if any, if the qualifying patient does not have a designated caregiver.

(i) A statement signed by the applicant, pledging not to divert cannabis to anyone who is not allowed to possess cannabis pursuant to this chapter and acknowledging that his or her diversion of cannabis is punishable as a class B felony and revocation of his or her registry identification card, in addition to other penalties for the illegal sale of cannabis.

II.(a) Except as provided in paragraph V, the department shall issue a registry identification card to a person applying as a designated caregiver who submits all of the following information:

(1) An application or a renewal application.

(2) A recent passport-sized photograph of the applicant's face.

(3) Name, residential and mailing address, and date of birth of the applicant.



1 (4) Name, residential and mailing address, and date of birth of the qualifying patient  
2 for whom the applicant will act as designated caregiver, except that if the qualifying patient is  
3 homeless, no residential address is required. A designated caregiver shall act on behalf of only one  
4 qualifying patient.

5 (5) Street address of the cultivation location, except that the designated caregiver  
6 may not include a cultivation location if the designated caregiver's qualifying patient has designated  
7 an alternative treatment center.

8 (6) A signed statement from the applicant agreeing to act as the designated  
9 caregiver for the qualifying patient named in the application and pledging not to divert cannabis to  
10 anyone who is not allowed to possess cannabis pursuant to this chapter and acknowledging that the  
11 diversion of cannabis is punishable as a class B felony and revocation of one's registry identification  
12 card, in addition to other penalties for the illegal sale of cannabis.

13 (7) A person who is applying to be a designated caregiver shall submit the results of  
14 a state and federal criminal records check obtained through the department of safety. The  
15 department of safety may exchange necessary data including fingerprint data with the Federal  
16 Bureau of Investigation without disclosing that the records check is related to the provisions of this  
17 chapter and acts permitted by it.

18 (b) In the case of a designated caregiver applying for a renewal, the applicant shall  
19 submit a sworn statement that he or she has not been convicted of a felony or other drug-related  
20 offense.

21 III. The department shall verify the information contained in an application or renewal  
22 submitted pursuant to this section. The department shall approve or deny an application or renewal  
23 for a qualifying patient within 15 days of receipt of the application. The department shall approve or  
24 deny an application or renewal to serve as a designated caregiver within 45 days of receipt of the  
25 application. The department may deny an application or renewal only if the applicant did not  
26 provide the information required pursuant to this section, or if the applicant previously had a  
27 registry identification card revoked for violating the provisions of this chapter or rules adopted by  
28 the department, or if the department determines that the information provided was falsified or did  
29 not meet the requirements of this chapter or rules adopted by the department. The department shall  
30 notify an applicant of the denial of an application. An applicant who is aggrieved by a department  
31 decision may request an administrative hearing at the department.

32 IV. The department shall issue a registry identification card to a person applying as a  
33 qualifying patient or designated caregiver within 5 days of approving an application or renewal.  
34 Each registry identification card shall expire one year after the date of issuance, unless the provider  
35 states in the written certification that the certification should expire at an earlier specified date,  
36 then the registry identification card shall expire on that date. Registry identification cards shall  
37 contain all of the following:



1 (a) Name, mailing address, and date of birth of the qualifying patient or designated  
2 caregiver.

3 (b) The date of issuance and expiration date of the registry identification card.

4 (c) A random 10-digit identification number, containing at least 4 numbers and at least 4  
5 letters, that is unique to the qualifying patient or the designated caregiver.

6 (d) A designation that the person is either a "qualifying patient" or a "designated  
7 caregiver." If the person is a designated caregiver, the identification card shall include the random  
8 10-digit identification number of the qualifying patient for whom he or she is providing care.

9 (e) The registry identification number corresponding with the alternative treatment  
10 center the qualifying patient designated, if any.

11 (f) A passport-sized photograph of the qualifying patient's or designated caregiver's face.

12 (g) A statement that the qualifying patient or designated caregiver is permitted under  
13 state law to possess cannabis pursuant to this chapter for the medical use of the qualifying patient.

14 (h) A statement noting whether or not the cardholder is exempt from state penalties for  
15 cultivating cannabis. The statement shall be determined as follows:

16 (1) A qualifying patient is exempt from state penalties for cultivating cannabis in  
17 accordance with this chapter if he or she does not have a designated caregiver. If a qualifying  
18 patient has selected a designated caregiver, he or she is not exempt from state penalties for  
19 cultivating cannabis.

20 (2) A designated caregiver is exempt from state penalties for cultivating cannabis in  
21 accordance with this chapter if the designated caregiver's qualifying patient has not also designated  
22 an alternative treatment center. If the designated caregiver's qualifying patient has also designated  
23 an alternative treatment center, the designated caregiver is not exempt from state penalties for  
24 cultivating cannabis.

25 V. The department shall not issue a registry identification card to an applicant under 18  
26 years of age who is applying as a qualifying patient unless:

27 (a) A custodial parent or legal guardian responsible for health care decisions for the  
28 qualifying patient submits a written certification from 2 providers, one of whom shall be a  
29 pediatrician.

30 (b) The applicant's provider has explained the potential risks and benefits of the  
31 therapeutic use of cannabis to the custodial parent or legal guardian with responsibility for health  
32 care decisions for the applicant; and

33 (c) The custodial parent or legal guardian with responsibility for health care decisions  
34 for the applicant consents in writing to:

35 (1) Allow the applicant's therapeutic use of cannabis; and

36 (2) Serve as the applicant's designated caregiver and control the acquisition of the  
37 cannabis and the frequency of the therapeutic use of cannabis by the applicant; and



1 (3) The custodial parent or legal guardian completes an application in accordance  
2 with the requirements of paragraph I on behalf of the applicant.

3 VI. The department shall provide each approved qualifying patient and caregiver a  
4 statement with the registry identification card explaining federal law on the possession of cannabis  
5 and that possession of a state registry identification card does not protect a person from federal  
6 criminal penalties.

7 VII. The department shall track the number of qualifying patients who have designated  
8 each alternative treatment center and issue a monthly written statement to the alternative  
9 treatment center identifying the number of qualifying patients who have designated that alternative  
10 treatment center along with the registry identification numbers of each patient and each patient's  
11 designated caregiver.

12 VIII. In addition to the monthly reports, the department shall also provide written notice to  
13 an alternative treatment center which identifies the names and registration identification numbers  
14 of a qualifying patient and his or her designated caregiver whenever any of the following events  
15 occur:

16 (a) A qualifying patient designates the alternative treatment center to serve his or her  
17 needs under this chapter;

18 (b) An existing qualifying patient revokes the designation of the alternative treatment  
19 center; or

20 (c) A qualifying patient who has designated the alternative treatment center loses his or  
21 her status as a qualifying patient under this chapter.

22 IX.(a) A qualifying patient shall notify the department before changing his or her designated  
23 caregiver or alternative treatment center.

24 (b) A qualifying patient and designated caregiver shall notify the department before  
25 changing his or her cultivation location.

26 (c) A qualifying patient shall notify the department of any change in his or her name or  
27 address within 10 days of such change. If the qualifying patient's certifying provider notifies the  
28 department in writing that the qualifying patient no longer suffers from a qualifying medical  
29 condition or should discontinue using cannabis for another compelling reason, the registry  
30 identification card shall become void upon notification by the department to the qualifying patient.

31 (d) When a qualifying patient or a designated caregiver notifies the department of any  
32 change to a name, address, or alternative treatment center, the department shall issue the  
33 qualifying patient or designated caregiver a new registry identification card with a new random 10-  
34 digit identification number within 20 days of receiving the updated information.

35 (e) If a qualifying patient notifies the department of a change in his or her designated  
36 caregiver and the prospective designated caregiver meets the requirements of this chapter, the  
37 department shall issue the designated caregiver a registry identification card with a new random 10-



1 digit identification number within 50 days of receiving the designated caregiver's application.

2 (f) A qualifying patient or designated caregiver who fails to notify the department of any  
3 changes to his or her name, address, designated caregiver, or cultivation location shall be guilty of a  
4 violation and may be subject to a fine not to exceed \$150 under rules adopted by the department.

5 (g) If a qualifying patient or designated caregiver loses his or her registry identification  
6 card, he or she shall notify the department within 10 days of losing the card. Within 5 days after  
7 such notification, the department shall issue a new registry identification card with a new random  
8 10-digit identification number. The fee for new registry cards shall be established in rules set by the  
9 department pursuant to RSA 541-A.

10 X. Mere possession of, or application for, a registry identification card shall not constitute  
11 probable cause or reasonable suspicion, nor shall it be used to support the search of the individual or  
12 property of the individual possessing or applying for the registry identification card. The possession  
13 of, or application for, a registry identification card shall not preclude the existence of probable cause  
14 if probable cause exists on other grounds.

15 XI.(a) The department shall create and maintain a confidential registry of each individual  
16 who has applied for and received a registry identification card as a qualifying patient or a designated  
17 caregiver in accordance with the provisions of this chapter. Each entry in the registry shall contain  
18 the qualifying patient's or designated caregiver's name, mailing address, date of birth, date of  
19 registry identification card issuance, date of registry identification card expiration, random 10-digit  
20 identification number, street address at which the cannabis plants will be cultivated or possessed,  
21 effective date of any change of cultivation location, and registry identification number of the  
22 qualifying patient's designated alternative treatment center, if any. The confidential registry and  
23 the information contained in it shall be exempt from disclosure under RSA 91-A.

24 (b)(1) Except as specifically provided in this chapter, no person shall have access to any  
25 information about qualifying patients or designated caregivers in the department's confidential  
26 registry, or any information otherwise maintained by the department about providers and  
27 alternative treatment centers, except for authorized employees of the department in the course of  
28 their official duties and local and state law enforcement personnel who have detained or arrested an  
29 individual who claims to be engaged in the therapeutic use of cannabis.

30 (2) If a local or state law enforcement officer submits a sworn affidavit to the  
31 department affirming that he or she has probable cause to believe cannabis is possessed or cultivated  
32 at a specific address, an authorized employee for the department may disclose whether the location  
33 is associated with a qualifying patient, designated caregiver, cultivation location, or alternative  
34 treatment center location.

35 (3) If a local or state law enforcement officer submits a sworn affidavit to the  
36 department affirming that he or she has probable cause to believe a specific individual possesses or  
37 cultivates cannabis, an authorized employee for the department may disclose whether the person is a



1 qualifying patient or a designated caregiver, provided that the law enforcement officer provides the  
2 person's name and address or name and date of birth.

3 (4) Counsel for the department may notify law enforcement officials about falsified  
4 or fraudulent information submitted to the department where counsel has made a legal  
5 determination that there is probable cause to believe the information is false or falsified.

6 XII. Within 5 days of learning of the death of a qualifying patient, a surviving family  
7 member, caretaker, executor, or the patient's designated caregiver shall notify the department that  
8 the qualifying patient has died. Within 5 days of learning of the death of a qualifying patient, the  
9 surviving family member, caretaker, executor, or the patient's designated caregiver shall either  
10 request that the local law enforcement agency remove any remaining cannabis or shall dispose of the  
11 cannabis in a manner that is specified in 126-W:2, XIV.

12 126-W:5 Affirmative Defense.

13 I. Except as provided in RSA 126-W:3, it shall be an affirmative defense to any prosecution  
14 for an offense involving cannabis or cannabis paraphernalia intended for therapeutic use if:

15 (a) The defendant is a qualifying patient in possession of a valid registry identification  
16 card and at the time of arrest or prosecution was in possession of a quantity of cannabis that was not  
17 more than allowed under this chapter, and the qualifying patient was engaged in the therapeutic use  
18 of cannabis in accordance with the provisions of this chapter; or

19 (b)(1) The defendant is a designated caregiver in possession of a valid registry  
20 identification card and at the time of arrest or prosecution was in possession of a quantity of  
21 cannabis that was not more than allowed under this chapter; and

22 (2) The designated caregiver was engaged in the therapeutic use of cannabis on  
23 behalf of a qualifying patient in accordance with the provisions of this chapter.

24 If a defendant proves the elements of the affirmative defense listed in subparagraph (I)(a) or (b),  
25 the charges shall be dismissed with prejudice.

26 II. A person who is arrested or cited for possession, cultivation, or transportation of  
27 cannabis, or possession of cannabis paraphernalia, may raise as an affirmative defense that he or  
28 she is person with a qualifying medical condition who is not yet in possession of a valid registry  
29 identification card if:

30 (a) Prior to the arrest, the person submitted to the department a valid application to  
31 become a qualifying patient, complete with a written certification, but the person had not yet  
32 received a registry identification card from the department; and

33 (1) The person does not possess more than 2 ounces of usable cannabis and any  
34 amount of unusable cannabis, if the cannabis is not on the person's property; or

35 (2) If the cannabis is on the person's property, the person does not possess more than  
36 6 ounces of usable cannabis and any amount of unusable cannabis and does not possess or is not  
37 cultivating more than 3 mature cannabis plants with a total canopy of no more than 50 square feet,



1 and 12 seedlings, which shall be in a locked and enclosed location on the person's property.

2 (b) The affirmative defense under this section shall not be available to a person who has  
3 violated any of the provisions of RSA 126-W:3, I-IV.

4 (c) If a defendant proves the elements of the affirmative defense listed in this paragraph,  
5 the defendant shall be acquitted of any charge to which the defendant proved the affirmative  
6 defense.

7 III. A person who is arrested or cited for possession, cultivation, or transportation of  
8 cannabis, or possession of cannabis paraphernalia, prior to the date on which the department begins  
9 accepting registry identification card applications may raise as an affirmative defense that he or she  
10 is a person with a qualifying medical condition who is not yet in possession of a valid registry  
11 identification card if:

12 (a) The person produces a written statement signed by a provider stating that in the  
13 provider's professional opinion, after having completed a full assessment made in the course of a  
14 provider-patient relationship of at least 3 months duration, the person has a qualifying medical  
15 condition. The 3-month requirement for the provider-patient relationship required in this paragraph  
16 shall not apply if the provider issuing the written certification certifies that the onset of the patient's  
17 qualifying medical condition occurred within the past 3 months and the certifying provider is  
18 primarily responsible for the patient's care related to his or her qualifying medical condition; and

19 (1) The person does not possess more than 2 ounces of usable cannabis and any  
20 amount of unusable cannabis, if the cannabis is not on the person's property; and

21 (2) If the cannabis is on the person's property, the person does not possess more than  
22 6 ounces of usable cannabis and any amount of unusable cannabis and does not possess or is not  
23 cultivating more than 3 mature cannabis plants with a total canopy of no more than 50 square feet,  
24 and 12 seedlings which shall be in a locked and enclosed location.

25 (b) The affirmative defense under this section shall not be available to a person who has  
26 violated any of the provisions of RSA 126-W:3, I-IV.

27 (c) If a defendant proves the elements of the affirmative defense listed in this paragraph,  
28 the defendant shall be acquitted of any charge to which the defendant proved the affirmative  
29 defense.

30 126-W:6 Departmental Rules.

31 I. Not later than 6 months days after the effective date of this chapter, the department shall  
32 adopt rules, pursuant to RSA 541-A, governing:

33 (a) The form and content of applications for issuance and renewals of registry  
34 identification cards for qualifying patients and designated caregivers.

35 (b) The form and content of providers' written certifications.

36 (c) Procedures for considering, approving, and denying applications for issuance and  
37 renewals of registry identification cards, and for revoking registry identification cards.





1 (d) Fees, pursuant to RSA 126-W:4, I(b) and paragraph II of this section for applications  
2 for registry identification cards, and pursuant to RSA 126-W:4, IX(g) for re-issuance of replacement  
3 registry identification cards.

4 (e) Fines pursuant to RSA 126-W:4, IX(f) for failure of the qualifying patient or  
5 designated caregiver to notify the department of any changes to his or her name, address, designated  
6 caregiver in the case of a qualifying patient, or cultivation location.

7 II. The department's rules shall establish application and renewal fees for registry  
8 identification cards in accordance with the following:

9 (a) The fee structure by the department for alternative treatment centers and registry  
10 identification cards shall generate revenues sufficient to offset all state expenses of implementing  
11 and administering this chapter; however,

12 (b) The department may accept donations from private sources without the approval of  
13 the governor and council in order to reduce the application and renewal fees for qualifying patients.

14 III.(a) Not later than one year after the effective date of this section, the department shall  
15 adopt rules, pursuant to RSA 541-A, governing alternative treatment centers and the manner in  
16 which it shall consider applications for registration certificates for alternative treatment centers,  
17 including, but not limited to:

18 (1) The form and content of registration and renewal applications.

19 (2) Administrative requirements.

20 (3) Security requirements, which shall include at a minimum, lighting, physical  
21 security, video security, alarm requirements, measures to prevent loitering, and on-site parking.

22 (4) Sanitary requirements.

23 (5) Electrical safety requirements.

24 (6) The specification of acceptable forms of picture identification that an alternative  
25 treatment center may accept when verifying a sale.

26 (7) Personnel requirements including how many volunteers an alternative treatment  
27 center is permitted to have and requirements for supervision.

28 (8) Labeling standards.

29 (9) Procedures for suspending or terminating the registration of alternative  
30 treatment centers that violate the provisions of this chapter or the rules adopted pursuant to this  
31 chapter, a schedule of fines for such violations, procedures for appealing any enforcement actions,  
32 and a schedule of fines.

33 (10) Procedures for inspections and investigations.

34 (11) Advertising restrictions, including a prohibition of misrepresentation and unfair  
35 practices.

36 (12) Permissible hours of operation.

37 (13) The fees for the processing and review of applications for registration as an



1 alternative treatment center and regulation of an alternative treatment center after it has been  
2 approved by the department. Such fees shall be established in an amount that covers all costs of the  
3 department for the review, registration, and regulation of alternative treatment centers.

4 (b) The department shall adopt rules with the goal of protecting against diversion and  
5 theft, without imposing an undue burden on the alternative treatment centers or compromising the  
6 confidentiality of qualifying patients and their designated caregivers.

7 126-W:7 Departmental Administration, Alternative Treatment Centers.

8 I. Within 30 days of the adoption of rules pursuant to RSA 126-W:6, the department shall  
9 begin accepting applications for the operation of alternative treatment centers.

10 II. Within 18 months of the effective date of this section, provided that at least 5  
11 applications have been submitted that score sufficiently high to receive a certificate, the department  
12 shall issue alternative treatment center registration certificates to the 5 highest-scoring applicants.  
13 Each registration certificate shall include a registry number that is unique to the alternative  
14 treatment center.

15 III. Any time an alternative treatment center registration certificate is revoked,  
16 relinquished, or expires without a renewal application being submitted, the department shall accept  
17 applications for a new alternative treatment center and issue registration certificates to the  
18 applicant who scores the highest.

19 IV. If at any time after one year after the effective date of this section, fewer than 5  
20 alternative treatment centers hold valid registration certificates in New Hampshire, the department  
21 shall accept applications for a new alternative treatment center. Except as provided in paragraph V,  
22 no more than 5 alternative treatment centers may hold valid registration certificates at one time.

23 V.(a) An alternative treatment center applicant shall submit a completed department-  
24 approved application form with all required documentation and a non-refundable fee in an amount  
25 set by department rule. The alternative treatment center application and supporting materials shall  
26 include, at a minimum:

27 (1) The legal name, articles of incorporation, and bylaws of the alternative treatment  
28 center.

29 (2) The proposed physical address of the alternative treatment center, if a precise  
30 address has been determined, or, if not, the general location where it would be located. This may  
31 include a second location for the cultivation of cannabis.

32 (3) A description of the enclosed, locked facility that would be used in the cultivation  
33 of cannabis by the alternative treatment center.

34 (4) The name, address, and date of birth of each principal officer and board member  
35 of the alternative treatment center. The board of directors for the non-profit shall include at least  
36 one physician, nurse, or pharmacist licensed to practice in New Hampshire and at least 3 patients  
37 qualified to register as qualifying patients. The majority of board members shall be New Hampshire



1 residents.

2 (5) Proposed security and safety measures that comply with the rules issued  
3 pursuant to RSA 126-W:6, including a description of interior and exterior lighting and security  
4 systems.

5 (6) The distance from any pre-existing private or public school.

6 (7) A copy of the proposed policy regarding services to qualifying patients who cannot  
7 afford to purchase cannabis for therapeutic use.

8 (8) Information demonstrating the applicant's knowledge of organic growing  
9 methods to be used in their growing and cultivation of cannabis.

10 (9) Steps that will be taken to ensure the quality of the cannabis, including purity  
11 and consistency of dose.

12 (10) A start-up timetable that provides an estimated time from registration of the  
13 alternative treatment center to full operation and the assumptions used for the basis of those  
14 estimates.

15 (11) Information showing the applicant's experience running a non-profit or other  
16 business.

17 (12) A description of any additional services that will be available to patients.

18 (13) The applicant's plans for record keeping and inventory control.

19 (b) Any time one or more alternative treatment center registration applications are  
20 being considered, the department may, in partnership with the local governing body of the town or  
21 city where the applicants would be located, solicit input from the qualifying patients, designated  
22 caregivers, and the residents of the towns or cities.

23 (c) Each time an alternative treatment center certificate is granted, the decision shall be  
24 based on the overall health needs of qualifying patients and the safety of the public. The department  
25 shall evaluate applications for alternative treatment center registration certificates using an  
26 impartial and numerically scored competitive bidding process developed by the department in  
27 accordance with this chapter. The department shall require applicants to meet a minimum score to  
28 be considered. The registration considerations shall include the following criteria:

29 (1) The suitability of the proposed location or locations, including compliance with  
30 any local zoning laws and geographic convenience to patients from throughout the state of New  
31 Hampshire to alternative treatment centers if the applicant were approved.

32 (2) The proposed alternative treatment center's plan for operations and services,  
33 whether it has sufficient capital to operate, and ability to provide a steady supply of cannabis to the  
34 qualifying patients in the state.

35 (3) The principal officer and board members' character and relevant experience,  
36 including any training or professional licensing related to medicine, pharmaceuticals, natural  
37 treatments, botany, or cannabis cultivation and preparation and their experience running a non-



profit organization or business.

(4) The applicant's plan for making cannabis available on an affordable basis to qualifying patients enrolled in Medicaid or receiving Supplemental Security Income or Social Security Disability Insurance.

(5) The applicant's plan for safe and accurate packaging and labeling of cannabis, including the applicant's plan for ensuring that all cannabis is free of contaminants.

(6) The sufficiency of the applicant's plans for record keeping and inventory control. Records shall be considered confidential health care information under New Hampshire law and shall be deemed protected health care information for purposes of the federal Health Insurance Portability and Accountability Act of 1996, as amended. Any dispensing records that an alternative treatment center is required to keep shall document transactions according to qualifying patients' and designated caregivers' registry identification numbers, rather than their names, to protect their confidentiality.

(7) The sufficiency of the applicant's plans for safety and security, including proposed location and security devices employed.

(8) Whether the entity possesses or has the right to use sufficient land, buildings, and equipment to properly carry out its duties as an alternative treatment center.

VI. After an alternative treatment center is approved, but before it begins operations, it shall submit the registration and regulation fee paid to the department in accordance with the rules adopted by the department.

VII. Information required to be submitted to the department on an application for an alternative treatment center identifying the locations where cannabis is proposed to be grown, cultivated, harvested, and otherwise prepared for distribution to qualifying patients, designated caregivers, and alternative treatment centers, and any other department records identifying such location, shall be considered to be confidential information and not subject to disclosure pursuant to RSA 91-A, except that:

(a) Such information may be disclosed to a law enforcement agency upon request for purposes of enforcement under this chapter;

(b) The location may be disclosed to towns and cities when seeking input on locations, provided that town and city representatives keep the information confidential; and

(c) The name, address, and phone number of alternative treatment centers may be disclosed to qualifying patients.

VIII. The alternative treatment center's certificate may be revoked at any time it commits a violation of this chapter or rules adopted by the department, including if it negligently or knowingly allows cannabis to be distributed to someone who is not exempt from penalties pursuant to this chapter.

IX. Not more than one year after an alternative treatment center receives its first registry



1 certificate, an alternative treatment center shall pay a fee in an amount determined by the  
2 department.

3 X. Not more than one year after an alternative treatment center receives its first registry  
4 certificate, the department shall evaluate an alternative treatment center's operations. A  
5 registration certificate may be revoked if the alternative treatment center:

6 (a) Committed violations of this act or department rules; or

7 (b) Is not operational.

8 XI. Alternative treatment centers shall be subject to inspection by the department. During  
9 an inspection, the department may review the alternative treatment center's records, including its  
10 confidential dispensing records, which shall track transactions according to qualifying patients'  
11 registry identification numbers to protect their confidentiality.

12 126-W:8 Alternative Treatment Centers; Requirements.

13 I. An alternative treatment center shall be operated on a not-for-profit basis for the benefit  
14 of its patients. An alternative treatment center need not be recognized as a tax-exempt organization  
15 by the Internal Revenue Service.

16 II. An alternative treatment center shall not be located in a residential district or within  
17 1,000 feet of the property line of a pre-existing public or private elementary or secondary school.

18 III. An alternative treatment center shall implement appropriate security measures to deter  
19 and prevent the unauthorized entrance into areas containing cannabis and the theft of cannabis and  
20 shall ensure that each location has an operational security alarm system.

21 IV.(a) An alternative treatment center shall conduct a state and federal criminal records  
22 check for every person seeking to become a principal officer, board member, agent, volunteer, or  
23 employee before the person begins working at the alternative treatment center. An alternative  
24 treatment center shall not allow any person to be an alternative treatment center agent who:

25 (1) Was convicted of a felony or any drug-related offense; or

26 (2) Is under 21 years of age.

27 (b) An alternative treatment center shall create an identification badge for each  
28 alternative treatment center agent before the alternative treatment center agent possesses,  
29 cultivates, or transports cannabis on behalf of the alternative treatment center. The badges may  
30 include the alternative treatment center's registration certificate number and either a unique  
31 number for each agent or his or her name.

32 (c) An alternative treatment center agent shall wear his or her badge at all times when  
33 working at an alternative treatment center, including at any cultivation location.

34 V. No person who has been convicted of a felony or any drug-related offense shall be an  
35 alternative treatment center agent. A person who is employed by or is an agent, volunteer, principal  
36 officer, or board member of an alternative treatment center who violates this paragraph shall be  
37 guilty of a violation punishable by a fine of up to \$1,000. A subsequent violation of this paragraph



1 shall be a misdemeanor.

2 VI. The operating documents of an alternative treatment center shall include procedures for  
3 the oversight of the alternative treatment center and procedures to ensure accurate record keeping.

4 VII. Each alternative treatment center shall keep the following records, in accordance with a  
5 records retention schedule established by the department:

6 (a) Records of the disposal of cannabis that is not distributed by the alternative  
7 treatment center to qualifying patients who have designated the alternative treatment center to  
8 cultivate for them.

9 (b) A record of each transaction, including the amount of cannabis dispensed, the  
10 amount of consideration, and the registry identification number of the qualifying patient, designated  
11 caregiver, or alternative treatment center.

12 VIII. Each alternative treatment center shall:

13 (a) Conduct an initial comprehensive inventory of all cannabis, including usable  
14 cannabis available for dispensing and mature cannabis plants at each authorized location on the  
15 date the alternative treatment center first dispenses cannabis.

16 (b) Conduct a monthly comprehensive inventory of all cannabis, including usable  
17 cannabis available for dispensing, mature cannabis plants, and seedlings at each authorized  
18 location.

19 IX. An alternative treatment center shall submit a department-approved incident report  
20 form on the next business day after it discovers a reportable incident. The report shall indicate the  
21 nature of the breach and the corrective actions taken by the alternative treatment center.  
22 Reportable incident shall mean:

23 (a) Confidential information accessed or disclosed in violation of department rules;

24 (b) Loss of inventory by theft or diversion;

25 (c) Unauthorized intrusion into the alternative treatment center or the additional  
26 location, if any;

27 (d) Any known violation of this chapter or department rules by an alternative treatment  
28 center agent; or

29 (e) Any other incident that the department by rule requires to be reported.

30 X. Alternative treatment centers shall not use pesticides in cannabis.

31 XI. No cannabis or paraphernalia at an alternative treatment center shall be visible from  
32 outside the property of the alternative treatment center.

33 XII. An alternative treatment center shall submit an annual report to the department that  
34 shall provide information required by the department in order to allow the department to evaluate  
35 the effectiveness and operations of the alternative treatment center.

36 XIII.(a) Each time an alternative treatment center agent dispenses cannabis to a qualifying  
37 patient directly or through the qualifying patient's designated caregiver, he or she shall consult the



1 alternative treatment center's records to verify that the records do not indicate that the dispensing of  
2 the cannabis would cause the qualifying patient to receive more cannabis than is permitted in a 10-  
3 day period. Each time cannabis is dispensed, the alternative treatment center agent shall record the  
4 date the cannabis was dispensed and the amount dispensed. All records shall be kept according to  
5 the registry identification number of the qualifying patient and designated caregiver, if any.

6 (b) Except as provided in subparagraph (c), a qualifying patient shall not obtain more  
7 than 2 ounces of usable cannabis directly or through the qualifying patient's designated caregiver  
8 during a 10-day period.

9 (c) After providing an opportunity for patients, experts, researchers, and physicians to be  
10 heard, the department may issue a rule adjusting the limit specified in subparagraph (a) to an  
11 amount that is reasonably necessary for a 10-day supply.

12 XIV.(a) Except when transporting cannabis in accordance with subparagraphs (b) or (c), an  
13 alternative treatment center agent shall only possess and manufacture cannabis at the alternative  
14 treatment center location or locations at which the alternative treatment center agents are  
15 employed. Volunteers shall only possess and manufacture cannabis at an alternative treatment  
16 center location. Volunteers shall not dispense cannabis.

17 (b) Distributions of cannabis to a qualifying patient or a designated caregiver for use by  
18 a qualifying patient shall be labeled with a document to identify the alternative treatment center,  
19 the patient's registry number, or the caregiver's number, the amount and form, the time and date of  
20 origin, and destination of the product.

21 (c) An alternative treatment center with an additional growing location shall label the  
22 cannabis that is being moved between the additional growing location and the alternative treatment  
23 center with a document that identifies the alternative treatment center by registry number, the  
24 time, date, origin, and destination of the material being transported, and the amount and form of  
25 cannabis and cannabis material that is being transported. Cannabis shall be transported only by an  
26 alternative treatment center agent who is not a volunteer.

27 XV.(a) An alternative treatment center shall not possess or cultivate cannabis in excess of  
28 the greater of the following quantities:

29 (1)(A) 80 cannabis plants, 160 seedlings, and 80 ounces of usable cannabis, or 6  
30 ounces of usable cannabis per qualifying patient; and

31 (B) Three mature cannabis plants, 12 seedlings, and six ounces for each  
32 qualifying patient who has designated the alternative treatment center to provide him or her with  
33 cannabis for medical use. An alternative treatment center may also possess cannabis seeds, stalks,  
34 and unusable roots.

35 (b) An alternative treatment center may possess cannabis seeds, stalks, and unusable  
36 roots.

37 (c) An alternative treatment center or alternative treatment center agent shall not



dispense, deliver, or otherwise transfer cannabis to a person other than:

(1) A qualifying patient who has designated the relevant alternative treatment center; or

(2) Such patient's designated caregiver.

(d) All cultivation of cannabis shall take place in an enclosed, locked facility registered with the department and which can only be accessed by alternative treatment center agents.

XVI.(a) All cannabis dispensed by an alternative treatment center shall include a label specifying the weight of the cannabis and any other information the department requires to appear on the label. The label shall also specify that the cannabis is for therapeutic use and that diversion is a class B felony requiring revocation of one's registry identification card.

(b) An alternative treatment center shall provide educational materials about cannabis to qualifying patients and their registered primary caregivers. Each alternative treatment center shall have an adequate supply of up-to-date educational material available for distribution. Educational materials shall be available for inspection by the department upon request. The educational material shall at least include information about the following:

(1) Strains of cannabis, routes of administration, and their different effects. Alternative treatment centers shall have educational materials available to assist in the selection of prepared cannabis. Alternative treatment centers shall provide tracking sheets to qualifying patients and registered primary caregivers who request them to keep track of the strains used and their effects.

(2) How to achieve proper dosage for different modes of administration. Emphasis shall be on using the smallest amount possible to achieve the desired effect. The impact of potency shall also be explained.

(3) Information on tolerance, dependence, and withdrawal shall be provided.

(4) Information regarding substance abuse signs and symptoms shall be available, as well as referral information.

(5) Information on whether the alternative treatment center's cannabis and associated products meet organic certification standards.

(6) Information about possible side effects from the use of cannabis for medical purposes.

XVII.(a) Each alternative treatment center shall develop, implement, and maintain on the premises employee and agent policies and procedures to address the following requirements:

(1) A job description or employment contract developed for all employees and a volunteer agreement for all volunteers, which includes duties, authority, responsibilities, qualifications, and supervision.

(2) Training in and adherence to confidentiality laws.

(3) The proper use of security measures and controls that have been adopted.





(4) Specific procedural instructions on how to respond to an emergency.

(b) All alternative treatment centers shall prepare training documentation for each employee and have employees sign a statement indicating the date, time, and place the employee received said training and topics discussed, to include name and title of presenters. The alternative treatment center shall maintain documentation of an employee's and a volunteer's training for a period of at least 6 months after termination of an employee's period of employment or the volunteer's period of voluntary service.

(c) Each alternative treatment center shall maintain a personnel record for each alternative treatment center agent that includes an application for employment or to volunteer and a record of any disciplinary action taken.

XVIII. A provider shall not:

(a) Accept, solicit, or offer any form of pecuniary remuneration from or to an alternative treatment center, except if the provider is employed by an alternative treatment center.

(b) Offer a discount or other thing of value to a patient who uses or agrees to use a particular alternative treatment center.

(c) Examine a patient in relation to issuing a written certification at a location where cannabis is sold or distributed.

(d) Hold an economic interest in an alternative treatment center if the provider issues written certifications to patients.

126-W:9 Therapeutic Use of Cannabis Advisory Council.

I. There is hereby established a therapeutic use of cannabis advisory council comprised of:

(a) Two members of the house of representatives, appointed by the speaker of the house of representatives.

(b) One member of the senate, appointed by the senate president.

(c) The commissioner of the department of health and human services, or designee.

(d) The commissioner of the department of safety, or designee.

(e) The attorney general, or designee.

(f) One physician with experience in therapeutic use of cannabis issues, appointed by the New Hampshire Medical Society.

(g) One nurse practitioner, appointed by the New Hampshire Nurse Practitioner Association.

(h) One representative of a community hospital, appointed by the governor.

(i) One representative of the New Hampshire Civil Liberties Union.

(j) One qualifying patient, appointed by the governor.

(k) One member of the public, appointed by the governor.

(l) One member from a hospital in New Hampshire, appointed by the governor.

(m) One member from the board of medicine, appointed by the executive director of the



1 board of medicine.

2 (n) One member from the board of nursing, appointed by the executive director of the  
3 board of nursing.

4 II. The advisory council shall:

5 (a) Assist the department in adopting and revising rules to implement this chapter.

6 (b) Collect information, including:

7 (1) Satisfaction of qualifying patients with the therapeutic use of cannabis program.

8 (2) Any effect the therapeutic use of cannabis law has had on referrals to regulatory  
9 boards.

10 (3) Best practices in other states that allow the therapeutic use of cannabis.

11 (4) The ability of qualifying patients in all areas of the state to obtain timely access  
12 to high-quality cannabis.

13 (5) Any research studies regarding health effects of cannabis for patients.

14 (6) The effectiveness of New Hampshire's therapeutic use of cannabis program.

15 (7) Efforts to educate New Hampshire physicians about research relating to the  
16 therapeutic use of cannabis.

17 (8) The effectiveness of alternative treatment centers, individually and collectively,  
18 in serving the needs of qualifying patients, including the provision of educational and support  
19 services, the reasonableness of their fees, whether they are generating any complaints or security  
20 problems, and the sufficiency of the number operating to serve the registered qualifying patients of  
21 New Hampshire.

22 (9) The sufficiency of the regulatory and security safeguards contained in this  
23 chapter and adopted by the department to ensure that access to and use of cannabis cultivated is  
24 provided only to persons authorized for such purposes.

25 (10) Any illegal distribution or diversion of cannabis cultivated pursuant to this  
26 chapter to individuals who are not alternative treatment center agents, qualifying patients, visiting  
27 qualifying patients, or designated caregivers.

28 (c) Make recommendations to the legislature and the department for any additions or  
29 revisions to the department rules or this chapter.

30 (d) Five years after the effective date of this chapter, issue a formal opinion on whether  
31 the program should be continued or repealed.

32 III. The advisory council may meet as often as is necessary to effectuate its goals. The first  
33 meeting shall be called by the commissioner of the department of health and human services, or  
34 designee within 45 days of the effective date of this chapter. At the first meeting, a chairman shall  
35 be elected by the members.

36 IV. On or before January 1 of each year, the advisory council shall provide a report to the  
37 department of health and human services and the health and human services oversight committee



1 established under RSA 126-A:13 on its findings.

2 126-W:10 Annual Report. The commissioner of the department of health and human services  
3 shall report annually on the therapeutic use of cannabis program established under this chapter to  
4 the health and human services oversight committee established under RSA 126-A:13. The initial  
5 report shall be filed with the chairman of the committee no later than December 1, 2014. The  
6 commissioner's report shall include the following information:

7 I. The number of designated caregivers and the number of qualifying patients, by county.

8 II. Any other issues related to the implementation of the therapeutic use of cannabis  
9 permitted under this chapter that the committee shall request.

10 III. A summary of the report submitted by alternative treatment centers as required under  
11 RSA 126-W:8, XII.

12 126-W:11 Registry Identification Card and Certificate Fund. There is hereby established in the  
13 office of the state treasurer a fund to be known as the registry identification card and certificate fund  
14 which shall be kept separate and distinct from all other funds. The fund is established to pay for the  
15 operational expenses of permitting the therapeutic use of cannabis as established in this chapter.  
16 The moneys in this fund shall be nonlapsing and continually appropriated to the department.  
17 Interest on fund balances shall accrue to the fund. All fines and other income received by the  
18 department and all monetary fees, gifts, grants, and donations received by the department pursuant  
19 to this chapter shall be deposited in the fund.

20 2 New Subparagraph; Application of Receipts; Registry Identification Card and Certificate  
21 Fund. Amend RSA 6:12, I(b) by inserting after subparagraph (310) the following new subparagraph:

22 (311) Moneys deposited in the registry identification card and certificate fund  
23 established in RSA 126-W:11.

24 3 New Paragraph; Controlled Drug Act; Acts Prohibited. Amend RSA 318-B:2 by inserting after  
25 paragraph I-a the following new paragraph:

26 I-b. It shall be unlawful for a qualifying patient or designated caregiver as defined under  
27 RSA 126-W:1 to sell cannabis to another person who is not a qualifying patient or designated  
28 caregiver. A conviction for the sale of cannabis to a person who is not a qualifying patient or  
29 designated caregiver shall not preclude or limit a prosecution or conviction of any person for sale of  
30 cannabis or any other offense defined in this chapter.

31 4 New Paragraph; Controlled Drug Act; Penalties. Amend RSA 318-B:26 by inserting after  
32 paragraph IX the following new paragraph:

33 IX-a. A qualifying patient or designated caregiver as defined in RSA 126-W:1 who is  
34 convicted of selling cannabis to a person who is not a qualifying patient or designated caregiver shall  
35 be guilty of a class B felony and shall be sentenced to a maximum term of imprisonment of not more  
36 than 7 years, a fine of not more than \$300,000, or both.

37 5 Effective Date. This act shall take effect upon its passage.



2013-0797h

AMENDED ANALYSIS

This bill authorizes the use of therapeutic cannabis in New Hampshire.

# Speakers

10:00 A.M.

## SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # H 13573-FNDate February 21, 2013Committee Health, Human Services and Elderly

\*\* Please Print All Information \*\*

Name	Address	Phone	Representing	(check one)	
				Pro	Con
<del>Richard Kearns</del>	<del>Carroll County 2</del>	<del>603-284-6433</del>	<del>self</del>	<del>X</del>	
RICHARD KEARNS				X	
Rep. Syndi White	Carroll County 2			X	
JOHN ENCARNACAO		NHSP-DOS			X
Quynh M. Merritt				X	
DONALD "TED" WRIGHT	CARROLL CTY 2			X	
Bill McManus	Wear	529-4446	self	✓	
Francis Paine		603-284-6433	self	✓	
Tym Rourke		603-305-8013	GO self		✓
Rep. Dyane E. Dyer	Hills 28			X	
John Wolczko	Westmoreland NH			X	
Jean Bastek	Manchester NH			✓	
Kristine Brooks	Northwood, NH			✓	
Kari DePhillips	LINCOLN, NH			X	
Mark Edgington	Westmoreland, NH			X	
Dr. Michael Elzy	Derry NH		self	X	
Kirk MacNeil	Derry NH		NH Compassion	X	
Dennis A. A. A.	Fremont			✓	
William Buchanan	Concord NH		self		
Chas. F. F.	Keene		Chesha 16	X	
Angela Harris	Manchester			X	
Caitlin Appell	Manchester			X	
Rep. Patricia Lovejoy	Stratham			X	

# Relatório marijuana for medicinal purposes

## SIGN UP SHEET

## To Register Opinion If Not Speaking

Bill # HB 573-FN Date 2-21-13

Committee Health, Human Services & Elderly Affairs

**\*\* Please Print All Information \*\***

[illegible]

# Hearing Minutes



**HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS**

**PUBLIC HEARING ON HB 573-FN**

**BILL TITLE:** relative to the use of marijuana for medicinal purposes.

**DATE:** February 21, 2013

**LOB ROOM:** 205      **Time Public Hearing Called to Order:** 10:05 a.m.

**Time Adjourned:** 2:00 p.m.

(please circle if present)

**Committee Members:** Reps. J. MacKay, Harding, M. MacKay, French, J. Tilton, Sherman, Andrews-Ahern, Helmstetter, Ticehurst, Jane Hunt, DiMartino, McMahon, B. Nelson, S. Schmidt, Emerson, Meaney, Lebrun, Culbert, Martel and Kotowski.

**Bill Sponsors:** Rep. Schlachman, Rock 18; Rep. Vaillancourt, Hills 15; Rep. Robertson, Ches 6; Rep. Wright, Carr 8; Rep. Renzullo, Hills 37; Rep. LeBruan, Hills 32; Rep. DeSimone, Rock 14; Rep. Kidder, Merr 5; Rep. Gale, Hills 28; Rep. Lovejoy, Rock 36; Sen Woodburn, Dist 1; Sen. Reagan, Dist 17; Sen Fuller Clark, Dist 21; Sen. Cataldo, Dist 6

**TESTIMONY**

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

**\*Rep. Schlachman - Prime sponsor. Supports the bill. Lets not hold patients hostage because of the problems with other drugs. This bill has been tightened up from past ones.**

**\*Sen. Reagan - Supports bill. Went to Maine to see how the dispensaries' work. Was very pleased with how the dispensaries ran. Employees at these dispensaries go through an education program. This education program will be part of the New Hampshire dispensaries. Studies show that the use of cannabis with people with anxiety lower the use of alcohol and suicide. He supports the amendment.**

**\*Seddon Savage, MD - Opposes HB 573. She is with the N. H. Medical Society. She feels Medical Marijuana is not safe. Marijuana is not a medicine, it is a herb.**

**John Williams and Michael Holt with the Department of Health and Human Services. They are here to provide information. No mention to how fees will be set. How will the fees cover the cost of this? Some technical issues that need to be worked on with this bill.**

**Timothy Rourke is with the Commission on Alcohol. He is here as himself. He opposes HB 573. His son has/had cancer. Timothy has seen lots of pain and suffrage. His son received pain management from his doctors. If we are going to make marijuana a medicine, lets just do it. The FDA has to make and get this medicine approved.**

**Rep. Ted Wright - Supports HB 573. Wife has cancer. He wants the grow piece in this bill.**

**HB 573 (New Title) relative to the use of cannabis for therapeutic purposes.**

**Page Two**

**Richard Crate Chief of Police from Enfield. He is here for NH Police Chiefs. He opposes HB 573. He brought documents \*by Herbert D. Kleber and & the document Cannabinoid Pharmacology and Clinical Promise from Dartmouth- Hitchcock. He states that the rate of marijuana use is up among the youth.**

**Clayton Holton from Rochester has MDS. He is 27 years old. He supports HB 573. Muscular Dystrophy causes wasting syndrome. He has a hard time with keeping his weight on. His condition is getting worse; this will be his last time here because he is so sick. He is in a great deal of pain. Marijuana gives him a better quality of life. Weight gain is a side effect and has helped him. This bill is so much tighter then the past bills.**

**\*Evalyn Merrick from Lancaster. She supports HB 573. She is a former State Representative. She has sponsored a form of this bill when she was a State Representative. Many cannot wait for the FDA to approve this. She hopes this will be the final chapter of the long journey around marijuana for medicinal purposes. This bill is long overdue.**

**\*Elizabeth Woodcock from the NH Attorney General Office. She is the Assistant Attorney General. She opposes HB 573. New Hampshire does have an addiction problem. This bill may interfere with Federal Laws. She is worried about the quality of marijuana from other states. She feels is could cause a problem with inmates. This bill does not let Medical Marijuana in prisons. Lawsuits could come about. It will put New Hampshire on conflict with Federal Law.**

**Richard Kearns - Supports HB 573. Is a former Rhode Island State Representative. 1937 the Federal Government outlawed marijuana.**

**\*Lieutenant John Encarnacao from the Department of Safety/ NH State Police. Opposes HB 573. Marijuana possession would still be illegal under the Federal law even if this passes. This bill clearly sends the wrong message.**

**Kaitlyn Hutchins and Nick Piscitello from Dover High School. They are with Youth to Youth. They are opposed to HB 573. They want to be strictly regulated.**

**Susan Bruce from Dunbarton supports HB 573. We treat our dying pets better then we treat humans.**

**HB 573 (New Title) relative to the use of cannabis for therapeutic purposes.**

**Page Three**

**Theresa Earle from Henniker Supports HB 573. She has PTSD and feels better when she uses marijuana.**

**\*Francis Paine - Has a chronic pain condition. He supports HB 573.**

**\*Matt Simon from the Marijuana Policy Project - Supports HB 573.**

**\*Kirk McNiel from NH Compassion. They have been advocating for Medical Marijuana. He asks that we study this review materials and feels it should pass.**

**Dennis Acton - Supports HB 573. He feels that there will be a Strong Patient Advocacy Group - who will self police and want to make sure HB 573 passes, works and continues.**

**Darlene Wilson - Supports HB 573. She is sick and could benefit medicinal marijuana.**

**Holly Whittaker from Henniker - Supports HB 573. She grew up in Hudson, New Hampshire. She came with her Service Dog "Rocky". She has pain throughout her body. If she uses marijuana the pain ends, she sleeps better and reduces stress.**

**Devon Chaffee from New Hampshire Civil Liberties Union - Supports HB 573. This is year, the time to act now. Eighteen states have Medical marijuana. This is a State issue. These patients are counting on you.**

**Angela Harris from Manchester - Supports HB 573. She is a Nurse, a hospice nurse for the past seven years.**

**SUBCOMMITTEE: Rep. Schmidt, E. Andrews-Ahearn, LeBrun and Rep. Emerson.**

**Respectfully Submitted:**

A handwritten signature in black ink, appearing to read "Lisa DiMartino". The signature is fluid and cursive, with a large initial "L" and "D".

**Rep. Lisa DiMartino, Clerk**

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 573-FN

BILL TITLE: relative to the use of marijuana for medicinal purposes.

DATE: Feb 21, 2013

LOB ROOM: 205

Time Public Hearing Called to Order: 10:05

Time Adjourned: 2:00

(please circle if present)

Committee Members: Reps. J. MacKay, (Harding, Donovan, French, J. Pilton, Sherman, Andrews-Ahern, Helmstetter, Ticehurst, Jane Hunt, DiMartino, McMahon, B. Nelson, S. Schmidt, Emerson, Meaney, Lebrun, Culbert, Martel and Kotowski.

Bill Sponsors: Rep. Schlachman, Rock 18; Rep. Vaillancourt, Hills 15; Rep. Robertson, Ches 6; Rep. Wright, Carr 8; Rep. Renzullo, Hills 37; Rep. LeBruan, Hills 32; Rep. DeSimone, Rock 14; Rep. Kidder, Merr 5; Rep. Gale, Hills 28; Rep. Lovejoy, Rock 36; Sen Woodburn, Dist 1; Sen. Reagan, Dist 17; Sen Fuller Clark, Dist 21; Sen. Cataldo, Dist 6

TESTIMONY

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

\* Rep Schlachman prime sponsor supports the bill - Lets not hold patients hostage because of the problems with other drugs. This bill has been tighten up from past ones.

\* Sen Reagan supports bill - went to Maine to see how the dispensaries work. was very pleased with how the dispensaries ran. Employees at these dispensaries go thru an education program. This education program will be ~~part~~ <sup>up to</sup> 100% of the NH dispensaries. studies show that the use of cannabis with people with anxiety

lowers the use of alcohol and suicide  
He supports the amendment

X Seddon Savage MD opposes HB573  
She is with the NH Medical Society.  
She feels Medical Marijuana is not safe.  
Marijuana is not a medicine, it is  
a herb

John Williams + Michael Holt with  
the Dept of Health + Human  
services. They are here to  
provide information.  
~~How is the~~ no mention so how fees  
~~will~~ will be set. How will  
the fees cover the cost of  
this? Some technical issues  
that need to be worked on with  
this bill

Timothy Runke is with the comm.  
on alcohol. He is here as himself  
He opposes HB573. His son  
has/had cancer. ~~He~~ Timothy has  
seen lots of pain & suffering.  
His son received pain management  
from his doctors. If we are going  
to make marijuana a medicine  
let's just do it. The FDA has  
to make this medicine  
approve.

(2)

HB 573

Rep Ted Wright supports HB 573  
wife has cancer. ~~He~~ wants  
the grow ~~of the~~ price in  
this bill.

Richard Crate Chief of police  
from Enfield. He is here for  
NH Police Chiefs. He opposes  
HB 573 he brought documents  
by Herbert D. Kleber +  
the ~~document~~ document Cannabineid  
Pharmacology + Clinical Promise  
from Dartmouth - Hitchcock.  
He states that the rate of  
marijuana use is up among  
the youth.

Clayton Walton from Rochester  
has MDS he is 27 years  
old. He supports HB 573  
Muscular Dystrophy ~~causes~~  
causes wasting syndrome.  
He has a hard time with keeping  
his weight on. His condition  
is getting worse, this will  
be his last time he because  
he is so sick. He is in a  
great deal of pain. Marijuana

3

gives him a better quality of life. Weight gain is a side effect and has helped him. This bill is so much tighter than the past bills.

~~XX~~ Evelyn Merrick from Lancaster. She supports HB 573. She is a former State Rep. She has sponsored a form of this bill when she was a State Rep.

Mary cannot wait for the FDA to approve this. She ~~hopes~~ <sup>hopes</sup> this will be the final chapter of the long journey around Maryland for medicinal purposes. This bill is long overdue.

~~XX~~ Elizabeth Woodcock from the NH Attorney General Office. She is the Assistant AG. She opposes HB 573. NH does have an addiction problem. This bill may interfere with federal laws. She is worried about the quality of marijuana from other states.

(4)

she

feels it could cause a problem with inmates. This bill does not let Medical Marijuana in prisons. Lawsuits could come about. It will put NH in conflict with federal law.

Richard Kearns Supports HB 573 is a former RI State Rep. 1937 ~~the~~ the Federal gov't outlawed marijuana.

\* Lieutenant John Encarnaco from the Dept of Safety / NH State Police opposes HB 573. Marijuana possession would still be illegal under the Federal law even if this passes. This bill clearly sends the wrong message.

Kathlyn Nutelin & Nick Piscitello from Dover High School they are with Youth to Youth. They <sup>are</sup> opposed to HB 573. They want to be strictly regulated.



5

Susan Bruce from Dunbarton supports HB 573. We treat our ~~dear~~ diving Pets better than we treat humans.

Theresa Earle supports HB 573 from Newry NH. She has PTSD and feels better when she uses marijuana.

\* Francis Paine - has a Chronic Pain condition. He supports HB 573.

\* Matt Simon from the Marijuana Policy Project supports HB 573.

\* Herb McNeil from NH Compassion. They have been Advocating for <sup>medical</sup> marijuana. He asks that we Study this review materials and feels it should Pass.

Dennis Acton supports HB 573. He feels that there will be a Strong Patient Advocacy group - who will Self Police & want to make sure HB 573 ~~works~~, passes, works continues.

(6)

Darlene Wilson supports HB 573. She is sick and could benefit medicinal marijuana.

Nolly Whittaker from Merrimack supports HB 573. She grew up in Hudson NH. She came her service dog Rocky. She has pain ~~through~~ <sup>through</sup> her body. If she uses Marijuana the pain ends, she sleeps better and reduces stress.

Devon Chaffee - from NH Civil Liberties Union supports HB 573. This is year, the time to act is now. 18 States have Medical marijuana. This is a State issue. These Patients are counting on you.

Angela Harris supports HB 573 from Manchester. She is a Nurse, a Hospice Nurse for the past 7 years.

Sub comm. Schmidt Andrew-Ahearn  
Libman & Emerson

# Sub-Committee Minutes

---

**HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS**

**SUBCOMMITTEE WORK SESSION ON HB 573-FN**

**BILL TITLE:** relative to the use of marijuana for medicinal purposes.

**DATE:** February 28, 2103

**Subcommittee Members:** Reps. Schmidt, LeBrun, Emerson, Cuthbert and MacKay

**Comments and Recommendations:** Discussions with NH Atty. General, NH Med. Associates on elements of bill. Hearing will be continued on March 5, 2013 at 8:30 a.m. In LOB Room 205.

**Amendments:**

Sponsor: Rep. Schlachman

OLS Document #:

Sponsor: Rep.

OLS Document #:

Sponsor: Rep.

OLS Document #:

**Motions:** OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

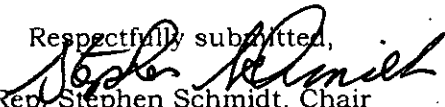
Vote:

**Motions:** OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,  
  
Rep. Stephen Schmidt, Chair  
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

SUBCOMMITTEE WORK SESSION ON HB 573-FN

BILL TITLE: relative to the use of marijuana for medicinal purposes.

DATE: 2-28-13

Subcommittee Members: Reps. Schmidt, Lofgren, Emerson, Cuthbert, Mackay

Comments and Recommendations: DISCUSSIONS WITH NH APPY GEN'L, NH MED ASSO  
on elements of Bill - Nothing will be continued on 3-5-13 @ 8:30AM  
in COR room 205

Amendments:

Sponsor: Rep. Schalmann

OLS Document #:

Sponsor: Rep.

OLS Document #:

Sponsor: Rep.

OLS Document #:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Vote to be on 3-5-13

Seconded by Rep.

Vote:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Stephen Schalmann

Subcommittee Chairman/Clerk

**HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS**

**SUBCOMMITTEE WORK SESSION ON HB 573-FN**

**BILL TITLE:** relative to the use of marijuana for medicinal purposes.

**DATE:** March 5, 2013

**Subcommittee Members:** Reps. Schmidt, LeBrun, Emerson, Ahearn and Culbert

**Comments and Recommendations:** Continuation of Subcommittee hearing.  
Amendment recommendation scheduled for March 6, 2013 at Session Lunch Break.

**Amendments:**

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

**Motions:** OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.


Vote:

**Motions:** OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,  
  
Rep. Stephen Schmidt  
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

SUBCOMMITTEE WORK SESSION ON HB 573-FN

**BILL TITLE:** relative to the use of marijuana for medicinal purposes.

**DATE:** March 5, 2013

**Subcommittee Members:** Reps. Schmidt, Lebrun, Emerson, Ahern  
Culbert

**Comments and Recommendations:** CONTINUATION OF SUB-COMMITTEE WORKING  
Committee recommendation scheduled for 3-6-13

**Amendments:**

Sponsor: Rep.

OLS Document #:

Sponsor: Rep.

OLS Document #:

Sponsor: Rep.

OLS Document #:

**Motions:** OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

**Motions:** OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

  
Respectfully submitted,

Rep.  
Subcommittee Chairman/Clerk

**HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS**

**SUBCOMMITTEE WORK SESSION ON HB 573-FN**

**BILL TITLE:** relative to the use of marijuana for medicinal purposes.

**DATE:** March 6, 2013

**Subcommittee Members:** Reps. Schmidt, LeBrun, Emerson, Ahearn and Culbert

**Comments and Recommendations:**

**Amendments:**

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

**Motions:** OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

**Motions:** OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Stephen Schmidt  
Subcommittee Chairman/Clerk



# Testimony



# State of New Hampshire

DEPARTMENT OF SAFETY  
JAMES H. HAYES BLDG. 33 HAZEN DR.  
CONCORD, N.H. 03305  
603/271-2559

JOHN J. BARTHELMES  
COMMISSIONER OF SAFETY

EARL M. SWEENEY  
ASSISTANT COMMISSIONER

## NH DEPARTMENT OF SAFETY

### LEGISLATIVE POSITION

#### HB 573 Relative to Medicinal Marijuana

#### POSITION: Opposed

Dear Honorable Members of the Committee:

This bill represents a different approach to previous legislative efforts to legalize so-called medical marijuana, but unfortunately it does not alleviate the basic concerns of law enforcement, who must weigh the value of medical marijuana against the potential for abuse and the possible negative consequences for society as a whole.

There are two simple facts that neither this bill or any previous legislative attempts can mitigate:

First, despite what might happen if this bill passes, marijuana possession would still be illegal under federal law. The United States Supreme Court has ruled in *Ashcroft v. Raich* that people who use marijuana for medical purposes can be prosecuted under the federal Controlled Substances Act, even if they are using it pursuant to a doctor's prescription and if such usage is legal under state law. Therefore, this bill creates a situation where a person is allowed to do something under state law that would make him or her a criminal under federal law.

Second, the experience of law enforcement in every state where medical marijuana has been legalized, is that the profit motive is so great, that unethical medical practitioners spring up practically overnight and are quite willing to accept any claim of a qualifying medical condition and in fact, when tested by undercover officers even solicit such claims by suggesting to persons who come to their office looking for prescriptions that they need only tell them they are experiencing some sort of pain and the prescription will be written. This has become a big business in those states and increased the incidence of drug impaired driving and fake claims of medical problems. The state of Montana, which is large in area but has a small population, soon after medical marijuana was legalized there, had a stunning 25,000 car-carrying citizens authorized to possess marijuana. If that was extrapolated to New Hampshire's population we could expect one out of every 33 New Hampshire citizens to possess these cards allowing them to grow and use marijuana. Despite how carefully these bills are written they seem to constitute the first step down a very slippery slope.

Since this law does not restrict medical marijuana to New Hampshire residents but would also allow it to be prescribed for and furnished to non-residents, our state could become a mecca for people seeking the drug. The bill even allows marijuana to be furnished to minor children.

THC, the active ingredient in marijuana, varies greatly from one type of plant and growing condition to another. It is not like FDA-approved medications where a doctor can prescribe a certain dosage level and accurately predict what is or is not a safe dose if the person is going to drive, operate machinery or care for children, for example.

Persons with medical marijuana permits will have the substance in their homes where their teenage sons and daughters may have access to it, pilfer it, and share it with or sell it to friends and acquaintances.

As just one example of the problems with this bill, in RSA 126-V: 2, I, a professional licensing entity such as the Board of Medicine could have problems trying to revoke the license of a doctor who played fast and loose with what does and does not constitute a qualifying medical condition.

Another problem with the bill is that although it requires criminal record checks for caregivers, the wording is in conflict with the provisions of federal law (Public law 92-544) governing access to the FBI's criminal record database for non-criminal justice purposes and the FBI would refuse to make the checks the way the bill is currently worded. It is also unclear who would capture the fingerprint images and whether there is a fee. Finally, there would be additional staffing required in the State Police Criminal Records Unit, which the Legislature requires to be totally self-funding from record fees, to process these requests.

The bill also constitutes a potential interference with the rights of the state's business community because it does not specifically permit a private employer or government agency employer from prohibiting an employee from having the drug at work, only for prohibiting them from being under the influence of it, making this virtually impossible for an employer to enforce. The bill allows a property owner to expel a guest, client, customer or visitor using marijuana from their property but says nothing about an employee. And, although it allows the arrest of anyone who is under the influence of marijuana in a public park, beach, or recreational center it does not allow them to prohibit the possession of the drug at such locations. So, if you see marijuana displayed or changing hands but not being smoked at Ellacoya Beach, Hampton Beach State Park or in your workplace it will be a consequence of this bill as drafted.

We do not believe this bill, or any other bill legalizing medical marijuana, will be ready for "prime time" until such time as Congress acts to permit it under federal law. As it stands, it is an extremely troubling bill that runs the risk of changing the face of New Hampshire, and not for the better, at a time where there are available medically approved, legal synthetic prescription drugs that mimic the pain relieving effects of marijuana.

Position Paper Approved:



Earl M. Sweeney  
Assistant Commissioner

From: Charles Jay Riffenburg III

To: House Committee on Health, Human Services, and Elderly Affairs

I am writing this letter in hopes that you will support the Medical Cannabis Bill - H.B. 573. Recently I attended the Legalize Cannabis bills HB-492 and HB-337 where I testified before the Criminal Justice and Public Safety Committee. During my testimony I explained to them why I am in favor of legalization and why everyone should be in favor of this plant.

I am academically trained as a philosopher and my professional career is in the Natural Products Industry. I am quite familiar with several hundred medicinal herb species. In the past I have managed two separate herb shops in St. Augustine, FL. Today, I work for one of the largest supplement and natural product companies in the U.S. and I continue to study herbs for a living. I am constantly reading the most cutting-edge science that pertains to health, herbs, vitamins, minerals, etc. I am here to tell you that Cannabis is the most useful, important plant in the entire world.

Obviously this bill is focused on the question of Medical Marijuana. No one should still be questioning the fact that marijuana is incredibly useful as a medicine. This is mainline science, from all around the world, proving to us that Marijuana is medicine. Not only is marijuana an excellent nervine (beneficial for the nervous system), it is a powerful antioxidant that we are just beginning to learn about. According to the PDR for Herbal Medicines, Cannabis possesses the following medicinal actions: Anticonvulsive action, Analgesic characteristics, Respiratory (bronchial dilation), Reduces intra-ocular pressure (why it is useful for Glaucoma), Antimicrobial action, and Tumor inhibiting effect among others. It is indeed powerful medicine.

From the entirety of human history we have found evidence of people using Cannabis as medicine in multiple forms. Traditional Chinese Medicine teaches us that the resin of the flowers as well as the seeds have been used for thousands of years, some sources say up to 7,000 years and possibly older. Indian Sadhus smoke Cannabis as part of their meditation and spiritual practices. The recreational use of Cannabis became popular after its initial discovery and application as a medicine. Today Cannabis is happily grown and consumed around the world, despite the horrible failure that is the American War on Drugs.

The plant itself is incredibly useful to humanity, providing an abundant source of fibers and polymers that enables us to build anything from shoes and pants to cars and houses. It also provides us with the nutritionally dense, complete protein hemp seed that is currently used in numerous protein powder supplements in the Natural Products Industry. Hempseed oil can be taken as a nutritional supplement internally, but also externally where it is not only an excellent moisturizer, but it can be used to soften skin, heal wounds, delivering antioxidants through the skin and hastening repair of tissues. It can also be used as healthy cooking oil or for machine oil.

Please do not take seriously the arguments that say Cannabis can cause mental illness. Millions and millions of people around the globe use Cannabis, often daily, and they get along just fine. The real threat to mental health in our society is the overprescribing of pharmaceutical psychiatric medications, especially to children or teenagers. This much is evident with nearly all of school shootings in recent history having featured a common SSRI or MAOI-style pharmaceutical prescription "medicine". These drugs are notorious for inducing violent, bizarre behavior, as well as suicides (our soldiers are now more medicated than ever before and are killing themselves in greater number than ever before). Even worse, it is well known that many of these pharmaceutical drugs are rushed through the approval process and remain on the market for years until they have harmed enough people that they must be recalled. This happens all the time with these so-called medicines. I would encourage you to look at the listed side-effects of these psychiatric medicines and then compare them to the known effects of Cannabis. There has never been a recorded death from Cannabis use ever. Typically, the only problem you will have if you are taking an herbal medicine is if you are combining it with a pharmaceutical drug. Herbal medicines are so much safer than common allopathic medicines that it is no wonder that the Natural Products Industry continues to grow exponentially around the world.

Lastly, everyone has a right to use this plant. The issue fundamentally comes down to individual health freedom. This is as basic of a right as the right to free speech or the right to defend oneself. As independent human beings we have the right to pursue the health care of our choosing. No one can force you to take a medicine that you do not wish to take. We all have the right to use whatever form of medicine we see fit, whether it be pharmaceutical drugs or natural substances. Sometimes it is necessary to use emergency, technological medicines, but for the most part, the body responds best to natural therapies. Please understand that patients who use Cannabis as a medicine are simply doing so because they find that the natural approach is what works best for them. The Law is ideally supposed to protect people's rights and for far too long the rights of patients have been trampled upon. Please do whatever is in your power to make Medical Marijuana a reality in New Hampshire.

In Good Health,

Charles Riffenburg III

P.S. I have enclosed a copy of *Cannabis Distribution Operations*, that was just released last month from the American Herbal Products Association, a highly respected organization in the field of medicinal plant research. This is the draft recommendations on the regulation of distribution (dispensing) of medical marijuana to regulators in three states that allow such practice. If you have not done so already, please examine this document closely and apply it to your understanding of Medical Cannabis. Thank you.

## DOT OFFICE OF DRUG AND ALCOHOL POLICY AND COMPLIANCE NOTICE



Recently, some states passed initiatives to permit use of marijuana for so-called "recreational" purposes.

We have had several inquiries about whether these state initiatives will have an impact upon the Department of Transportation's longstanding regulation about the use of marijuana by safety-sensitive transportation employees – pilots, school bus drivers, truck drivers, train engineers, subway operators, aircraft maintenance personnel, transit fire-armed security personnel, ship captains, and pipeline emergency response personnel, among others.

We want to make it perfectly clear that the state initiatives will have no bearing on the Department of Transportation's regulated drug testing program. The Department of Transportation's Drug and Alcohol Testing Regulation – 49 CFR Part 40 – does not authorize the use of Schedule I drugs, including marijuana, for any reason.

Therefore, Medical Review Officers (MROs) will not verify a drug test as negative based upon learning that the employee used "recreational marijuana" when states have passed "recreational marijuana" initiatives.

We also firmly reiterate that an MRO will not verify a drug test negative based upon information that a physician recommended that the employee use "medical marijuana" when states have passed "medical marijuana" initiatives.

It is important to note that marijuana remains a drug listed in Schedule I of the Controlled Substances Act. It remains unacceptable for any safety-sensitive employee subject to drug testing under the Department of Transportation's drug testing regulations to use marijuana.

We want to assure the traveling public that our transportation system is the safest it can possibly be.

Jim L. Swart  
Director  
Office of the Secretary of Transportation  
Office of Drug and Alcohol Policy and Compliance  
Department of Transportation  
December 3, 2012

**House Bill 573: Use of Marijuana for Medicinal Purposes**  
**Testimony of Elizabeth C. Woodcock, Assistant Attorney General**  
**February 21, 2013**

The Office of the Attorney General opposes this bill.

**1. Law enforcement and safety of the public concerns:**

New Hampshire already has an addiction problem. One out of ten Granite Staters has an addiction issue. Marijuana is involved in 20 percent of the fatal crashes in New Hampshire.

The bill, in effect, recognizes that marijuana should not be widely available. Section 126-W: 5 lists the areas in which it should be prohibited – schools, the work place, public parks. It points out that driving while under the influence will still be illegal and that a person who operates heavy machinery or dangerous equipment shall still be subject to arrest and prosecution.

Although the bill attempts to control the distribution of marijuana to others who would not qualify as patients, those attempts to restrict distribution are undercut by other sections of the bill. For example, Section 126-W: IV(a) (page 4) permits the redistribution of marijuana seeds, seedlings, plants from jurisdictions outside New Hampshire and within New Hampshire itself. The only restriction is that the person(s) distributing the marijuana are “authorized” by their states. But there is no way to determine if the marijuana in a Massachusetts facility was actually grown in an “authorized” facility, or if it was grown in violation of another state’s laws and brought to Massachusetts.

As a result, the efforts at general control will not, in the Office of Attorney General’s view, have the stated effect.

**2. The law does not change the federal prohibition on medical marijuana.**

To the extent that it leads New Hampshire residents into believing that medical marijuana is legal, it misleads them.

Section I, VI states that because states are not required to enforce federal law, “compliance with this act does not put the state of New Hampshire in violation of federal law.” Two points: (1) marijuana remains a schedule I controlled substance under federal criminal law; and (2) in addition to the federal criminal law, there are civil forfeiture laws that allow confiscation of property used in furtherance of trafficking contraband. So, while passing the law may not put the state of New Hampshire “in violation of federal law,” it puts it in contradiction with federal law and the people who attempt to use the provisions of this act will be in violation of federal law.

United States Attorney General Eric Holder has expressed reservations about enforcing federal law against the users of medicinal marijuana, but that is not the federal law, it is simply

the policy of the Department of Justice under this administration. That view could change under a new administration or even with the change of an attorney general.

Indeed, in 2011, there were Drug Enforcement Administration (DEA) raids on marijuana dispensaries in Michigan, Montana, and California.

In 2012, the Internal Revenue Service ruled that dispensaries cannot deduct ordinary business expenses – some of which are listed in this bill as requirements. For example, the dispensaries cannot deduct security expenses as a business expense. The IRS employed Section 280-E in refusing to allow deductions for payroll or rent.

The assurances under Section 126-W: 2, VIII, to physicians in respect to prosecution, for example, are meaningless under federal law.

The statement about probable cause Section 126-W: 3, X (page 10) is not applicable to federal investigations or prosecutions.

The same would be true of Section 126-W: 2, XIII, which states that a law enforcement agent “shall not provide any information to any law enforcement authority that does not recognize the protection of this chapter.” Two points here: (1) the person must “credibly assert”; and (2) the prohibition does not create an exception for federal law enforcement purposes.

Point 1: “credibly asserts.” Who is the determinant of that? Is it the officer, the law enforcement agency, the prosecutor, the court, or even the jury? If the person does not “credibly assert,” has he or she made statements that may be used against him or her in a criminal prosecution?

Point 2: Because marijuana remains illegal under federal law, the statute would put state and local law enforcement at odds with federal law enforcement. It is not clear, for example, whether this law seeks to prevent compliance with a duly authorized federal grand jury subpoena for records or testimony from a law enforcement officer or agency.

Notably, if the restriction does apply to state law enforcement responding federal subpoenas, the bill requires state law enforcement to risk contempt of court. No similar restriction applies to a landlord or an employer who comes across the same information.

Under Section 126-W: 2, V(a) and (c) (page 5), the bill uses the phrase “unless failing [or failure] to do so” would be a violation of federal law. Setting aside the federal criminal and forfeiture laws, as well as the obligations under the federal tax code, there are a number of federal laws that affect federal funding for research grants, highway funding, and federal contracts that have broad prohibitions against drug use and restrict funding on that ground. For example, 41 U.S.C. § 702 requires a drug-free work place for recipients of federal grants.



### **3. The bill raises a number of other concerns.**

Although under Section 126-W: 3, IV(a) (page 4) in-state and out-of-state facilities may redistribute their seeds, plants, etc., there is no provision for quality control if the marijuana is grown out-of-state. As a result, the bill cannot prevent the distribution of adulterated or "laced" marijuana. It cannot even prevent the distribution of counterfeit drugs.

Under Section 126-W: 3, IV, there is a provision for record checks for the agents or caregivers. I did not see any "cause and effect" from those record checks. Will a person who has a felony conviction be allowed to be an agent or a caregiver? This is particularly significant for two reasons: (1) people who have controlled substance convictions might find these centers are an opportunity to continue drug trafficking; and (2) records checks for care givers protect the vulnerable. If the checks are done and there are no restrictions as a result, the checks themselves are ineffective.

Will there be similar record checks for the patients who wish to use the marijuana? For example, will a controlled substance conviction make a patient ineligible? Under Section 126-W: 5, II medicinal marijuana is not allowed in a prison. It is not clear from the legislation if the State of New Hampshire is intended to be immune from lawsuits filed by otherwise eligible patients who happen to be prisoners in our state prisons.

Under 126-W: 3, IX(e) (Page 9), the family of a patient who dies must report the death within 24 hours. There is no penalty associated with the failure to do so and there did not appear to be any other provision in the act that penalized the failure to do so.

# FindLaw<sup>®</sup> FOR LEGAL PROFESSIONALS

## 41 U.S.C. § 702 : US Code - Section 702: Drug-free workplace requirements for Federal grant recipients

### Search 41 U.S.C. § 702 : US Code - Section 702: Drug-free workplace requirements for Federal grant recipients

- [Search by Keyword or Citation](#)

Search

(a) Drug-free workplace requirement

(1) Persons other than individuals

No person, other than an individual, shall receive a grant from any Federal agency unless such person agrees to provide a drug-free workplace by -

(A) publishing a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

(B) establishing a drug-free awareness program to inform employees about -

(i) the dangers of drug abuse in the workplace;

(ii) the grantee's policy of maintaining a drug-free workplace;

(iii) any available drug counseling, rehabilitation, and employee assistance programs; and

(iv) the penalties that may be imposed upon employees for drug abuse violations;

(C) making it a requirement that each employee to be engaged in the performance of such grant be given a copy of the statement required by subparagraph (A);

(D) notifying the employee in the statement required by subparagraph (A), that as a condition of employment in such grant, the employee will -

(i) abide by the terms of the statement; and

(ii) notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no

later than 5 days after such conviction;

(E) notifying the granting agency within 10 days after receiving notice of a conviction under subparagraph (D)(ii) from an employee or otherwise receiving actual notice of such conviction;

(F) imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is so convicted, as required by section 703 of this title; and

(G) making a good faith effort to continue to maintain a drug-free workplace through implementation of subparagraphs (A),

(B), (C), (D), (E), and (F).

## (2) Individuals

No Federal agency shall make a grant to any individual unless such individual agrees as a condition of such grant that the individual will not engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in conducting any activity with such grant.

(b) Suspension, termination, or debarment of grantee

(1) Grounds for suspension, termination, or debarment

Each grant awarded by a Federal agency shall be subject to suspension of payments under the grant or termination of the grant, or both, and the grantee thereunder shall be subject to suspension or debarment, in accordance with the requirements of this section if the agency head of the granting agency or his official designee determines, in writing, that -

(A) the grantee violates the requirements of subparagraph

(A), (B), (C), (D), (E), (F), or (G) of subsection (a)(1) of this section; or

(B) such a number of employees of such grantee have been convicted of violations of criminal drug statutes for violations occurring in the workplace as to indicate that the grantee has failed to make a good faith effort to provide a drug-free workplace as required by subsection (a)(1) of this section.

(2) Conduct of suspension, termination, and debarment proceeding  
A suspension of payments, termination, or suspension or debarment proceeding subject to this subsection shall be conducted in accordance with applicable law, including Executive Order 12549 or any superseding Executive order and any regulations promulgated to implement such law or Executive order

(3) Effect of debarment

Upon issuance of any final decision under this subsection requiring debarment of a grantee, such grantee shall be ineligible for award of any grant from any Federal agency and for

participation in any future grant from any Federal agency for a period specified in the decision, not to exceed 5 years.

[Notes]

« Prev

Drug-free  
workplace  
requirements for  
Federal  
contractors

Up

Drug-free  
workplace

Next »

Employee  
sanctions and  
remedies

Copyright © 2013 FindLaw, a

Thomson Reuters business. All rights reserved.

GOOD MORNING HONORABLE CHAIR AND MEMBERS OF THE HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS COMMITTEE. FOR THE RECORD, MY NAME IS EVALYN MERRICK, FORMERLY A NH STATE REPRESENTATIVE AND 6 YEAR MEMBER OF THIS COMMITTEE! FROM LANCASTER, NH, AND I NO LONGER REPRESENT 9 TOWNS, WHICH I WON'T LIST!

TODAY BEGINS WHAT SO MANY OF US HOPE WILL BE THE FINAL CHAPTER IN CREATING A LAW TO GIVE SAFE, LEGAL ACCESS TO An ALTERNATIVE TREATMENT for disease-stricken patients. Medical marijuana HAS BEEN PROVEN TO BRING COMFORT, AND PAIN RELIEF, AND MINIMIZES SUFFERING FOR SO MANY OF OUR SICKEST AND TERMINALLY ILL CITIZENS.

MANY OF YOU SITTING IN FRONT OF ME HAVE BEEN A PART OF THIS JOURNEY. YOU HAVE WATCHED AND EVEN PARTICIPATED IN THE EVOLUTION OF WHAT BEGAN OVER 6 YEARS AGO. The legislation you have before you, HB 573, is the result of years of trial and error. It is AN EXTRAORDINARILY PRECISE, CLEAR AND TIGHT BILL.

It is A BILL THIS COMMITTEE, THIS LEGISLATURE AND THIS STATE CAN TAKE PRIDE IN. HB 573 IS MORE THOROUGHLY WRITTEN AND VETTED THEN EVER, AND WILL PROVE TO BE THE MODEL

LEGISLATION FOR THIS COUNTRY WHEN IT COMES TO PROVIDING ACCESS TO medical marijuana, A MOST IMPORTANT OPTION TO THE HEALTHCARE REGIMENT OF THOSE PATIENTS IN NEED.

FROM MY EXPERIENCE AND INVOLVEMENT WITH the collaborative EFFORT FOR OVER 6 YEARS, and BEING A CHAMPION AND CO-AUTHOR OF THE ON-GOING work to create this LEGISLATION, I most emphatically believe HB 573 IS FINALLY, EXACTLY WHAT THE DOCTOR ORDERED! REP.

SCHLACHMAN AND HER TEAM continue to work with all of the stakeholders to remove ambiguity and craft a benchmark piece of legislation that ensures clarity and control.

ALTHOUGH I ACKNOWLEDGE THERE ARE POTENTIAL RISKS WITH THE USE OF CANNABIS, SO IT IS TRUE WITH EVERY LEGALIZED DRUG, MEDICINE, OTC REMEDY, and practically every other alternative therapy. I cannot stress enough that THE CONTROLLED USE OF CANNABIS PROVIDES CLEAR AND UNQUESTIONABLE RELIEF FOR MANY PATIENTS, WITHOUT THE SOMETIMES HORRIFIC SIDE EFFECTS OF ACCEPTED PHARMACUTICALS AND EVEN OTCS, WHICH HAVE BEEN PROVEN TO CAUSE DEATH. THIS LEGISLATION PROVIDES regulated USE OF medical marijuana, WITH OVERSIGHT by THE Department of Health and Human Services, CLEAR AND PRECISE

LIMITATIONS, AND THE PROTECTION OF THE LAW FOR ANYONE WHO HAS QUALIFIED AND IS AN REGISTERED PATIENT. Our government does not PROVIDE THE SAME CONTROL FOR MANY MORE DANGEROUS SUBSTANCES.

PASSING HB 573 AND DOING ALL YOU CAN TO MAKE SURE THIS LEGISLATION BECOMES LAW IS critical to improving the lives of so many people you serve. WE OWE IT TO THOSE PEOPLE SITTING AND STANDING IN THIS ROOM, TO EVERY PATIENT WHO IS SUFFERING, DYING OR CONFINED TO A LIFE OF PTSD WITHOUT RELIEF. WE OWE IT TO EVERY CITIZEN OF THIS STATE WHO, YEAR AFTER YEAR, HAS COME TO THIS ROOM, THIS BUILDING, THIS BODY OF GOVERNMENT WHICH REPRESENTS THE WILLINGNESS, COMMITMENT AND DESIRE TO ACT IN THE VERY BEST INTEREST OF its citizens.

PLEASE support the majority of NH citizens and PASS HB 573. IT'S TIME IS Long OVERDUE.

THANK YOU FOR YOUR TIME.

HON. EVALYN MERRICK

*New Hampshire*  
**MEDICAL SOCIETY**

ADVOCATING FOR PHYSICIANS & PUBLIC HEALTH SINCE 1791

**Testimony on Behalf of the New Hampshire Medical Society in Opposition to HB573**

**Seddon R. Savage MD, MS**

*Past President, New Hampshire Medical Society*

*Director, Dartmouth Center on Addiction, Recovery and Education*

*Immediate Past President, American Pain Society*

**Mr. Chairman and Members of the Committee,**

There is no question that herbal marijuana contains potent pharmacologically active substances called "cannabinoids" that can relieve pain, reduce nausea and improve appetite. Two marijuana-derived medications, each containing a different cannabinoid, are approved for medical use in the United States. A third medication containing biologically active cannabinoids more closely mirroring marijuana, is available in Europe and Canada. It is undergoing clinical trials in the United States and is expected to be approved for use soon. The National Institutes of Health and the global pharmaceutical industry are actively engaged in research to better understand natural human cannabinoid systems and to develop safe and effective medications for pain and other indications. This work is promising.

Herbal marijuana historically served a valuable role in healing, before modern medications were available; relieving suffering in circumstances as diverse as complicated childbirths, traumatic injury and terminal diseases. In the context of contemporary health care and pharmaceutical safety standards, however, herbal marijuana cannot appropriately be viewed as a medication.

Drugs approved for medical use in the United States undergo extensive safety and efficacy studies. Production and delivery systems are carefully monitored to assure uniform dosing and freedom from toxic contaminants. After drugs are introduced into clinical practice, post-marketing studies monitor them for unanticipated outcomes and withdraw approval when risks outweigh benefits. Prescription medications are prescribed and monitored by qualified clinicians who consider intended therapeutic actions against potential side effects for individual patients.

Herbal marijuana meets none of these criteria. Dosing of the active cannabinoids in marijuana is unpredictable due to variable levels in raw biologic material, as well as variable delivery systems (smoking, eating, vaporizing, distilling, etc.) and patient factors such as size, gender and metabolic pathways. Combusted marijuana contains numerous cancer-causing and otherwise harmful hydrocarbons and may contain potentially toxic contaminants such as molds or pesticides. Physicians cannot prescribe and safely monitor marijuana use because of the unpredictability of actions of the biologic materials. The actual distribution chain for dispensed marijuana in other states rarely is limited to for whom other interventions haven't worked, but makes marijuana widely available to those who simply want to use marijuana and find a doctor to certify a qualifying condition.



Further, calling marijuana “medical marijuana” or “medicine” suggests that marijuana use is safe. In reality chronic marijuana use is associated with impaired brain development in young people, diverse physical and psychological problems, and poor work and school performance. And, despite common misperceptions that marijuana has a low addiction rate, it is in fact second only to alcohol, as a drug for which individuals seek addiction treatment in the United States.

There are very few patients whose pain or other symptoms cannot be well controlled with thoughtful medical care using medications or procedures currently approved for use in the United States. Numerous barriers exist to adequate pain and symptom management, however, including: lack of access to primary care, inadequate care coordination, limited availability of mental health services, poor reimbursement for care of complex chronic conditions, lack of awareness of available pain treatment options, and misunderstandings regarding the use of controlled substances, among many others.

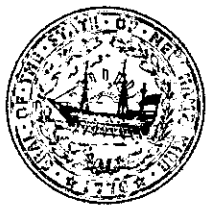
The introduction of “medical marijuana” into New Hampshire as proposed in this bill will not overcome these barriers and improve patient care; rather it will introduce additional public health and administrative challenges that confound care. Rather than advancing herbal marijuana and the many challenges that will inevitably accompany it, further draining New Hampshire’s limited financial, administrative and clinical resources, legislators should work to improve access by all citizens to quality care for complex chronic conditions, including pain.

If legislators believe herbal marijuana is essential to the care of exceptional patients whose pain, nausea, anxiety or other symptoms do not respond to approved, comprehensive medical treatments, we urge you do the following to mitigate the public health risks:

- Frame marijuana as an herbal remedy, not a medical treatment.
- Craft an herbal marijuana distribution system that
  - Reflects the very limited actual clinical need for herbal marijuana
  - State and local law enforcement leaders support because it allows them to prevent diversion without undue strain on their resources.
- Clearly focus the indications for herbal marijuana and require that patients have adequate trials of approved medical interventions, including FDA-approved cannabinoids/marijuana derivatives, prior to qualifying for herbal marijuana.
- Require that all potential users are counseled on the risks of use as stated above.

As written, HB 573 does not appear to be aimed at making herbal marijuana available for rare patients with unmet clinical needs, rather it appears to create an infrastructure for widespread distribution of marijuana. It is not in the interest of the citizens of New Hampshire to pass legislation that is opposed by leaders in the healthcare and law enforcement communities that will be responsible for supporting its implementation.

We urge you to engage with healthcare and law enforcement leaders to consider how we might safely meet any unmet medical needs of patients without creating extensive adverse public health consequences.



# State of New Hampshire

GENERAL COURT

CONCORD

February 21, 2013

Mister Chair and Honorable Members of the House Health, Human Services and Elderly Affairs Committee,

I am pleased to be the Prime Sponsor of **HB 573-FN** to legalize the prescribing of marijuana for medicinal purposes. The amended bill you have before you is detailed in its provisions, which I will review with you this morning. What I want to emphasize is that this bill is the culmination of several years of work by the New Hampshire House and Senate, as well as the result of New Hampshire having the luxury of observing other states' experiences with the legalization of medicinal marijuana. We have learned of some measures that have worked well and areas that we could improve upon. I am confident that the law we pass will be a model for other states that are coming along behind us.

HB573 combines HB422 and SB409, from 2008 and 2010 sessions respectively, in that it has both provision for alternative treatment centers, also called dispensaries, and provisions for patients or their caregivers to grow plants themselves. The bill lays out the parameters for patients being eligible for a card-carrying qualifying patient, and it makes it clear the restrictions of growing and/or possessing marijuana. The prescribing of this medicine, unlike any other prescription drugs, comes with a layer of accountability and restrictions that are tight and clear, as are the penalties for violating any part of this law.

I hope you will join me in supporting HB 573-FN for the sake of the many patients who are waiting for legal access to the only medicine that has successfully treated their diseases and disabilities.

A handwritten signature in cursive script, reading "Donna Schlachman".

Rep. Donna Schlachman  
Vice Chair, Commerce and Consumer Affairs  
Rockingham District #18, Exeter



# ACLU

NEW HAMPSHIRE  
CIVIL LIBERTIES UNION

## NEW HAMPSHIRE CIVIL LIBERTIES UNION

18 Low Avenue  
Concord, New Hampshire 03301  
603-225-3080  
www.NHCLU.org

DEVON CHAFFEE  
EXECUTIVE DIRECTOR

To: Chair James McKay and other members of the Health, Human Services & Elderly Affairs Committee,  
New Hampshire House of Representatives.  
From: Devon Chaffee, Executive Director, New Hampshire Civil Liberties Union  
Date: February 21, 2013  
Re: **In support of House Bill 573 with amendment**

---

Dear Mr. Chair and other members of the Committee:

I submit this testimony on behalf of the New Hampshire Civil Liberties Union (NHCLU)—a non-partisan, nonprofit organization that works to protect civil liberties throughout New Hampshire. NHCLU strongly supports HB 573 with the amendment offered today by Representative Schlachman.

- **HB 573 w/am WILL GIVE THOSE SUFFERING SERIOUS ILLNESSES IN NEW HAMPSHIRE ACCESS TO MEDICAL RELIEF.** In New Hampshire over 8,300 cases of new cancers were diagnosed in 2012<sup>i</sup>, more than 2,300 individuals have been identified as coping with Multiple Sclerosis,<sup>ii</sup> and over 1,700 individuals are living with HIV/AIDs. For some of these patients, currently available medications are ineffective in treating terrible symptoms like pain, muscle spasms, nausea, and wasting—symptoms for which medical marijuana may provide relief. HB 573 w/am would, with a physician's recommendation, provide such patients with the option of accesses such relief without risking arrest or imprisonment.
- **HB 573 IS SUPPORTED BY MEDICAL RESEARCH RECOGNIZING THE THERAPEUTIC VALUE OF MEDICAL MARIJUANA.** In 1999, the congressionally chartered Institute of Medicine (IOM) issued the most comprehensive study of medical marijuana to date finding that the existing data supported the therapeutic value of medical marijuana. The report concluded that, "nausea, appetite loss, pain and anxiety...all can be mitigated by marijuana."<sup>iii</sup> In February 2007, a major study in the journal *Neurology* concluded that AIDS patients suffering from a painful nerve condition in their hands or feet received as much or more relief from smoking marijuana as they would typically get from prescription drugs, though with fewer side effects.<sup>iv</sup>
- **MANY MEDICAL ASSOCIATIONS AND ORGANIZATION SUPPORT MARIJUANA ACCESS FOR MEDICAL PURPOSES.** These organizations include, but are not limited to: the New England Journal of Medicine; The American Public Health Association (APHA); Arthritis Research Campaign; The Lymphoma Foundation of America (LFA); the American Academy of Family Physicians, the American Medical Students Association; The National Association for Public Health Policy; The American Academy of HIV Medicine (AAHIVM); and the American Nurses Association (ANA).
- **A GROWING NUMBER OF STATES THROUGHOUT THE COUNTRY ARE PROTECTING MEDICAL USES OF MARIJUANA.** Under state law, 18 states and Washington, D.C. currently provide legal protection for seriously ill patients whose doctors recommend the medical use of marijuana: Alaska, Arizona, California, Connecticut, Colorado, Delaware, Hawaii, Maine, Massachusetts, Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Washington, and Vermont. Generally, these laws are working well and providing patients with relief and protection from arrest.

It is passed time that New Hampshire take the compassionate and common sense step of allowing suffering individuals to have access to medication that could effectively relieve their suffering and improve their quality of life. I respectfully urge the Committee to vote **ought to pass** on HB 573.



**NEW HAMPSHIRE CIVIL LIBERTIES UNION**

18 Low Avenue

Concord, New Hampshire 03301

603-225-3080

DEVON CHAFFEE

EXECUTIVE DIRECTOR

[www.NHCLU.org](http://www.NHCLU.org)

---

<sup>i</sup> American Cancer Society, Facts and Figures at:

<http://www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-031941.pdf>.

<sup>ii</sup> National Multiple Sclerosis Society, Central New England Chapter at: <http://www.nationalmssociety.org/chapters/mam/take-action/priority-issues/new-hampshire/index.aspx>.

<sup>iii</sup> Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr. Marijuana and Medicine: Assessing the Science Base, Division of Neuroscience and Behavioral Research, Institute of Medicine (Washington, DC: National Academy Press, 1999).

<sup>iv</sup> D.I. Abrams, MD; C.A. Jay, MD; S.B. Shade, MPH; H. Vizoso, RN; H. Reda, BA; S. Press, BS; M.E. Kelly, MPH; M.C. Rowbotham, MD; and K.L. Petersen, MD. "Cannabis in painful HIV-associated sensory neuropathy: A randomized placebo-controlled trial." Journal of Neurology. February 2007. AAN Enterprises, Inc

## **PART [X] – Cannabis distribution operations**

---

<b>Subpart A – General provisions</b> .....	<b>2</b>
<b>Section 1.1 Subject operations</b> .....	<b>2</b>
<b>Section 1.2 Other statutory provisions and regulations</b> .....	<b>2</b>
<b>Section 1.3 Definitions</b> .....	<b>2</b>
<b>Subpart B – Distribution operations</b> .....	<b>4</b>
<b>Section 2.1 Types of distribution operations</b> .....	<b>4</b>
<b>Section 2.2 Ancillary operations</b> .....	<b>4</b>
<b>Section 2.3 Personnel</b> .....	<b>5</b>
<b>Section 2.4 Physical facilities</b> .....	<b>5</b>
<b>Section 2.5 Security</b> .....	<b>6</b>
<b>Subpart C – Cannabis product</b> .....	<b>7</b>
<b>Section 3.1 Subject cannabis products</b> .....	<b>7</b>
<b>Section 3.2 Cannabis product acquisition</b> .....	<b>8</b>
<b>Section 3.3 Cannabis product information</b> .....	<b>9</b>
<b>Section 3.4 Cannabis product recalls</b> .....	<b>10</b>
<b>Subpart D – Compliant individuals</b> .....	<b>10</b>
<b>Section 4.1 Requirements for purchase</b> .....	<b>10</b>
<b>Section 4.2 Purchase limits</b> .....	<b>11</b>
<b>Section 4.3 Personal information</b> .....	<b>11</b>
<b>Section 4.4 Adverse event records</b> .....	<b>11</b>
<b>Section 4.5 Rights and responsibilities of compliant individuals</b> .....	<b>12</b>

## **SUBPART A – GENERAL PROVISIONS**

### **Section 1.1 Subject operations**

- (a) Except as provided by paragraph (b) of this section, any person, group of persons, or business entity that provides cannabis or cannabis-derived product to compliant individuals in the jurisdiction in which this part applies<sup>1</sup> is engaged in a cannabis distribution operation, and is subject to this part.
- (b) A compliant individual who transfers or gives cannabis or cannabis-derived product to another compliant individual at no charge is not a cannabis distribution operation and is not subject to this part.

### **Section 1.2 Other statutory provisions and regulations**

In addition to this part, distribution operations must comply with all other applicable statutory provisions and regulations related to providing cannabis or cannabis-derived product in the jurisdiction in which this part applies, and related to all other business activities undertaken in conducting the distribution operation.

### **Section 1.3 Definitions**

The following definitions apply to this part:

*Cannabis* means any part of a plant in the genus *Cannabis* that is used by a compliant individual, or that is used as an ingredient in manufacturing a cannabis-derived product, and does not mean hemp.

*Cannabis-derived product* means a product, other than cannabis itself, that contains or is derived from cannabis, and does not mean a product that contains or is derived from hemp.

*Compliant individual* means a person who has met all legal requirements to obtain and use cannabis or cannabis-derived product in the jurisdiction where this part applies.

*Co-owned operation* means a cultivation, processing, or manufacturing operation that has the same ownership as a distribution operation.

*Cultivate* means to grow plants in the genus *Cannabis*. A person, group of persons, or business entity that cultivates is a *cultivator*, and a facility where cannabis plants are cultivated is a *cultivation operation*.

*Delivery service* means a distribution operation that delivers cannabis or cannabis-derived product to compliant individuals.

*Direct-from-garden or caregiver operation* means a distribution operation whereby compliant individuals obtain cannabis or cannabis-derived product directly from a cannabis cultivator.

---

<sup>1</sup> This term "in the jurisdiction where this part applies" may be replaced throughout with the name of the specific jurisdiction.

*Distribution operation* means a person, group of persons, or business entity that provides cannabis or cannabis-derived product to compliant individuals, and includes *delivery services, direct-from-garden operations, growing co-ops, and storefront operations.*

*Growing co-op* means a distribution operation that consists of a group of compliant individuals who grow cannabis collectively on property belonging to, leased or rented by, or otherwise authorized for use by the entire group, or by a member of the group, or who cooperatively produce cannabis-derived product for use by members of the group.

*Hemp* means any part of a plant in the genus *Cannabis*, whether growing or not, with a delta-9 tetrahydrocannabinol concentration of not more than 0.3 (three-tenths) percent on a dry weight basis.

*Manufacture* means to make or otherwise produce cannabis-derived product. A person, group of persons, or business entity that manufactures is a *manufacturer*, and a facility where manufacture occurs is a *manufacturing operation*.

*May* is used to indicate an action or activity that is permitted; *may not* is used to indicate an action or activity that is not permitted.

*Must* is used to state a requirement.

*Oral cannabis or edible* means cannabis or cannabis-derived product that is ingested through the mouth and into the digestive system.

*Process* means to inspect, grade, package, label, or otherwise prepare cannabis prior to providing to compliant individuals, and does not mean to manufacture. A person, group of persons, or business entity that processes is a *processor*, and the facility where the described processes occur is a *processing operation*.

*Provide* means to offer for sale or to sell, including by barter, cannabis or cannabis-derived product to compliant individuals.

*Should* is used to state recommended or advisory procedures.

*Smoked cannabis* means cannabis or cannabis-derived product that is burned and inhaled into the lungs.

*Storefront operation* means a distribution operation that provides cannabis or cannabis-derived product to compliant individuals at a physical location.

*Topical cannabis or topical* means a cannabis-derived product intended to be rubbed on the skin and not intended for oral consumption.

*Vaporized cannabis* means cannabis or a cannabis-derived product that is heated to a temperature at which the contained constituents are released into a vapor without combustion of the material.

**FOR DISCUSSION. Prepared for consideration by state or local regulatory agencies in states within the United States.**

*Vendor* means a person, group of persons, or business entity that supplies cannabis or cannabis-derived product to storefront or delivery service distribution operations, and may be either the direct representative of a cultivation, processing, or manufacturing operation, or may function independently of such operations by purchasing cannabis or cannabis-derived product from such operations and reselling it to distribution operations.

## **SUBPART B – DISTRIBUTION OPERATIONS**

### **Section 2.1 Types of distribution operations**

- (a) Except as provided by paragraph (c) of this section, cannabis or cannabis-derived product may be provided by any of the following types of distribution operations, as defined in section 1.3, that are in compliance this part:
- (1) Storefront operations, which may also operate a delivery service operation from the same physical location;
  - (2) Delivery service operations, which may operate either with or without a storefront operation; and
  - (3) Direct-from-garden operations, which may:
    - (i) Operate either with or without a storefront operation; and
    - (ii) Be located either at the same location as cultivation occurs, or at another location.
  - (4) Growing co-op operations.
- (b) Distribution operations may provide:
- (1) Cannabis that is cultivated by:
    - (i) The distribution operation itself;
    - (ii) A co-owned cultivation operation; or
    - (iii) A cultivation operation that is not co-owned, which may be obtained by the distribution operation either:
      - (A) Directly from the cultivation operation; or
      - (B) From a vendor of the cannabis;
  - (2) Cannabis-derived product that is manufactured by:
    - (i) The distribution operation itself;
    - (ii) A co-owned manufacturing operation; or
    - (iii) A manufacturing operation that is not co-owned, which may be obtained by the distribution operation either:
      - (A) Directly from the manufacturing operation; or
      - (B) From a vendor of the cannabis-derived product.
- (c) Notwithstanding paragraph (a) of this section, distribution operations must be in compliance with all other legal requirements in the jurisdiction where this part applies.

### **Section 2.2 Ancillary operations**

- (a) In addition to providing cannabis or cannabis-derived product, a distribution operation described in section 2.1 may also engage in other operations, including:
- (1) Cultivation of cannabis;

**FOR DISCUSSION. Prepared for consideration by state or local regulatory agencies in states within the United States.**



- (2) Processing, packaging and labeling of cannabis;
  - (3) Manufacturing, packaging, and labeling of cannabis-derived product;
  - (4) Laboratory operations; and
  - (5) Sale and marketing of products other than cannabis or cannabis-derived product.
- (b) The ancillary operations identified in section 2.2(a) may be conducted:
- (1) At the same location as providing cannabis or cannabis-derived product, so long as such operations are permitted at this location in the jurisdiction in which this part applies; or
  - (2) At another location at which such operations are permitted in the jurisdiction in which this part applies.
- (c) The ancillary operations identified in section 2.2(a) must be conducted in compliance with all regulations relevant to such operations in the jurisdiction in which this part applies.

### **Section 2.3 Personnel**

- (a) All distribution operation employees must have the education, training, or experience to perform all assigned functions.
- (b) Distribution operations must:
- (1) Provide employees who have any assigned functions that involve providing compliant individuals with cannabis or cannabis-derived product with training that includes:
    - (i) Specific uses of cannabis or a specific cannabis-derived product;
    - (ii) Clinical application of the specific constituents of cannabis;
    - (iii) The laws, regulations, and policies relevant to providing cannabis or cannabis-derived product to compliant individuals in the jurisdiction where this part applies.
  - (2) Provide all employees with training on the U.S. federal laws, regulations, and policies relating to individuals employed in distribution operations, and the implications of these for employees and for compliant individuals; and
- (c) Distribution operations should:
- (1) Provide all employees with training that includes instructions regarding regulatory inspection preparedness and law-enforcement interactions; and
  - (2) Maintain a mechanism for communicating with all employees.
- (d) Storefront operations should be prepared to administer cardiopulmonary resuscitation (CPR) at all times during which the operation is open for business. To do so, the operation should:
- (1) Ensure that one or more employee has received adequate training to be capable of performing CPR;
  - (2) Schedule personnel to ensure that one such CPR-trained employee is on the premises at all times during which the operation is open for business.

### **Section 2.4 Physical facilities**

- (a) Physical facilities of distribution operations must:
- (1) Be operated in adherence with any regulation in the jurisdiction in which this part applies that is relevant to its specific operations, including:

**FOR DISCUSSION. Prepared for consideration by state or local regulatory agencies in states within the United States.**

- (i) Locations and zoning, which can vary depending upon the specific operation or operations undertaken at each facility.
    - (ii) Business hours;
    - (iii) Parking;
    - (iv) Drive-through services; and
    - (v) Signage;
  - (2) Be maintained in a clean and orderly condition;
  - (3) Be equipped with such utensils and equipment as are necessary to conduct all operations, including ancillary operations as described in section 2.2 of this part, that occur at the facility;
  - (4) Implement policies that ensure the privacy of financial transactions; and
  - (5) Have information available to compliant individuals regarding local and federal laws on cannabis possession.
- (b) Physical facilities of distribution operations should:
- (1) Provide and use adequate refrigeration if it stores cannabis-derived product, as needed to ensure the safety of products that require refrigeration and to reduce spoilage;
  - (2) Provide and use a secure area for storage of cannabis or cannabis-derived product in inventory; and
  - (3) Provide and use a secure area to keep money that is needed to be kept at the facility, and remove money from the facility on a regular basis.
- (c) Storefront operations must:
- (1) Maintain Americans with Disabilities Act (ADA) compliance;
  - (2) Establish a policy regarding on-site consumption of cannabis or cannabis-derived product, except that, if a statutory or regulatory requirement exists in the location of the operation with regard to this practice, the operations must comply with such requirement. Any voluntary on-site consumption policy should address:
    - (i) The type or types of consumption allowed (e.g., eating; smoking; vaporizing; or topical application);
    - (ii) A limit on the amount of time that can be spent in on-site consumption if such a time limit is advisable;
    - (iii) A ventilation plan, if needed;
    - (iv) A protocol to prevent and to address a compliant individual who is or becomes over-medicated;
    - (v) Additional issues as needed.

## **Section 2.5 Security**

- (a) Distribution operations must provide any security that is required by regulation<sup>2</sup> for the specific operation and each facility it operates.
- (b) Distribution operations should:
  - (1) Provide additional security as needed and in a manner that reflects the community where it operates, and should include, as necessary:
    - (i) For storefront operations:

---

<sup>2</sup> It may be desirable to state any such regulation in this section.

- (A) In-store security personnel in sufficient number to ensure the safety of staff and served compliant individuals;
  - (B) In-store security cameras; and
  - (C) Monitoring of dedicated parking, if any, either with security personnel or with security cameras.
- (ii) For delivery service operations:
  - (A) Security personnel at the facility where product is acquired, stored, or processed in sufficient number to ensure the safety of staff and security of all cannabis and cannabis-derived product on site.
  - (B) Training for delivery staff to ensure awareness of how to maintain personal and product safety and to provide contact information to police or other emergency personnel.
  - (C) Restriction of deliveries only to a private address and never to a public location.
  - (D) Compliance with local regulations regarding delivery areas and hours of operation.
- (iii) For direct-from-garden and growing co-op operations:
  - (A) Security practices at the growing facility, and at associated locations where cannabis or cannabis-derived product or money are kept or from which money or cannabis or cannabis-derived product is transferred, sufficient to ensure the safety of staff and security of cannabis on site.
- (2) Refrain from arming security personnel, except as allowed and in full compliance with all relevant legal requirements in the jurisdiction in which this part applies; and
- (3) Provide training to make all staff aware of the operation's security procedures, and each individual employee's security roles and responsibilities.
- (c) Distribution operations that are also engaged in cultivation, processing, or manufacturing operations must also comply with all security measures required for such operations, and should also establish and implement any relevant security measures recommended for such operations.

## **SUBPART C – CANNABIS PRODUCT**

### **Section 3.1 Subject cannabis products**

- (a) Distribution operations that are subject to this part may provide cannabis and cannabis-derived product that meet any of the following definitions, as stated in section 1.3, and that are intended to be consumed consistent with these definitions:
  - (1) Smoked cannabis;
  - (2) Vaporized cannabis;
  - (3) Oral cannabis (edibles); and
  - (4) Topical cannabis (topicals).
- (b) Each distribution operation must keep an up-to-date record of the cannabis and cannabis-derived product it provides, including:

**FOR DISCUSSION. Prepared for consideration by state or local regulatory agencies in states within the United States.**

- (1) Identification of the cannabis and cannabis-derived product it provides, as described in section 3.1 (a)(1)-(a)(4);
- (2) Information to indicate whether each cannabis or cannabis-derived product it offers to compliant individuals is provided or produced by a co-owned operation, or from an operation that is not co-owned;
- (3) For cannabis and cannabis-derived product obtained from an operation that is not co-owned:
  - (i) If obtained directly from a cultivation, processing, or manufacturing operation, the identity of the operation; or
  - (ii) If obtained from a vendor, the identity of the vendor;
- (4) Restrictions, if any, on providing any specific cannabis or cannabis-derived product to compliant individuals, such as, for example:
  - (i) Limitations as to employees who may, or who may not, provide the specific cannabis or cannabis-derived product to compliant individuals;
  - (ii) Limitations as to compliant individuals who may, or who may not, obtain the specific cannabis or cannabis-derived product.

### **Section 3.2 Cannabis product acquisition**

- (a) Distribution operations that receive cannabis or cannabis-derived product from one or more cultivation, processing, or manufacturing operation, or from one or more vendor, should establish and implement policies for acquisition of such cannabis or cannabis-derived product, including policies on:
  - (1) Locations for receipt of cannabis or cannabis-derived product;
  - (2) Scheduling of deliveries, which may be made either:
    - (i) By scheduling appointments with specific vendors; or
    - (ii) By establishing open vending times, during which any vendor may make a delivery without a specific appointment.
  - (3) Any policies required of cultivation, processing, or manufacturing operations, or of vendors, if any, with regard to:
    - (i) Cultivation practices;
    - (ii) Processing or manufacturing;
    - (iii) Packaging or labeling;
    - (iv) Chemical analysis; or
    - (v) Transport conditions, such as refrigeration.
  - (5) In establishing and implementing policies to comply with this section 3.2 (a) of this part, distribution operations must ensure that all such policies conform to all relevant legal requirements in the jurisdiction in which this part applies.
- (b) Distribution operations that receive cannabis or cannabis-derived product from one or more cultivation, processing, or manufacturing operations, or from one or more vendor must:
  - (1) Record each receipt of cannabis and cannabis-derived product, such record to include:
    - (i) The name of the cultivation, processing, or manufacturing operation, or of the vendor;
    - (ii) A description of the cannabis or cannabis-derived product of sufficient specificity; and

**FOR DISCUSSION. Prepared for consideration by state or local regulatory agencies in states within the United States.**

- (iii) A statement of the quantity of each cannabis or cannabis-derived product.
- (2) If the operation is a storefront, minimize deliveries at times and in locations where compliant individuals are present, if space allows.
- (3) Inform all cultivation, processing, and manufacturing operations and all vendors of the policies established in compliance with paragraph (a) of this section, and of the requirements set forth in paragraph (b) of this section.

### **Section 3.3 Cannabis product information**

- (a) Information provided by a distribution operation, whether written or verbal, about the identity, quality, and cultivation conditions of cannabis it provides must be accurate.
- (b) A distribution operation must disclose the extent and type of testing it conducts, or causes to have conducted, on the cannabis it provides, including:
  - (1) The type of test or examination used, if any, to determine the particular strain or cultivar of each lot of cannabis provided;
  - (2) Whether or not the cannabis provided is tested to determine the quantitative levels of contained constituents, and if so, the type of testing used;
  - (3) Whether or not the cannabis provided is tested to determine the absence or presence of specific classes of potential contaminants, and if so, the type of testing used. The information required by this paragraph must be disclosed for each of the following:
    - (i) Pesticides;
    - (ii) Yeasts and molds; and
    - (iii) Other microbiological contaminants.
  - (4) The information required to be disclosed by this paragraph must be made available:
    - (i) At each physical facility maintained by a storefront distribution operation, either:
      - (A) With posted and readily visible signage; or
      - (B) With printed handouts that are provided to each compliant individual prior to purchase of any cannabis.
    - (ii) On any website at which cannabis or cannabis-derived products are available for ordering by or sale to compliant individuals, by posting the information so that compliant individuals will see the information prior to ordering and purchasing.
- (c) Information provided by a distribution operation about cannabis-derived product it provides must:
  - (1) Be provided in whatever manner is required in the jurisdiction in which this part applies, whether with labeling or with other markings, or with other written or verbal information;
  - (2) Be accurately conveyed:
    - (i) If manufactured by a co-owned operation, through labeling or other accurate markings or communications, in a manner that complies with all relevant requirements; or
    - (ii) If manufactured by another person or business entity, by providing the information as provided by each product's manufacturer, such that the

distribution operation may not modify the labeling or other information provided by such product's manufacturer.

- (3) In the event that a distribution operation has reason to believe that the information provided by the manufacturer of a cannabis-derived product is not accurate, the distribution operation must seek clarification or correction of any such information.

### **Section 3.4 Cannabis product recalls**

- (a) Each distribution operation must establish a policy for communicating a recall of a cannabis or cannabis-derived product that has been shown to present a reasonable or a remote probability that the use of or exposure to the product will cause serious adverse health consequences, or could cause temporary or medically reversible adverse health consequences. This policy should include:
  - (1) A mechanism to contact all customers who have, or could have, obtained the product from the distribution operation, which communication must include information on the policy for return or destruction of the recalled product;
  - (2) A mechanism to contact the cultivation, processing, or manufacturing operation, or the vendor which supplied the product to the distribution operation; and
  - (3) Communication and outreach via media, as necessary and appropriate.
- (b) Any recalled cannabis or cannabis-derived product that is returned to a distribution operation must either:
  - (1) Be disposed of by the distribution operation in manner that ensures that it cannot be salvaged and will not be used by a compliant individual or by any other person; or
  - (2) Be returned to its cultivator, processor, or manufacturer for such disposal.

## **SUBPART D – COMPLIANT INDIVIDUALS**

### **Section 4.1 Requirements for purchase**

- (a) Distribution operations may provide cannabis or cannabis-derived product only to compliant individuals and may not provide cannabis or cannabis-derived product to any other person.
- (b) If any restrictions exist by statute or regulation in the jurisdiction in which this part applies on the health or medical conditions for which cannabis or cannabis-derived product can be recommended, distribution operations may not recommend use of any cannabis or cannabis-derived product for any other condition.
- (c) Distribution operation employees who have any assigned functions that involve providing compliant individuals with cannabis or cannabis-derived product must be aware of the legal requirements for becoming a compliant individual.
- (d) Distribution operations must make available information on the regulations that apply in the jurisdiction in which this part applies to obtaining and maintaining status as a compliant individual.

**FOR DISCUSSION. Prepared for consideration by state or local regulatory agencies in states within the United States.**

## **Section 4.2 Purchase limits**

(a) Quantitative limitations on the amount of cannabis or cannabis-derived product obtained by a compliant individual in any given timeframe:

- (1) Must be enforced by a distribution operation in conformity with any statutory or regulatory restriction, if any exists in the jurisdiction in which this part applies;
- (2) May be established by a distribution operation in the absence of any statutory or regulatory limitation; and
- (3) Should be clearly communicated to compliant individuals.

## **Section 4.3 Personal information**

(a) Distribution operations should obtain identifying information for each compliant individual to whom cannabis or cannabis-derived product is provided, including:

- (1) The individual's name;
- (2) Contact information of sufficient specificity to serve as a means of contact, such as a phone number, email address, or mailing address;
- (3) A physician of record identified by the compliant individual; and
- (4) Health or medical conditions for which cannabis or cannabis-derived product is used.

(b) All identifying information obtained about any compliant individual must be obtained and stored in compliance the privacy and security rules of the Health Insurance Portability and Accountability Act (HIPPA).<sup>3</sup>

## **Section 4.4 Adverse event records**

(a) Distribution operations should establish a policy for receiving and recording adverse event reports associated with use of the cannabis or cannabis-derived products it provides. Such policy should include:

- (1) Identification of the minimum data elements to record for any adverse event report, which could include:
  - (i) An identifiable individual who is reported to have experienced the adverse event;
  - (ii) An initial reporter, who may be the same as the identifiable individual or another person;
  - (iii) The identity of the specific cannabis or cannabis-derived product used, if known; and
  - (iv) A description of the adverse event.
- (2) A procedure for determining if an adverse event should:
  - (i) Be reported to any public health authority;
  - (ii) Be reported to the physician of record for the compliant individual reported to have experienced the adverse event, if known;
  - (iii) Require a product recall.
- (3) Procedures for communicating the policy to:
  - (i) Employees of the distribution operation with task assignments that require knowledge of the policy; and

---

<sup>3</sup> These can be found at <http://www.hhs.gov/ocr/privacy>.

- (ii) Compliant individuals who are provided with cannabis or cannabis-derived products by the distribution operation.
- (b) For purposes of this section, an adverse event is a health-related event associated with use of cannabis or a cannabis-derived product that is adverse, and that is unexpected or unusual.
- (c) For purposes of this section, an adverse event report recorded under a policy established by a distribution operation may not be construed as an admission or as evidence that the cannabis or cannabis-derived product involved caused or contributed to the adverse event.

#### **Section 4.5 Rights and responsibilities of compliant individuals**

- (a) Each distribution operation should establish a policy that describes the rights and responsibilities of compliant individuals who obtain cannabis or cannabis-derived products from the distribution operation. Such policy should include:
  - (1) How compliant individuals can expect to be treated by employees of the distribution operation;
  - (2) Information that each compliant individual will be required or requested to provide to the distribution operation;
  - (3) A procedure for providing feedback and suggestions, including procedures for communicating commendations and complaints;
  - (4) Contact information for the distribution operation, and for specific employees for a compliant individual to contact;
  - (4) Hours of operation; and
  - (5) The distribution operation's policies related to:
    - (i) Payment for cannabis and cannabis-derived products;
    - (ii) Use of cannabis and cannabis-derived product on the premises;
    - (c) Any other applicable policies.



Medical Marijuana Testimony - H.B. 573 - February 21 at 10 a.m. ET in Rooms 205-207

My name is Angela Harris and I'm a resident of Manchester. I have been a registered nurse for 14 years and a hospice nurse for 9 of those years. As I'm sure most are aware, the philosophy of hospice is to help provide comfort, dignity, and improved quality of life for those with terminal illnesses. A large component of that objective is symptom management, for if the symptoms of a disease aren't managed, patients are deprived of the opportunity to spend their final days enjoying the company of their loved ones and doing those things that bring their lives meaning. Through the course of my career, I have cared for many patients that have used cannabis medicinally, albeit illegally, because their prescribed pharmaceuticals were not sufficiently effective.

One particular case I remember is of a man I will call Pete. Pete was an older gentleman; he had just passed retirement age when he developed pancreatic cancer. His world was turned upside down and this previously independent man found himself having to rely on his children and friends to help him through his day. I met him at his home to explain hospice care to him and to help him determine what services would best suit his needs. Sitting in his modest living room on one of the hottest days of the summer, he informed me that not only was his cancer causing him abdominal pain, but he had no appetite and had lost more than 40 pounds over the previous year. He was often nauseated and vomited almost daily. In addition to that, he had near-constant burning sensations in his hands and feet resulting from his chemotherapy treatments. Pete was frustrated and anxious because, as he said, his medications weren't "worth squat". I asked him if he used any other kinds of treatments to alleviate his symptoms, and he very sheepishly said, "Yes, but I don't want to say." After reassuring him that I was not there to judge or condemn, he admitted to me that his daughter purchased cannabis for him after they both had researched the medicinal benefits; Pete was desperate to find relief although he had never used marijuana before and was unsure what to expect. He reported to me that using cannabis a couple of times per day had helped his pain, appetite, and the burning sensations, and had even helped him be less anxious and fearful about his prognosis. He was able to eat meals with his family without having to leave for the bathroom and could spend time playing with the grandchildren that he would probably leave behind by Christmas. His biggest concern was for his daughter; he was worried that she would be caught purchasing his "medications". He worried about her future and the future of his grandchildren should she be arrested and convicted for the simple act of trying to make her father's last days more comfortable. I developed a bond with Pete during the few hours we spent together, and although I wasn't his regular nurse, I found myself checking in on him from time to time. He was indeed gone by Christmas, but over the three or four months since I met him, Pete was able to enjoy a quality of life that I believe he would not have been able to had he not used cannabis.

Pete's story is just one example of the number of patients I have worked with that used cannabis to help alleviate symptoms. Like Pete, many had never used it before, and nearly all were reluctant to try it because of the potential legal ramifications for them or their loved ones. But every one of them had positive results when using it, whether they took it for pain, nausea, vomiting, anxiety, insomnia, anorexia, cachexia (wasting syndrome), or even seizures. I know I am not alone in my experience, and every hospice worker I have discussed the issue with, regardless of discipline, has been in favor of legalization of medical marijuana because it is a safe and effective remedy. For many patients with chronic and terminal illness, it is their only option to have the quality of life they deserve. I strongly encourage you to support this bill.

Thank you.

From: Kirk McNeil, Executive Director NHCompassion.org

To: House Committee on Health, Human Services, and Elderly Affairs

I am delivering this testimony to ask you to vote "ought to pass" in support of the Medical Cannabis Bill - H.B. 573.

For more than five years, my organization has been pursuing this type of legislation on behalf of patients in NH. In several instances, we have come within one or two votes of overriding a gubernatorial veto on the issue. It is abundantly clear, as you have heard from many people today, that medicinal cannabis is a beneficial option for patients and is a tool that their doctors wish they were able to utilize in this state. These facts are no longer in question. It is only sad that we come to this point after many people who have appeared before the NH legislator in the past have died before seeing this goal become a reality. I urge you to hear their pleas, the requests of their families, the science put forward by researchers, and to your own conscience. Pass this bill.

If after these hearings, you wish further, more detailed information, or would like to discuss specifics (or amendments) regarding the methodology of implementation, I put myself and my organization at your disposal.

Thank you,

Kirk McNeil  
mobilekirkmcneil@gmail.com  
603-552-0137

[www.nhcompassion.org](http://www.nhcompassion.org)



# THE DEA POSITION ON MARIJUANA



January 2011

# Table of Contents

---

The DEA Position On Marijuana.....	2
The Fallacy of Marijuana For Medicinal Use.....	3
Smoked Marijuana Is Not Medicine .....	3
The Legalization Lobby.....	6
The Failure of Legalized Marijuana Efforts .....	11
The Consequences Of Marijuana Grows .....	15
Dangers of Marijuana .....	22
Marijuana Is Dangerous To The User And Others .....	22
Mental Health Issues Related To Marijuana.....	23
Physical Health Issues Related To Marijuana .....	26
Marijuana As A Precursor To Abuse Of Other Drugs.....	31
Dependency And Treatment .....	32
Dangers To Non Users.....	33
Delinquent Behaviors.....	33
Drugged Drivers.....	34
Other Consequences Of Marijuana Use.....	38
Marijuana And Incarceration .....	41
The Foreign Experience With Marijuana .....	42
Other Considerations .....	47
Marijuana Use Among Youth Is Rising As Perception Of Risk Decreases .....	47
Increased Eradication.....	48
In Their Own Words .....	49
Appendix.....	51
Acronyms Used In "The DEA Position on Marijuana" .....	51
Endnotes.....	52

## THE DEA POSITION ON MARIJUANA

***Marijuana is properly categorized under Schedule I of the Controlled Substances Act (CSA), 21 U.S.C. § 801, et seq. The clear weight of the currently available evidence supports this classification, including evidence that smoked marijuana has a high potential for abuse, has no accepted medicinal value in treatment in the United States, and evidence that there is a general lack of accepted safety for its use even under medical supervision.***

The campaign to legitimize what is called “medical” marijuana is based on two propositions: first, that science views marijuana as medicine; and second, that the DEA targets sick and dying people using the drug. Neither proposition is true. Specifically, smoked marijuana has not withstood the rigors of science—it is not medicine, and it is not safe. Moreover, the DEA targets criminals engaged in the cultivation and trafficking of marijuana, not the sick and dying. This is true even in the 15 states that have approved the use of “medical” marijuana.<sup>1</sup>

On October 19, 2009 Attorney General Eric Holder announced formal guidelines for federal prosecutors in states that have enacted laws authorizing the use of marijuana for medical purposes. The guidelines, as set forth in a memorandum from Deputy Attorney General David W. Ogden, makes clear that the focus of federal resources should not be on individuals whose actions are in compliance with existing state laws, and underscores that the Department will continue to prosecute people whose claims of compliance with state and local law conceal operations inconsistent with the terms, conditions, or purposes of the law. He also reiterated that the Department of Justice is committed to the enforcement of the Controlled Substances Act in all states and that this guidance does not “legalize” marijuana or provide for legal defense to a violation of federal law.<sup>2</sup> While some people have interpreted these guidelines to mean that the federal government has relaxed its policy on “medical” marijuana, this in fact is not the case. Investigations and prosecutions of violations of state and federal law will continue. These are the guidelines DEA has and will continue to follow.

## THE FALLACY OF MARIJUANA FOR MEDICINAL USE

### SMOKED MARIJUANA IS NOT MEDICINE

In 1970, Congress enacted laws against marijuana based in part on its conclusion that marijuana has no scientifically proven medical value. Likewise, the Food and Drug Administration (FDA), which is responsible for approving drugs as safe and effective medicine, has thus far declined to approve smoked marijuana for any condition or disease. Indeed, the FDA has noted that “there is currently sound evidence that smoked marijuana is harmful,” and “that no sound scientific studies support medical use of marijuana for treatment in the United States, and no animal or human data support the safety or efficacy of marijuana for general medical use.”<sup>3</sup>

The United States Supreme Court has also declined to carve out an exception for marijuana under a theory of medical viability. In 2001, for example, the Supreme Court decided that a ‘medical necessity’ defense against prosecution was unavailable to defendants because Congress had purposely placed marijuana into Schedule I, which enumerates those controlled substances without any medical benefits. See *United States v. Oakland Cannabis Buyers’ Cooperative et al.*, 532 U.S. 483, 491-92 (2001).

In *Gonzales v. Raich*, 545 U.S. 1 (2005), the Court had another opportunity to create a type of ‘medical necessity’ defense in a case involving severely ill California residents who had received physician approval to cultivate and use marijuana under California’s Compassionate Use Act (CUA). See *Raich*, 545 U.S. at 9. Despite the state’s attempt to shield its residents from liability under CUA, the Supreme Court held that Congress’ power to regulate interstate drug markets included the authority to regulate wholly intrastate markets as well. Consequently, the Court again declined to carve out a ‘medical necessity’ defense, finding that the CSA was not diminished in the face of any state law to the contrary and could support the specific enforcement actions at issue.

In a show of support for the *Raich* decision, the International Narcotics Control Board (INCB) issued this statement urging other countries to consider the real dangers of cannabis:

Cannabis is classified under international conventions as a drug with a number of personal and public health problems. It is not a ‘soft’ drug as some people would have you believe. There is new evidence confirming well-known mental health problems, and some countries with a more liberal policy towards cannabis are reviewing their position. Countries need to take a strong stance towards cannabis abuse.<sup>4</sup>

***The DEA and the federal government are not alone in viewing smoked marijuana as having no documented medical value. Voices in the medical community likewise do not accept smoked marijuana as medicine:***

- The American Medical Association (AMA) has always endorsed “well-controlled studies of marijuana and related cannabinoids in patients with serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.” In November 2009, the AMA amended its policy, urging that marijuana’s status as a Schedule I controlled substance be reviewed “with

the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods.” The AMA also stated that “this should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for prescription drug product.”<sup>5</sup>

- **The American Society of Addiction Medicine’s (ASAM)** public policy statement on “Medical Marijuana,” clearly rejects smoking as a means of drug delivery. ASAM further recommends that “all cannabis, cannabis-based products and cannabis delivery devices should be subject to the same standards applicable to all other prescription medication and medical devices, and should not be distributed or otherwise provided to patients ...” without FDA approval. ASAM also “discourages state interference in the federal medication approval process.”<sup>6</sup>
- **The American Cancer Society (ACS)** “does not advocate inhaling smoke, nor the legalization of marijuana,” although the organization does support carefully controlled clinical studies for alternative delivery methods, specifically a tetrahydrocannabinol (THC) skin patch.<sup>7</sup>
- **The American Glaucoma Society (AGS)** has stated that “although marijuana can lower the intraocular pressure, the side effects and short duration of action, coupled with the lack of evidence that its use alters the course of glaucoma, preclude recommending this drug in any form for the treatment of glaucoma at the present time.”<sup>8</sup>
- **The American Academy of Pediatrics (AAP)** believes that “[a]ny change in the legal status of marijuana, even if limited to adults, could affect the prevalence of use among adolescents.” While it supports scientific research on the possible medical use of cannabinoids as opposed to smoked marijuana, it opposes the legalization of marijuana.<sup>9</sup>
- **The National Multiple Sclerosis Society (NMSS)** has stated that it could not recommend medical marijuana be made widely available for people with multiple sclerosis for symptom management, explaining: “This decision was not only based on existing legal barriers to its use but, even more importantly, because studies to date do not demonstrate a clear benefit compared to existing symptomatic therapies and because side effects, systemic effects, and long-term effects are not yet clear.”<sup>10</sup>
- **The British Medical Association (BMA)** voiced extreme concern that downgrading the criminal status of marijuana would “mislead” the public into believing that the drug is safe. The BMA maintains that marijuana “has been linked to greater risk of heart disease, lung cancer, bronchitis and emphysema.”<sup>11</sup> The 2004 Deputy Chairman of the BMA’s Board of Science said that “[t]he public must be made aware of the harmful effects we know result from smoking this drug.”<sup>12</sup>

In 1999, **The Institute of Medicine (IOM)** released a landmark study reviewing the supposed medical properties of marijuana. The study is frequently cited by “medical” marijuana advocates, but in fact severely undermines their arguments.

- After release of the IOM study, the principal investigators cautioned that the active compounds in marijuana may have medicinal potential and therefore should be researched further. However, the study concluded that “there is little future in smoked marijuana as a medically approved medication.”<sup>13</sup>
- For some ailments, the IOM found “...potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation.”<sup>14</sup> However, it pointed out that “[t]he effects of cannabinoids on the symptoms studied are generally modest, and in most cases there are more effective medications [than smoked marijuana].”<sup>15</sup>
- The study concluded that, at best, there is only anecdotal information on the medical benefits of smoked marijuana for some ailments, such as muscle spasticity. For other ailments, such as epilepsy and glaucoma, the study found no evidence of medical value and did not endorse further research.<sup>16</sup>
- The IOM study explained that “smoked marijuana . . . is a crude THC delivery system that also delivers harmful substances.” In addition, “plants contain a variable mixture of biologically active compounds and cannot be expected to provide a precisely defined drug effect.” Therefore, the study concluded that “there is little future in smoked marijuana as a medically approved medication.”<sup>17</sup>
- The principal investigators explicitly stated that using smoked marijuana in clinical trials “should not be designed to develop it as a licensed drug, but should be a stepping stone to the development of new, safe delivery systems of cannabinoids.”<sup>18</sup>

Thus, even scientists and researchers who believe that certain active ingredients in marijuana may have potential medicinal value openly *discount the notion that smoked marijuana is or can become “medicine.”*

The Drug Enforcement Administration supports ongoing research into potential medicinal uses of marijuana’s active ingredients. As of December 2010:

- There are 111 researchers registered with DEA to perform studies with marijuana, marijuana extracts, and non-tetrahydrocannabinol marijuana derivatives that exist in the plant, such as cannabidiol and cannabinal.
- Studies include evaluation of abuse potential, physical/psychological effects, adverse effects, therapeutic potential, and detection.
- Fourteen of the researchers are approved to conduct research with smoked marijuana on human subjects.<sup>19</sup>

At present, however, *the clear weight of the evidence is that smoked marijuana is harmful.* No matter what medical condition has been studied, other drugs already approved by the FDA have been proven to be safer than smoked marijuana.



The only drug currently approved by the FDA that contains the synthetic form of THC is Marinol®. Available through prescription, Marinol® comes in pill form, and is used to relieve nausea and vomiting associated with chemotherapy for cancer patients and to assist with loss of appetite with AIDS patients.

Sativex®, an oromucosal spray for the treatment of spasticity due to Multiple Sclerosis is already approved for use in Canada and was approved in June 2010 for use in the United Kingdom. The oral liquid spray contains two of the cannabinoids found in marijuana – THC and cannabidiol (CBD) - but unlike smoked marijuana, removes contaminants, reduces the intoxicating effects, is grown in a structured and scientific environment, administers a set dosage and meets criteria for pharmaceutical products.<sup>20</sup>

Organizers behind the “medical” marijuana movement have not dealt with ensuring that the product meets the standards of modern medicine: quality, safety and efficacy. There is no standardized composition or dosage; no appropriate prescribing information; no quality control; no accountability for the product; no safety regulation; no way to measure its effectiveness (besides anecdotal stories); and no insurance coverage. Science, not popular vote, should determine what medicine is.

*The legalization movement is not simply a harmless academic exercise. The mortal danger of thinking that marijuana is “medicine” was graphically illustrated by a story from California. In the spring of 2004, Irma Perez was “in the throes of her first experience with the drug Ecstasy... when, after taking one Ecstasy tablet, she became ill and told friends that she felt like she was... ‘going to die’... Two teenage acquaintances did not seek medical care and instead tried to get Perez to smoke marijuana. When that failed due to her seizures, the friends tried to force-feed marijuana leaves to her, “apparently because [they] knew that drug is sometimes used to treat cancer patients.” Irma Perez lost consciousness and died a few days later when she was taken off life support. She was 14 years old.<sup>21</sup>*

#### THE LEGALIZATION LOBBY

The proposition that smoked marijuana is “medicine” is, in sum, false-trickery used by those promoting wholesale legalization.

- The Marijuana Policy Project (MPP) provides funding and assistance to states and localities to promote “marijuana as medicine” initiatives and legislation. Yet their vision statement clearly indicates that they have a much broader goal of decriminalizing marijuana. At the same time the marijuana legalization proponents are soliciting support for laws allowing marijuana to be used as medicine, they are working to *modify policies to regulate marijuana similarly to alcohol*.<sup>22</sup>
- Ed Rosenthal, senior editor of *High Times*, a pro-drug magazine, once revealed the legalization strategy behind the “medical” marijuana movement. While addressing an effort to seek public sympathy for glaucoma patients, he said, “I have to tell you that I also use marijuana medically. I have a latent glaucoma which has never been diagnosed. The reason why it’s never been diagnosed is because I’ve been treating it.” He continued, “I have to be honest,

there is another reason why I do use marijuana . . . and that is because I like to get high. Marijuana is fun.”<sup>23</sup>

- A few billionaires—not broad grassroots support—started and sustain the “medical” marijuana and drug legalization movements in the United States. Without their money and influence, the drug legalization movement would shrivel. According to National Families in Action, four individuals—George Soros, Peter Lewis, George Zimmer, and John Sperling—contributed \$1,510,000 to the effort to pass a “medical” marijuana law in California in 1996, a sum representing nearly 60 percent of the total contributions.<sup>24</sup>
- In 2000, *The New York Times* interviewed Ethan Nadelmann, Director of the Lindesmith Center. Responding to criticism that the medical marijuana issue is a stalking horse for drug legalization, Mr. Nadelmann stated: “Will it help lead toward marijuana legalization? . . . I hope so.”<sup>25</sup>
- When a statute dramatically reducing penalties for “medical” marijuana took effect in Maryland in October 2003, a defense attorney noted that “[t]here are a whole bunch of people who like marijuana who can now try to use this defense.” The attorney observed that lawyers would be “neglecting their clients if they did not try to find out what ‘physical, emotional or psychological’” condition could be enlisted to develop a defense to justify a defendant’s using the drug. “Sometimes people are self-medicating without even realizing it,” he said.<sup>26</sup>
- In 2004, Alaska voters faced a ballot initiative that would have made it legal for adults age 21 and older to possess, grow, buy, or give away marijuana. The measure also called for state regulation and taxation of the drug. The campaign was funded almost entirely by the Washington, D.C.-based MPP, which provided “almost all” the \$857,000 taken in by the pro-marijuana campaign. Fortunately, Alaskan voters rejected the initiative.<sup>27</sup>
- In October 2005, Denver voters passed Initiative 100 decriminalizing marijuana based on incomplete and misleading campaign advertisements put forth by the Safer Alternative for Enjoyable Recreation (SAFER). A Denver City Councilman complained that the group used the slogan “Make Denver SAFER” on billboards and campaign signs to mislead the voters into thinking that the initiative supported increased police staffing. Indeed, the Denver voters were never informed of the initiative’s true intent to decriminalize marijuana.<sup>28</sup>
- In 2006, the legalization movement funded three state marijuana-related initiatives, which were defeated in the November election. In Colorado, SAFER was behind Amendment 44, which allowed for possession of up to one ounce of marijuana. The amendment was defeated by 60 percent of the vote. In Nevada, Question 7, which was supported by the MPP, sought to permit the manufacture, distribution, and sale of marijuana to adults aged 21 or older. The measure was defeated by 56 percent of the vote. In South Dakota, South Dakotans for Medical Marijuana pushed Measure 4, allowing medical marijuana access. The measure was defeated by 52 percent of the vote.<sup>29</sup>
- The legalization movement was more successful at the local level in 2006. MPP-funded local groups were able to pass measures in three California cities: Santa Barbara (Sensible Santa

Barbara), Santa Cruz (Santa Cruz Citizens for Sensible Marijuana Policy), and Santa Monica (Santa Monicans for Sensible Marijuana Policy); and in Missoula, Montana (Citizens for Responsible Crime Policy). Residents voted to make marijuana possession the lowest law enforcement priority in their cities.<sup>30</sup>

- Three other legalization groups also won local initiatives: the NORML (the National Organization for the Reform of Marijuana Laws) chapter at the University of Arkansas at Fayetteville helped make possession of one ounce or less of marijuana a misdemeanor in Eureka Springs, Arkansas; Americans for Safe Access assisted Albany, CA with passing Measure D, allowing a medical marijuana dispensary in the City of Albany; and the Drug Policy Forum of Massachusetts helped four districts pass non-binding policy statements from voters allowing for possession of up to one ounce of marijuana be a civil violation subject only to a \$100 fine (2 districts) and allowing seriously ill patients to possess and grow marijuana with a doctor's recommendation.<sup>31</sup>
- In 2007 in Hailey, Idaho, the ballot initiatives to legalize industrial hemp, legalize medical use of marijuana and to allow marijuana laws to receive the lowest enforcement priority passed, but have not been implemented. The initiative to regulate and tax marijuana sales and use failed. Mayor Rick Davis, City Councilman Don Keim, and Chief of Police Jeff Gunter filed a Declaratory Judgment action alleging that the three initiatives were illegal. "The lawsuit primarily alleges that the three initiatives are illegal because they are contrary to the general laws of the State of Idaho and the United States."<sup>32</sup> Ryan Davidson, director of The Liberty Lobby of Idaho, put the initiatives back on the May ballot, and again they passed. "Davidson's efforts in Hailey are part of a larger grassroots agenda to have marijuana laws reformed statewide and nationally."<sup>33</sup> In March, 2009 Blaine County 5<sup>th</sup> District Court Judge Robert Elgee filed a decision to void the initiatives that would have legalized marijuana use in the city and would have made enforcement of marijuana laws the lowest priority for Hailey police. The judge also voided language in the initiative that would have required individual city officials to advocate for marijuana reform.<sup>34</sup>
- In 2008, with support from the Michigan Coalition for Compassionate Care, Michigan became the 13<sup>th</sup> state to approve marijuana for medicinal purposes.<sup>35</sup>
- Massachusetts, backed by the Committee for Sensible Marijuana Policy, replaced criminal penalties for one ounce of marijuana with a civil fine in 2008.<sup>36</sup>
- Voters in four districts (15 towns) in Massachusetts, supported by local legalization groups, passed a ballot measure to instruct a representative from each district to vote in favor of legislation that would allow seriously ill patients, with a doctor's written recommendation, to possess and grow small amounts of marijuana for their personal medical use.<sup>37</sup>
- In the same year, voters in Fayetteville, Arkansas, supported by Sensible Fayetteville, voted to make adult marijuana possession law the lowest priority for local law enforcement.<sup>38</sup>

- In California, Proposition 5, also known as the Non-Violent Offender Rehabilitation Act, and supported by the Drug Policy Alliance, called for more funding for addiction treatment and decriminalization of up to an ounce of marijuana. This initiative did not pass.<sup>39</sup>
- The legalizers were also less successful in New Hampshire, where although the state legislature approved a bill to legalize “medical” marijuana, Governor John Lynch vetoed the bill in July 2009, citing concerns over cultivation, distribution and the potential for abuse.<sup>40</sup>
- Rhode Island became the 3<sup>rd</sup> state to allow the sale of marijuana for medicinal purposes. In June 2009, the Rhode Island legislature overrode Governor Circieri’s veto of bills that allow for the establishment of three compassionate care centers regulated by the state department of health.<sup>41</sup>
- New Mexico opened its first “medical” marijuana dispensary in June 2009, becoming the 4<sup>th</sup> state to allow “medical” marijuana dispensaries.<sup>42</sup>
- In November 2009, Maine became the 5<sup>th</sup> state to allow dispensaries. The voters also approved the expansion of the “medical” marijuana law, to include defining debilitating medical conditions and incorporating additional diseases that can be included under the law. This effort was funded by the Drug Policy Alliance.<sup>43</sup>
- On November 4, 2009, Breckenridge, Colorado citizens voted to decriminalize possession of up to 1 ounce of marijuana for adults over 21 years of age. The measure, however, is symbolic, because pot possession is still against state law. Sean McAllister, a Breckenridge lawyer who pushed for the decriminalization measure said that “the vote shows people want to skip medical marijuana and legalize pot for everyone.”<sup>44</sup>
- In January 2010, New Jersey became the 14<sup>th</sup> state to allow the use of marijuana for medicinal purposes. With the most restrictive law in the country, only residents with one of twelve chronic illnesses (not including chronic pain) will be able to get a prescription from their doctor to buy up to two ounces a month from one of six dispensaries.<sup>45</sup> Implementation of the program, originally scheduled for October 1, 2010, has been extended by the state legislature until January 1, 2011, to give the Governor more time to determine who will grow and dispense marijuana.<sup>46</sup> As of January 31, 2011 final details of the program were still being negotiated.
- In Massachusetts voters in 18 legislative districts approved non-binding measures calling on state lawmakers to pass ‘medical’ marijuana legislation or a bill to regulate marijuana like alcohol. The organizers of these measures included the Drug Policy Forum of Massachusetts, the Massachusetts Cannabis Reform Coalition, Suffolk University NORML and the University of Massachusetts Amherst Cannabis Reform Coalition.<sup>47</sup>
- In November 2010, Arizona became the 15<sup>th</sup> state to allow the use of marijuana for medicinal purposes. Proposition 203, the Arizona Medical Marijuana Act, sponsored by the Arizona Medical Marijuana Policy Project with financial support from George Soros, passed with 50.13 percent of the vote. The program, which will be established and implemented by the

Department of Health Services, allows residents with certain medical conditions to obtain a doctor's written certification to purchase up to 2.5 ounces of marijuana every two weeks from a state approved dispensary or grow their own if they live 25 miles or more from a dispensary.<sup>48</sup>

- In South Dakota residents once again refused to support efforts to legalize marijuana. Measure 13, which sought to authorize the possession, use and cultivation of marijuana by and for persons with specific debilitating medical conditions, was defeated by 63.3 percent of the vote.<sup>49</sup>
- In Oregon 58 percent of the voters said no to Measure 74, which would have established a 'medical' marijuana supply system and allow for the sale of marijuana and marijuana-laced products in shops throughout the state. The measure was financially backed by billionaire Peter Lewis, a known legalization activist, who resides in Florida.<sup>50</sup>
- In California, voters defeated Proposition 19 (The Regulate, Control and Tax Cannabis Act of 2010), which sought to legalize the possession and cultivation of limited amounts of marijuana for use by individuals 21 years of age and older. Had it passed, California would have been the first state to legalize marijuana for recreational purposes.<sup>51</sup> The initiative garnered much debate. Fueled by financial support from legalization activists, including one million dollars each from Oakland cannabis entrepreneur Richard Lee and billionaire George Soros, proponents for the initiative used the media to attempt to sway public opinion.<sup>52</sup> Nine former DEA Administrators called upon U.S. Attorney General Eric H. Holder Jr. to clarify the federal position and reiterate the law.<sup>53</sup> In response, Attorney General Holder stated the Department of Justice's position.

“...the Department of Justice will remain firmly committed to enforcing the Controlled Substances Act (CSA) in all states. Prosecution of those who manufacture, distribute or possess any illegal drugs – including marijuana – and the disruption of drug trafficking organizations is a core priority of the Department. Accordingly, we will vigorously enforce the CSA against those individuals and organization who possess, manufacture, or distribute marijuana for recreational use, even if such activities are permitted under state law.”<sup>54</sup>

- On July 25, 2007, the U.S. House of Representatives defeated, by a vote of 165-262, an amendment (HR-3093) that would have prevented the DEA and the Department of Justice from arresting or prosecuting medical marijuana patients and providers in the 12 states where medical marijuana was then legal.<sup>55</sup>
- Two Congressional initiatives on marijuana also failed in 2008. HR5842, Medical Marijuana Patient Protection Act and HR5843, Act to Remove Federal Penalties for the Personal Use of Marijuana by Responsible Adults, both died in committee.
- Three Congressional initiatives were introduced in Congress in 2009: HR2835 Medical Marijuana Patient Protection Act; HR2943 Personal Use of Marijuana by Responsible Adults Act of 2009; and HR3939 Truth in Trials Act. None were passed.

- The Consolidated Appropriations Act of 2010 (HR 3288) became law in December 2009 without the "Barr Amendment," a provision that has been included in the Appropriations bill for the District of Columbia since 1999.<sup>56</sup> The Barr Amendment had prohibited "... any funds to be used to conduct a ballot initiative which seeks to legalize or reduce the penalties associated with the possession, use, or distribution of any Schedule I substance under the Controlled Substances Act (or any tetrahydrocannabinoids derivative)."<sup>57</sup>
- The elimination of the Barr Amendment enabled the District of Columbia to implement Initiative 59, a ballot initiative that was approved in 1998 to allow for the use of marijuana for medical treatment. In May 2010, the District of Columbia City Council approved a bill that would allow chronically ill patients to receive a doctor's prescription to use marijuana and buy up to two ounces a month from a city-sanctioned distribution center. The Legalization of Marijuana for Medical Treatment Amendment Act of 2010 became law in July. The District of Columbia government is still working on the details of the program to ensure strict regulatory controls are in place prior to implementation.<sup>58</sup>

### *THE FAILURE OF LEGALIZED MARIJUANA EFFORTS*

The argument that "caregivers" who participate in legalized marijuana efforts are "compassionate" is contradicted by revelations that all too often cannabis clubs are fronts for drug dealers, not health facilities. Even the author of Proposition 215 believes the program is "a joke."

- Reverend Scott T. Imler, co-author of Proposition 215, the 1996 ballot initiative that legalized medical marijuana in California, expressed his disappointment with the way the program has been implemented in a series of interviews in late 2006.
  - "We created Prop. 215 so patients would not have to deal with black market profiteers. But today it is all about the money. Most of the dispensaries operating in California are a little more than dope dealers with store fronts."<sup>59</sup>
  - "When we wrote 215, we were selling it to the public as something for seriously ill people....It's turned into a joke. I think a lot of people have medicalized their recreational use."<sup>60</sup>
  - "What we set out to do was put something in the statutes that said medicine was a defense in case they got arrested using marijuana for medical reasons," Imler says. "What we got was a whole different thing, a big new industry."<sup>61</sup>
- In an interview with National Public Radio in August 2009, Reverend Imler stated that he believes that the law has been subverted. "What we have is de-facto legalization." The article continues, "He never envisioned that medicinal pot would turn into a business, open to virtually anyone."<sup>62</sup>

Rev. Imler's observations that 'its all about the money' are consistent with the financial realities that have been exposed by criminal investigations of cannabis clubs or dispensaries. Cannabis clubs or

dispensaries are generating disproportionately large sums of cash through the sales of marijuana and marijuana tainted products when they should be operating as essentially nonprofit enterprises.

- Under California State law, financial responsibilities of cannabis clubs are governed, in part, by the Health & Safety § 11362.765 (c) and the California Attorney General's Guidelines for the Security and Non-diversion of Marijuana Grown for Medical Use Attorney (August 2008), which states in relevant part: "a primary caregiver who receives compensation for actual expenses, including reasonable compensation incurred for services provided to an eligible qualified patient or person with an identification card to enable that person to use marijuana under this article, or for payment for out-of-pocket expenses incurred in providing those services...."
- Both by statute and the Guidelines, revenue is framed in the context of "compensation for actual expenses" which should not be attributed beyond those "actual expenses" incurred through the manufacturing of marijuana by the primary caregiver, and only for those limited and quantified "patients."
- Further the statute, Guidelines and the courts have affirmed reasonable compensation for services or out-of-pocket expenses need to be confined to the context of the primary caregiver wherein those services and out-of-pocket expenses relate to the housing, health, or safety of the qualified patient.
- Therefore, the acquisition of marijuana from the illicit open market and large scale commercial cultivation operations is beyond the statutory limited immunity and renders the commercial enterprise illicit by nature, whether or not resold at cost or at a loss.

Cannabis clubs or dispensaries are generating disproportionately large sums of cash through the sales of marijuana and marijuana tainted products when they should be operating as essentially nonprofit enterprises. Most of these profits are going unreported. According to the California Board of Equalization, the state collects anywhere from \$58 million to \$105 million in taxes from medical marijuana each year from approximately \$700 million to \$1.3 billion in marijuana sales.<sup>63</sup>

- "There is a clear indication that many dispensaries are intentionally evading their taxes, distributing illegal products and may be laundering illegally acquired money," Jerome E. Horton, California State Board of Equalization Vice Chairperson.<sup>64</sup>

Additionally, the Board of Equalization estimated in 2008 that about 300 dispensaries currently pay taxes, with another 500 evading them<sup>65</sup> (other media outlets have estimated the number of dispensaries to be between 1000-and 1500). If the tax and revenue projections are based on the 300 reporting entities, then, based on California Board of Equalization estimates, total medical marijuana revenues are between \$1.87 and \$3.47 billion per year.

It is a well proven maxim that the money from illegal drugs is so substantial that it attracts organized criminal groups and makes criminals out of otherwise honest citizens. All of this is proving true with the cannabis clubs.

- For example: On November 21, Luke Scarmazzo and Ricardo Montes were sentenced in the Eastern District of California to 262 months and 240 months imprisonment, respectively. A forfeiture judgment of \$8.89 million was imposed. Scarmazzo and Montes were convicted on May 15 of engaging in a Continuing Criminal Enterprise, possession with intent to distribute marijuana, and firearms charges. From 2004 to 2006, Scarmazzo and Montes operated California Healthcare Collective, a medical marijuana dispensary, in Modesto, California, from where they sold marijuana to approximately 400 customers per day, exceeding \$9 million in drug proceeds. This 34-month investigation resulted in the arrest of nine individuals, and the seizure of 1,000 marijuana plants, \$330,000 in U.S. currency, and 11 firearms.<sup>66</sup>
- Drug proceeds generated by dispensaries taint more than just their owners. Depository institutions (banks, savings and loans, etc) that knowingly avail and continue to afford their products and services to commercialized cannabis cooperatives or clubs in order to meet payroll, utilities, security, maintain leases and acquire additional merchandise, do so in violation of federal anti-money laundering statutes by promoting the specified unlawful activity of drug trafficking.

In Oregon, where voters legalized "medical" marijuana for qualifying patients in November 1998, patients must grow their own marijuana or have a licensed grower provide it for them through an unpaid arrangement. While the initiative had good intentions, numerous problems exist.

- According to Lt. Michael Dingeman, Director of the Oregon State Police Drug Enforcement Section, many calls from cardholders are about never receiving the marijuana from their designated growers. The "growers are simply using the cardholders for cover, and selling their crops on the black market. In fact, some county sheriffs estimate that as much as one half of the illegal street marijuana they're seeing is being grown under the protection of the state's medical marijuana program."<sup>67</sup>
- Deputy Chief Tim George of the Medford Police Department says that the region is "swimming in weed," and the problem keeps getting worse. "People are traveling with large sums of money to buy marijuana. Weed is being shipped out of Oregon at record levels. Medical Marijuana has made it easier for criminals to grow it."<sup>68</sup>
- Sergeant Erik Fisher of the Drug Enforcement Section of the Oregon State Police says that the perception of the marijuana drug trade is mellowed than other drug operations is wrong." He notes that almost all the distributors and growers carry firearms. "The other striking trend has been the increase in home invasion robberies of medical marijuana folks, and how absolutely violent they can be. We have more home invasions going on with medical marijuana people than any other drug dealer I can think of."<sup>69</sup>

Neighborhood residents, doctors and other professionals associated with marijuana dispensaries admit there have been problems.



- In a letter to the Editor of the Denver Post, Dr. Christian Thurstone, Medical Director of an Adolescent Substance Abuse Treatment Program in Denver, has seen what impact Colorado's policies regarding "medical" marijuana has had on young adults.
  - "About 95 percent of the hundreds of young people referred to my clinic each year have problems with marijuana. I see teenagers who choose pot over family, school, friends and health every day. When they're high, these young people make poor choices that lead to unplanned pregnancies, sexually transmitted diseases, school dropouts and car accidents that harm people. When teenagers are withdrawing from marijuana, they can be aggressive and get into fights or instigate conflicts that lead to more trouble."
  - Dr. Thurstone talks about a 19-year-old who he was treating for severe addiction for several months. "He recently showed up at my clinic with a medical marijuana license. How did he get it? He paid \$300 for a brief visit with another doctor to discuss his "depression." The doctor took a cursory medical history that certainly didn't involve contacting me. The teenager walked out with the paperwork needed not only for a license to smoke it, but also for a license permitting a "caregiver" to grow up to six marijuana plants for him. My patient, who had quit using addictive substances after a near-death experience, is back to smoking marijuana daily, along with his caregiver."
  - In a three month period, Dr. Thurstone saw over a dozen patients between 18 and 25 with histories of substance abuse who had received a recommendation from other doctors to smoke marijuana.
  - "Kids without licenses tell me about potent pot they buy from caregivers whose plants yield enough supply to support sales on the side."<sup>70</sup>
- The White Mountain Independent reported that "In Colorado treatment centers, clinicians are treating more and more teens for marijuana addiction since the state legalized marijuana for medicinal use. At the Denver Health Medical Center, treatment for referrals has tripled with 83 percent of teens that smoke pot daily saying that they obtained it from a medical marijuana patient."<sup>71</sup>
- A study by the Associated Press of doctors prescribing 'medical' marijuana to patients in California found that beyond a medical license, the physicians do not need to have any relevant training, familiarity with the scientific literature on pot's benefit and side-effects or special certification. There are no reporting requirements and no central database to track doctors or patients. Researchers identified 233 of these doctors and checked the names against state medical board files, finding that most doctors prescribing marijuana had clean records. However, researchers found that 68 physicians had blemished records. Some of the disciplinary actions against them included fraud, incorrectly prescribing drugs, misuse of prescription or illicit drugs, and negligence. They also found:
  - A San Francisco doctor who received four years probation after she failed to heed a psychiatrist's request to reconsider her marijuana recommendation to a 19-year-old patient suffering from depression. The patient committed suicide six months later. The doctor now operates medical marijuana practices in eight cities.

- A Glendale obstetrician-gynecologist who pleaded guilty last year to billing Medicare for \$77,000 worth of diagnostic tests he never performed while working in Texas. Since moving to Los Angeles, he helped set up pot evaluation offices in 11 locations.
- A Fresno osteopath who was arrested in June 2008 for driving under the influence of alcohol and whose urine tested positive for marijuana, anti-anxiety drugs and a prescription stimulant. Two months later he was arrested again for driving with a suspended license, and involuntarily hospitalized as a suicide risk. He was convicted in both cases, and DEA revoked his license to prescribe narcotics. He is now giving pot recommendations at his private practice.<sup>72</sup>
- In a professional pharmacology journal, a doctor of pharmacology wrote, "The ethical quandary that I have as a pharmacist is allowing lay people to open dispensaries for profit and supply marijuana to people without any quality control over what's dispensed or accountability to those being dispensed this potent drug."<sup>73</sup>
- The owners of a Satellite Beach house in Brevard County, Florida were told the renters would take care of the lawn and clean the pool themselves. What they didn't know is that they would be using the water from the swimming pool as part of the irrigation system for a hydroponic indoor marijuana grow in three of the four bedrooms of their home. "They even dug into the foundation of the house to put pipes and wires in," according to Kathleen Burgess, one of the owners, who estimated the property damage at \$60,000. The Brevard County Sheriff's Office found 24 marijuana plants inside with a possible yield of 200 pounds of cannabis.<sup>74</sup>
- According to a Los Angeles press report, homeowners in Fair Oaks, California called the local cannabis club a "free for all." Conflicts among customers, sometimes 300 per day, had to be resolved by security guards. It was apparent that not all of the customers were legitimate patients. Even Dr. Charles Moser, a local physician who voted for Prop 215, said that he "... saw people coming up on bikes and skateboards, with backpacks, healthy-looking young men."<sup>75</sup>

#### *THE CONSEQUENCES OF MARIJUANA GROWS*

- In addition to problems with the cannabis clubs themselves, California residents are also complaining about marijuana grows that supply the clubs. In Willits, California, residents and officials pointed out numerous problems, including the side-effects of resin from a cannabis growing operation that affected residents' health. Additionally, residents complained about the influx of homeless people looking for work at marijuana harvest time. "Since this medical marijuana thing our town has gone to hell," said Jolene Carrillo. "Every year we have all these creepy people. They sleep behind the Safeway and Rays and go to the bathroom there. They go to Our Daily Bread and eat the food poor people need."<sup>76</sup>
- In the city of Arcata, California, LaVina Collenberg discovered that the nice young gentleman who rented her home on the outskirts of town was using it to grow marijuana after a neighbor

called to tell her the house was on fire. In the charred remains she found grow lights, 3-foot-high marijuana plants, seeds germinating in the spa, air vents cut through the roof, and water from the growing operation soaking the carpeting and sub-flooring. Fire Protection District Chief John McFarland says "that most local structural fires involve marijuana cultivation." "Law enforcement officials estimate that 1,000 of the 7,500 homes in this Humboldt County community are being used to cultivate marijuana, slashing into the housing stock, spreading building-safety problems and sowing neighborhood discord."<sup>77</sup>

- "Arcata Mayor Mark Wheetley said that marijuana growing has become a quality-of-life issue in this town of 17,000. People from all camps say enough is enough. It is like this renegade Wild West mentality." Humboldt State University President Rollin Richmond is concerned that "so many houses have been converted into pot farms that the availability of student rentals has been reduced and the community's aura of marijuana is turning off some prospective students. My own sense is that people are abusing Proposition 215 to allow them to use marijuana...as recreational drugs."<sup>78</sup>
- A couple in Altadena, California bought their first home, what seemed to be a buyers dream, with fresh paint, carpet and fixtures. After they moved in their dream house became a nightmare. The smell of fresh paint was overtaken by the smell of stachybotrys mold growing throughout the house, forcing them to move and spend over \$42,000 in repairs. Months later an electrical fire put them out again. The mold, bad wiring, and gas leaks all stemmed from the undisclosed past of the house as a marijuana grow.<sup>79</sup>
- Marijuana grows also hurt the environment. In October 2010 the state Department of Fish and Game wardens in California discussed recent cases involving the diversion of water from creeks. "When people divert water from creeks they deprive wildlife of its most basic water need," said DFG warden and spokesman Patrick Foy. "(Growers) also allow chemicals needed for cultivation to drain back onto the creek...poisoning everything downstream for who knows how long. We walk upstream to find out why the fish have died, and more often now than 25 years ago, we're finding the cause is marijuana gardens," Foy said.<sup>80</sup>

The detection and dismantling of these operations have become increasingly dangerous through the introduction and presence of firearms and "booby-traps" deployed to protect their capital investment. In addition, Mexican drug trafficking organizations (DTO) have realized that the lucrative California marijuana cultivation business eliminates the need to breach the southern border with contraband. The DTOs have tapped the expanding and voracious consumer appetite through outlets provided by the dispensaries, generating millions of dollars in cash which is easily smuggled south of the border back to the DTOs.

A marked increase in narco-terrorism throughout Mexico has been driven, in part, by the kidnapping and forced servitude of Mexican nationals in working the illicit cultivation operations in northern California (and elsewhere) to avoid retribution to themselves or extended families by the DTOs.

Many drug users are taking advantage of the guise of "compassionate care" to obtain and sell marijuana for non-medical use.

- In Great Falls, Montana, school counselors are seeing an increase in the use of marijuana by students. According to Earlene Ostberg, a school Chemical Awareness/Responsive Education Counselor, most of the students that are failing are smoking pot. "When I ask 'why,' a lot of kids are real defensive. They say "Mrs. Ostberg, it's medicinal. I could get a green (medical marijuana) card."<sup>81</sup>
- "The owner of six Los Angeles-area medical marijuana dispensaries was arrested by federal agents ... after an investigation sparked by a traffic accident in which a motorist high on one of the dispensaries' products plowed into a parked SUV, killing the driver and paralyzing a California Highway Patrol Officer." The driver had a large amount of marijuana and marijuana edibles in his pickup truck, purchased from the Holistic Caregivers facility in Compton. The owner, Virgil Grant, had an expired business license to operate an herbal retail store. In another of his dispensaries an employee was observed selling \$5,700 worth of marijuana out the back door. Mr. Grant, who had previous convictions on drugs and weapons related-offenses, has been "charged with drug conspiracy, money laundering, and operating a drug-involved premise within 1,000 feet of a school."<sup>82</sup>
- A *Rolling Stone* article describes the "wink and nod" given to customers seeking marijuana for non-medical purposes by some dispensaries. "At the counter, a guy in a USC shirt is talking to the goateed clerk (Daniel's employees are paid approximately twenty dollars per hour, plus a free gram per day). With all the options, the customer -- er, patient -- doesn't know what to buy." "The muffins look nice," he says. "They're about a gram and a half of hash, which is pretty good," says the clerk. Then he points to the goo -- superpotent powdery hash mixed with honey. "This is what you want," he says. "This will definitely get you medicated."<sup>83</sup>
- A Santa Cruz, California man, Edwin Hoey, was arrested in December, 2006. Deputies found 100 pounds of marijuana at his residence during an investigation. His attorney claimed that his client was providing pot for local medical marijuana dispensaries. However, law enforcement found among his possessions more than \$500,000 in cash and a French wine collection valued at \$150,000. Investigators found that Mr. Hoey was making a big profit from medical pot, some of which he sold to non-medicinal customers on the East Coast.<sup>84</sup>
- Two East County (California) teenagers were suspended for showing up at school high, with a medical marijuana card as their excuse.<sup>85</sup>
- A news article reports the ease with which patients are able to obtain medical marijuana. Primary caregivers are authorized by law to grow, transport and provide marijuana to patients. Caregivers do not need any background in health care to hold this status, and they are not required to register with the state. All it takes is an oral or written agreement between the caregiver and a patient designating you as their primary caregiver.<sup>86</sup>
- *Rolling Stone* magazine reported on abuses associated with Proposition 215. "... business is good for ...compassionate caregivers, freedom fighters, botanists in love with the art of growing, Long Beach homeys, Valley Boys, Oakland thugs, and even one savvy gal who wants her girlfriends to sell medical marijuana while wearing pasties. But as in any drug business, a

criminal element persists—storage lockers of product, safes of cash, hustlers trying to rob those lockers and safes, guns to protect one from the hustlers, and the constant risk of arrest.”<sup>87</sup>

- A news reporter for the Santa Cruz *Sentinel* interviewed a defense attorney who acknowledged that he turns away clients who admit they have taken advantage of the law to use marijuana for non-medical purposes. “These people aren't sick... and are simply trying to hide behind the Compassionate Use Act for recreational or profit-making reasons.” This lawyer estimates that up to 30 percent of those seeking his assistance are involved with marijuana for non-medical uses.<sup>88</sup>

Because of abuses associated with the cannabis clubs, law enforcement and localities have cracked down on these fronts for marijuana dealers.

- In Montana, where voters approved “medical” marijuana in 2004, there has been a recent influx of registered “medical” marijuana cardholders. As of June 2009 there were only 2,923 cardholders; now there are approximately 15,000 cardholders. As a result of this increase, there has been a proliferation of storefront dispensaries, with an increase from 919 to over 5,000. The existing law does not have the proper regulations to manage these businesses and ensure public safety.<sup>89</sup>
  - In Billings, the City Council approved a six-month moratorium on new medical businesses in May 2010 after two evenings of violence against dispensaries. They also ordered the closure of 25 of the 81 dispensaries for not being properly registered with the state.<sup>90</sup>
  - In Kalispell, they recently banned any new “medical” marijuana stores in the city following the bludgeoning death of a patient that authorities believe was related to the theft of “medical” marijuana plants.<sup>91</sup>
  - In April 2010 the principal and counselors from Great Falls High School testified that teenagers are smoking more marijuana than ever before. Principal Dick Kloppel stated that “I firmly believe it is directly attributable to the increased availability of the drug through caregivers and cardholders.”<sup>92</sup>
  - Mikie Messman, Chemical Awareness/Responsive Education Coordinator for the school district testified that the students told her that marijuana relieves their stress. Instead of learning how to cope with stress, they are covering it up. “These kids are using it as medication so they don’t have to deal with adolescence,” Messman said.<sup>93</sup>
  - In response to the information provided by school personnel and others who testified, in June 2010 Great Falls city commissioners voted to ban medical marijuana businesses from the city.<sup>94</sup>
  - A block from the state capitol in Helena, the Cannabis Caregivers Network, set up a cannabis caravan, a makeshift clinic, using a band of doctors and medical marijuana advocates roaming Montana to sign up thousands of patients to become “medical” marijuana cardholders. For \$150 patients see a doctor who provides a recommendation

that they be allowed to buy and smoke “medical” marijuana. The Montana Medical Board has been working to curtail the practice of such mass screenings. They recently fined a doctor who participated in a similar clinic for seeing 150 patients in 14 and 1/2 hours, or approximately a patient every six minutes. There was no way a thorough examination, a medical history, discussion of alternative treatments and oversight of the patients could have occurred.<sup>95</sup>

- One caravan recently ran a clinic in a hotel in Helena, where they processed between 200 and 300 people seeking a doctor’s recommendation. The group then assisted the patient with sending the application and doctor’s recommendation to the state health department. Afterwards patients were ushered into another room where half a dozen marijuana providers competed for their business.<sup>96</sup>
- In November 2010 the Montana Board of Medical Examiners stated that internet-based video examinations for people seeking approval to use medical marijuana did not meet the Board’s standards and requires that doctors must conduct a hands-on physical examination before signing off on someone receiving “medical” marijuana.<sup>97</sup>
- Although Colorado approved the use of “medical” marijuana in 2000, it wasn’t until 2009 that dispensaries began to proliferate throughout the state and the medical marijuana card registry grew by the thousands.
  - In order to avoid the problems experienced by other states, legislators wrote bills to regulate the industry. In June 2010 Governor Bill Ritter signed House Bill 1284, which requires that dispensaries be licensed at the state and local level, and still allows localities to ban them. He also signed Senate Bill 109, which requires doctors who recommend medical marijuana to complete a full assessment of the patient’s medical history, discuss their medical condition, and be available for follow-up care.<sup>98</sup>
  - The State’s Senior Director of Enforcement at the Department of Revenue, Matt Cook, was put in charge of drawing up a stringent regulation scheme that aims to turn the industry into a legitimate enterprise. “We plan to track the entire commodity from the seed to the sale. We will see virtually everything from the time a seed goes into the ground to the time the plants are harvested, cultivated, processed, packaged, stored.” Applying for a license requires completing a form detailing immediate family and personal finance history. No felons need apply. Small dispensaries will pay at least \$7,500 for a license. Rules will require that at least 70 percent of the marijuana is grown there. Every jar of cannabis will have to be labeled with the chemicals used during its production. These regulations will decrease the number of dispensaries and increase public safety.<sup>99</sup>
  - Colorado will be the first state to regulate production of medical marijuana. Right now patients have no way to verify that the product they are purchasing is what is advertised. Given that marijuana is not approved as a medicine and regulated by the FDA, nor as a legitimate crop that is overseen by the U.S. Department of Agriculture, there are no guidelines to follow.

- According to an article in Time magazine, "Owners will soon be required to place video cameras throughout the cultivation sites and dispensaries so regulators can log on to the internet and trace the movement of every marijuana bud from the moment its seeds are planted to the point of sale. The video will be transmitted to a website accessible to regulators around the clock. The regulators will dictate where the cameras must be placed and at what angle."<sup>100</sup> A current attempt to challenge the new regulation requiring videotaping as a violation of marijuana patients' constitutional right to privacy was rejected by the Colorado Supreme Court.<sup>101</sup>
- According to an article in the *Los Angeles Times*, in 2007 there were 186 marijuana dispensaries registered with the city. Recognizing that hundreds of dispensaries were proliferating across the city, the City Council imposed a moratorium on new ones until regulations are put in place. However, operators were allowed to appeal for a hardship exemption. The City Council did not grant any exemptions, but dispensaries were allowed to open. The City Council has since eliminated the hardship exemption and is proposing an ordinance that would shut down dispensaries that opened during the moratorium.<sup>102</sup>
- On September 10, 2009, 14 search warrants were served at 14 marijuana dispensaries and six associated residences in San Diego. According to San Diego County District Attorney Bonnie M. Dumanis, "these so-called 'marijuana dispensaries' are nothing more than for-profit storefront drug dealing operations run by drug dealers hiding behind the state's medical marijuana law." For profit marijuana dispensaries are not legal according to state law. "We have not, and will not prosecute people who are legitimately and legally using medical marijuana." Residents living near some of the storefronts complained to law enforcement and local government about the increase in crimes associated with the dispensaries and about their proximity to schools and areas frequented by children.<sup>103</sup>
- On November 13, 2009 the Los Angeles City Attorney's Office submitted a new draft medical marijuana ordinance for council to review.<sup>104</sup>
- On November 18, 2009, Los Angeles County District Attorney Steve Cooley warned the Los Angeles City Council that he intends to prosecute dispensaries that sell drugs even if the city's leaders decide to allow those transactions. DA Cooley said that "state laws do not allow medical marijuana to be sold." Both Cooley and City Attorney Carmen Trutanich agree that recent court decisions clearly state that collectives cannot sell marijuana over the counter, but can be reimbursed for the cost of growing the marijuana.<sup>105</sup> Los Angeles County Superior Court Judge James C. Chalfant agreed that state law does not allow medical marijuana to be sold. "I don't believe that a storefront dispensary that sells marijuana is lawful."<sup>106</sup>
- In February 2010, District Attorney Steve Cooley charged Jeff Joseph, operator of a Culver City dispensary with 24 felonies, including selling and transporting marijuana, and money laundering. In addition, the Los Angeles City Attorney's office has joined in a civil lawsuit against Joseph and two other dispensaries, charging that they are public nuisances and are operating illegally.<sup>107</sup>

- In January 2010 the Los Angeles City Council adopted a comprehensive medical marijuana ordinance that enforces strict controls on dispensaries, forcing hundreds of shops to close. Although the ordinance sets the limit to 70, the number would be closer to 150 by allowing those registered with the city in 2007 to remain. New requirements include banning consumption at the dispensary and not locating within 1,000 feet of schools, parks, libraries and other dispensaries.<sup>108</sup>
- In May 2010 the Los Angeles city prosecutors began notifying 439 dispensaries that they had to shut down by June 7, 2010. Property owners and dispensary operators were sent letters informing them that violations could lead to six months in jail and a \$1,000 fine. Additional civil penalties could be added.<sup>109</sup>
- “In Mendocino County, where plants grow more than 15 feet high, medical marijuana clubs adopt stretches of highway, and the sticky, sweet aroma of cannabis fills this city’s streets during the autumn harvest,...residents are wondering if the state’s embrace of marijuana for medicinal purpose has gone too far....Some residents and law enforcement officials say the California law has increasingly and unintentionally provided legal cover for large-scale marijuana growers – and the problems such big-money operations can attract.” On June 3, 2008, the County passed Measure B, which reduced the number of plants allowed to be grown. Numerous initiatives like these throughout the state demonstrate that residents want to see more, not less, regulation of the medical marijuana program.<sup>110</sup>
- In March, 2006, DEA worked with state and local law enforcement to dismantle the largest marijuana-laced candy manufacturing organization in the western United States. The five-month investigation resulted in the arrest of the organization’s leader and the seizure of more than 4,000 marijuana plants, \$100,000 in U.S. currency, three firearms, and hundreds of marijuana-laced food products. The marijuana-laced products, packaged to mimic legitimate food products, included labels such as “Buddafingers,” “Munchy Way,” and “Pot Tarts.” The items were packaged in large boxes for distribution to cannabis clubs throughout the West Coast and over the Internet.
- Many cities and counties in California have refused to allow cannabis clubs to operate, despite the passage of Proposition 215. One hundred and forty-two cities and 12 counties have banned cannabis clubs outright; 14 counties and 102 cities have moratoria against them; 42 cities and nine counties have ordinances regulating them.<sup>111</sup>
- In San Francisco, things got so out of control that Mayor Gavin Newsom had to close many of the “clinics” because drug addicts were clustering around them, causing fear among city residents.<sup>112</sup>



## DANGERS OF MARIJUANA

### *MARIJUANA IS DANGEROUS TO THE USER AND OTHERS*

Legalization of marijuana, no matter how it begins, will come at the expense of our children and public safety. It will create dependency and treatment issues, and open the door to use of other drugs, impaired health, delinquent behavior, and drugged drivers.

This is not the marijuana of the 1970s; today's marijuana is far more powerful. On May 14, 2009, analysis from the National Institute on Drug Abuse (NIDA)-funded University of Mississippi's Potency Monitoring Project revealed that marijuana potency levels in the U.S. are the highest ever reported since the scientific analysis of the drug began.

- According to the latest data, the average amount of THC in seized samples has reached 10.1 percent. This compares to an average of just under four percent reported in 1983 and represents more than a doubling of the potency of the drug since that time.<sup>113</sup>
- NIDA Director Dr. Nora Volkow stated that, "Although the overall number of young people using marijuana has declined in recent years, there is still reason for great concern, particularly since roughly 60 percent of first-time marijuana users are under 18 years old. During adolescence and into young adulthood, the brain continues to develop and may be vulnerable to marijuana's deleterious effects. Science has shown that marijuana can produce adverse physical, mental, emotional, and behavioral changes, and contrary to popular belief--it can be addictive."<sup>114</sup>

Skunk, the more potent form of marijuana being used in the United Kingdom today, contains 15 to 20 percent THC, and new resin preparations have up to 30 percent.<sup>115</sup>

Increasingly, the international community is joining the United States in recognizing the fallacy of arguments claiming marijuana use is a harmless activity with no consequences to others.

- Antonio Maria Costa, then Executive Director of the United Nations Office on Drugs and Crime, noted in an article published in *The Independent on Sunday* "The debate over the drug is no longer about liberty; it's about health." He continued, "Evidence of the damage to mental health caused by cannabis use--from loss of concentration to paranoia, aggressiveness and outright psychosis--is mounting and cannot be ignored. Emergency-room admissions involving cannabis is rising, as is demand for rehabilitation treatment. ...It is time to explode the myth of cannabis as a 'soft' drug."<sup>116</sup>
- As ONDCP Director R. Gil Kerlikowske noted, "The concern with marijuana is not born out of any culture war mentality, but out of what science tells us about the drug's effects."<sup>117</sup>

## MENTAL HEALTH ISSUES RELATED TO MARIJUANA

There is mounting evidence that use of marijuana, particularly by adolescents, can lead to serious mental health problems.

- “Nearly one in ten first-year college students at a mid-Atlantic university have a cannabis use disorder (CUD) according to a NIDA-funded study of drug use conducted by investigators from the Center for Substance Abuse Research at the University of Maryland.” “Students who had used cannabis five or more times in the past year – regardless of whether or not they met the criteria for CUD – reported problems related to their cannabis use, such as concentration problems (40.1 percent), regularly putting themselves in physical danger (24.3 percent), and driving after using marijuana (18.6 percent).”<sup>118</sup>
- According to a recent report by the Office of National Drug Control Policy on teens, depression and marijuana use:<sup>119</sup>
  - Depressed teens are twice as likely as non-depressed teens to use marijuana and other illicit drugs.
  - Depressed teens are more than twice as likely as their peers to abuse or become dependent on marijuana.
  - Marijuana use can worsen depression and lead to more serious mental illness such as schizophrenia, anxiety, and even suicide.
  - Teens who smoke marijuana at least once a month are three times more likely to have suicidal thoughts than non-users.
  - The percentage of depressed teens is equal to the percentage of depressed adults, but depressed teens are more likely than depressed adults to use marijuana than other drugs.
- According to a recent Australian study, there is now conclusive evidence that smoking cannabis hastens the appearance of psychotic illnesses by up to three years. Dr. Mathew Large from the University of New South Wales reports that “...in addition to early cannabis smoking bringing on schizophrenia it brings it on early by an average of 2.7 years early – earlier than you would have otherwise developed it had you not been a cannabis smoker. The risks for older people is about a doubling of the risk.” “For young people who smoke cannabis regularly, instead of having around a one percent chance of developing schizophrenia during their life they will end up with something like a five percent chance of developing schizophrenia.” Philip Mitchell, head of Psychiatry at the University stated that while “this research can’t distinguish about whether cannabis causes schizophrenia or brings it out in vulnerable people...it makes it very clear that cannabis is playing a significant role in psychosis.”<sup>120</sup>

- Researchers from the University of Oulu in Finland interviewed over 6,000 youth ages 15 and 16 and found that “teenage cannabis users are more likely to suffer psychotic symptoms and have a greater risk of developing schizophrenia in later life.”<sup>121</sup>
- Australian researchers report that long-term, heavy cannabis use may be associated with structural abnormalities in areas of the brain which govern memory, emotion, and aggression. Brain scans showed that the hippocampus was 12 percent smaller and the amygdale 7 percent smaller in men who smoked at least 5 cigarettes daily for almost 10 years. Dr. Mura Yucel, the lead researcher stated that “this new evidence plays an important role in further understanding the effects of marijuana and its impact on brain functions. The study is the first to show that long-term cannabis use can adversely affect all users, not just those in the high-risk categories such as the young, or those susceptible to mental illness, as previously thought.”<sup>122</sup>
- A two-year study by the National Cannabis Prevention and Information Centre, at the University of New South Wales in Sydney, Australia found that cannabis users can be as aggressive as crystal methamphetamine users, with almost one in four men and one in three women being violent toward hospital staff or injuring themselves after acting aggressively. Almost 12 percent were considered a suicide risk. The head of the Emergency Department at St. Vincent’s Hospital, Gordian Fulde, said “that most people still believed marijuana was a soft drug, but the old image of feeling sleepy and having the munchies after you’ve smoked is entirely inappropriate for modern-day marijuana. With hydroponic cannabis, the levels of THC can be tenfold what they are in normal cannabis so we are seeing some very, very serious fallout.”<sup>123</sup>
- A study published in the March 2008 Journal of the American Academy of Child and Adolescent Psychiatry cited the harm of smoking marijuana during pregnancy. The study found a significant relationship between marijuana exposure and child intelligence. Researchers concluded that “prenatal marijuana exposure has a significant effect on school-age intellectual development.”<sup>124</sup>
- Doctors at Yale University documented marijuana’s damaging effect on the brain after nearly half of 150 healthy volunteers experienced psychotic symptoms, including hallucinations and paranoid delusions, when given THC, the drug’s primary active ingredient. The findings were released during a May 2007 international health conference in London.<sup>125</sup>
- U.S. scientists have discovered that the active ingredient in marijuana interferes with synchronized activity between neurons in the hippocampus of rats. The authors of this November 2006 study suggest that action of tetrahydrocannabinol, or THC, might explain why marijuana impairs memory.<sup>126</sup>
- A pair of articles in the *Canadian Journal of Psychiatry* reflects that cannabis use can trigger schizophrenia in people already vulnerable to the mental illness and assert that this fact should shape marijuana policy.<sup>127</sup>
- Memory, speed of thinking, and other cognitive abilities get worse over time with marijuana use, according to a new study published in the March 14, 2006 issue of *Neurology*, the

scientific journal of the American Academy of Neurology. The study found that frequent marijuana users performed worse than non-users on tests of cognitive abilities, including divided attention and verbal fluency. Those who had used marijuana for 10 years or more had more problems with their thinking abilities than those who had used marijuana for 5-to-10 years. All of the marijuana users were heavy users, which was defined as smoking four or more joints per week.<sup>128</sup>

- John Walters, then the Director of the Office of National Drug Control Policy, Charles G. Curie, then the Administrator of the Substance Abuse and Mental Health Services Administration, and experts and scientists from leading mental health organizations joined together in May 2005 to warn parents about the mental health dangers marijuana poses to teens. According to several recent studies, marijuana use has been linked with depression and suicidal thoughts, in addition to schizophrenia. These studies report that weekly marijuana use among teens doubles the risk of developing depression and triples the incidence of suicidal thoughts.<sup>129</sup>
- Dr. Andrew Campbell, a member of the New South Wales (Australia) Mental Health Review Tribunal, published a study in 2005 which revealed that four out of five individuals with schizophrenia were regular cannabis users when they were teenagers. Between 75-80 per cent of the patients involved in the study used cannabis habitually between the ages of 12 and 21.<sup>130</sup> In addition, a laboratory-controlled study by Yale scientists, published in 2004, found that THC “transiently induced a range of schizophrenia-like effects in healthy people.”<sup>131</sup>
- Carleton University researchers published a study in 2005 showing that current marijuana users who smoke at least five “joints” per week did significantly worse than non-users when tested on neurocognition tests such as processing speed, memory, and overall IQ.<sup>132</sup>
- Robin Murray, a professor of psychiatry at London’s Institute of Psychiatry and consultant at the Maudsley Hospital in London, wrote an editorial which appeared in *The Independence on Sunday*, on March 18, 2007, in which he states that the British Government’s “mistake was rather to give the impression that cannabis was harmless and that there was no link to psychosis.” Based on the fact that “...in the late 1980s and 1990s psychiatrists like me began to see growing numbers of young people with schizophrenia who were taking large amounts of cannabis” Murray claims that “...at least 10 percent of all people with schizophrenia in the UK would not have developed the illness if they had not smoked cannabis.” By his estimates, 25,000 individuals have ruined their lives because they smoked cannabis. He also points out that the “skunk” variety of cannabis, which is very popular among young people in Great Britain, contains “15 to 20 percent THC, and new resin preparations have up to 30 percent.”<sup>133</sup>
- Dr. John MacLeod, a prominent British psychiatrist states: “If you assume such a link (to schizophrenia with cannabis) then the number of cases of schizophrenia will increase significantly in line with increased use of the drug.” He predicts that cannabis use may account for a quarter of all new cases of schizophrenia in three years’ time.<sup>134</sup>
- A study by Scientists at the Queensland Brain Institute in Australia on long-term marijuana use and the increased risk of psychosis confirms earlier findings. “Compared with those who had

never used cannabis, young adults who had six or more years since first use of cannabis were twice as likely to develop a non-affective psychosis (such as schizophrenia), " McGrath wrote in a study published in the Archives of General Psychiatry Journal. "They were also four times as likely to have high scores in clinical tests of delusion."<sup>135</sup>

- According to Margaret Trudeau, "Marijuana can trigger psychosis." "Quitting cannabis has been an important part of my recovery from mental illness," Margaret Trudeau, ex-wife of former Canadian prime Minister Pierre Trudeau, reported at a press conference at the Canadian Mental Health Conference in Vancouver on February 15, 2007. "Every time I was hospitalized it was preceded by heavy marijuana use."<sup>136</sup>
- A study by doctors from the National Institute of Drug Abuse found that people who smoked marijuana had changes in the blood flow in their brains even after a month of not smoking. The marijuana users had PI (pulsatility index) values somewhat higher than people with chronic high blood pressure and diabetes, which suggests that marijuana use leads to abnormalities in the small blood vessels in the brain. These findings could explain in part the problems with thinking and remembering found in other studies of marijuana users.<sup>137</sup>
- In a presentation on "Neuroimaging Marijuana Use and Effects on Cognitive Function" Professor Krista Lisdahl Medina suggests that chronic heavy marijuana use during adolescence is associated with poorer performance on thinking tasks, including slower psychomotor speed and poorer complex attention, verbal memory and planning ability. "While recent findings suggest partial recovery of verbal memory functioning within the first three weeks of adolescent abstinence from marijuana, complex attention skills continue to be affected. Not only are their thinking abilities worse, their brain activation to cognitive task is abnormal."<sup>138</sup>

#### *PHYSICAL HEALTH ISSUES RELATED TO MARIJUANA*

Marijuana use also affects the physical health of users.

- Under the Safe Drinking Water and Toxic Enforcement Act of 1986, the Governor of California is required to revise and republish at least once a year the list of chemicals known to the state to cause cancer or reproductive toxicity. On September 11, 2009, the California Environmental Protection Agency, Office of Environmental Health Hazard Assessment, published the latest list. The list includes a new chemical added in June, marijuana smoke, and lists cancer as the type of toxicity.<sup>139</sup>
- A study by researchers at the Erasmus University Medical Center in Rotterdam, Netherlands found woman who smoked pot during pregnancy may impair their baby's growth and development in the womb. The babies born to marijuana users tended to weigh less and have smaller heads than other infants, both of which are linked to increased risk of problems with thinking, memory, and behavioral problems in childhood.<sup>140</sup>
- A long-term study of over 900 New Zealanders by the University of Otago, New Zealand School of Dentistry has found that "heavy marijuana use has been found to contribute to gum disease, apart from the known effects that tobacco smoke was already known to have."<sup>141</sup>

- A study from Monash University and the Alfred Hospital in Australia has found that “bullous lung disease occurs in marijuana smokers 20 years earlier than tobacco smokers. Often caused by exposure to toxic chemicals or long-term exposure to tobacco smoke, bullae is a condition where air trapped in the lungs causes obstruction to breathing and eventual destruction of the lungs.” Dr. Matthew Naughton explains that “marijuana is inhaled as extremely hot fumes to the peak inspiration and held for as long as possible before slow exhalation. This predisposes to greater damage to the lungs and makes marijuana smokers more prone to bullous disease as compared to cigarette smokers.”<sup>142</sup>
- In December 2007 researchers in Canada reported that “marijuana smoke contains significantly higher levels of toxic compounds -- including ammonia and hydrogen cyanide -- than tobacco smoke and may therefore pose similar health risks.” “Ammonia levels were 20 times higher in the marijuana smoke than in the tobacco smoke, while hydrogen cyanide, nitric oxide and certain aromatic amines occurred at levels 3-5 times higher in the marijuana smoke.”<sup>143</sup>
- Marijuana worsens breathing problems in current smokers with chronic obstructive pulmonary disease (COPD), according to a study released by the American Thoracic Society in May 2007. Among people age 40 and older, smoking cigarettes and marijuana together boosted the odds of developing COPD to 3.5 times the risk of someone who smoked neither.<sup>144</sup>
- Scientists at Sweden’s Karolinska Institute, a medical university, have advanced their understanding of how smoking marijuana during pregnancy may damage the fetal brain. Findings from their study, released in May 2007, explain how endogenous cannabinoids exert adverse effects on nerve cells, potentially imposing life-long cognitive and motor deficits in afflicted new born babies.<sup>145</sup>
- A study from New Zealand reports that cannabis smoking may cause five percent of lung cancer cases in that country. Dr. Sarah Aldington of the Medical Research Institute in Wellington presented her study results at the Thoracic Society conference in Auckland on March 26, 2007.<sup>146</sup>
- Researchers at the Fred Hutchinson Cancer Research Center in Seattle found that frequent or long-term marijuana use may significantly increase a man’s risk of developing the most aggressive type of testicular cancer, nonseminoma. Nonseminoma is a fast-growing testicular malignancy that tends to strike early, between the ages of 20 and 35, and accounts for about 40 percent of all testicular-cancer cases. Dr. Stephen Schwartz stated that researchers are still studying the long-term health consequences of marijuana smoking, especially heavy marijuana smoking and “in the absence of more certain information, a decision to smoke marijuana recreationally means that one is taking a chance on one’s future health.”<sup>147</sup>
- According to the 2009 Drug Abuse Warning Network (DAWN), there were 973,591 emergency department (ED) visits involving an illicit drug. Marijuana was involved in 376,467 of these visits, second only to cocaine.<sup>148</sup>

- Among ED visits made by patients aged 20 or younger resulting in drug misuse or abuse, after alcohol, marijuana was the most commonly involved illicit drug (125.3 visits per 100,100).<sup>149</sup>
- On an average day in 2008 there were 723 drug related ED visits for youth 12 to 17 years of age. Of those visits, 129 involved marijuana.<sup>150</sup>
- According to researchers at the Yale School of Medicine, long-term exposure to marijuana smoke is linked to many of the same kinds of health problems as those experienced by long-term cigarette smokers. "...[C]linicians should advise their patients of the potential negative impact of marijuana smoking on overall lung health."<sup>151</sup>
- While smoking cigarettes is known to be a major risk factor for the bladder cancer most common among people age 60 and older, researchers are now finding a correlation between smoking marijuana and bladder cancer. In a study of younger patients with transitional cell bladder cancer, Dr. Martha Terriss found that 88.5 percent had a history of smoking marijuana. Marijuana smoke has many of the same carcinogen-containing tars as cigarettes and may get even more into the body because marijuana cigarettes are unfiltered and users tend to hold the smoke in their lungs for prolonged periods. Dr. Terriss notes that more research is needed, but does recommend that when doctors find blood in a young patient's urine sample, they may want to include questions about marijuana use in their follow-up.<sup>152</sup>
- Smoking marijuana can cause changes in lung tissue that may promote cancer growth, according to a review of decades of research on marijuana smoking and lung cancer. However, it is not possible to directly link pot use to lung cancer based on existing evidence. Nevertheless, researchers indicate that the precancerous changes seen in studies included in their analysis, as well as the fact that marijuana smokers generally inhale more deeply and hold smoke in their lungs longer than cigarette smokers, and that marijuana is smoked without a filter, do suggest that smoking pot could indeed boost lung cancer risk. It is known, they add, that marijuana smoking deposits more tar in the lungs than cigarette smoking does.<sup>153</sup>
- Smoking three cannabis joints will cause you to inhale the same amount of toxic chemicals as a whole pack of cigarettes according to researchers from the French National Consumers' Institute. Cannabis smoke contains seven times more tar and carbon monoxide than cigarette smoke. Someone smoking a joint of cannabis resin rolled with tobacco will inhale twice the amount of benzene and three times as much toluene as if they were smoking a regular cigarette.<sup>154</sup>
- According to research, the use of marijuana by women trying to conceive or those recently becoming pregnant is not recommended, as it endangers the passage of the embryo from the ovary to the uterus and can result in a failed pregnancy. The researchers from Vanderbilt University say a study with mice has shown that marijuana exposure may compromise the pregnancy outcome because an active ingredient in marijuana, tetrahydrocannabinol (THC), interferes with a fertilized egg's ability to implant in the lining of the uterus.<sup>155</sup>
- Infants exposed to marijuana in the womb show subtle behavioral changes in their first days of life, according to researchers in Brazil. The newborns were more irritable than non-exposed

infants, less responsive, and more difficult to calm. They also cried more, startled more easily, and were jitterier. Such changes have the potential to interfere with the mother-child bonding process. "It is necessary to counter the misconception that marijuana is a 'benign drug' and to educate women regarding the risks and possible consequences related to its use during pregnancy," Dr. Marina Carvahlo de Moraes Barros and her colleagues concluded.<sup>156</sup>

- Marijuana smoking has been implicated as a causative factor in tumors of the head and neck and of the lung. The marijuana smokers in whom these tumors occur are usually much younger than the tobacco smokers who are the usual victims of these malignancies. Although a recent study published by the Medical College of Georgia and Stanford University suggests a causal relationship between marijuana exposure and bladder cancer, larger scale epidemiologic and basic science studies are needed to confirm the role of marijuana smoking as an etiologic agent in the development of transitional cell carcinoma.<sup>157</sup>
- According to a 2005 study of marijuana's long-term pulmonary effects by Dr. Donald Tashkin at the University of California, Los Angeles, marijuana smoking deposits significantly more tar and known carcinogens within the tar, such as polycyclic aromatic hydrocarbons, into the airways. In addition to precancerous changes, marijuana smoking is associated with impaired function of the immune system components in the lungs.<sup>158</sup>
- Smoked marijuana has also been associated with an increased risk of the same respiratory symptoms as tobacco, including coughing, phlegm production, chronic bronchitis, shortness of breath and wheezing. Because cannabis plants are contaminated with a range of fungal spores, smoking marijuana may also increase the risk of respiratory exposure by infectious organisms (i.e., molds and fungi).<sup>159</sup>
- Marijuana takes the risks of tobacco and raises them. Marijuana smoke contains more than 400 chemicals and increases the risk of serious health consequences, including lung damage.<sup>160</sup>
- An April 2007 article published by the *Harm Reduction Journal*, and funded by the pro-legalization Marijuana Policy Project, argues that the use of a vaporizer has the potential to reduce the danger of cannabis as far as respiratory symptoms are concerned. While these claims remain scientifically unproven, serious negative consequences still remain. For example, driving skills are still impaired, heavy adolescent use may create deviant brain structure, and 9-12 percent of cannabis users develop symptoms of dependence. A vaporizer offers no protection against these consequences.<sup>161</sup>
- According to two studies, marijuana use narrows arteries in the brain, "similar to patients with high blood pressure and dementia," and may explain why memory tests are difficult for marijuana users. In addition, "chronic consumers of cannabis lose molecules called CB1 receptors in the brain's arteries," leading to blood flow problems in the brain which can cause memory loss, attention deficits, and impaired learning ability.<sup>162</sup>
- A small study (50 patients) was conducted by the University of California San Francisco from 2003 to 2005, leading researchers to find that smoked marijuana eased HIV-related foot pain. This pain, known as peripheral neuropathy, was relieved for 52 percent of the patients in the



controlled experiment. Dr. Donald Abrams, director of the study said that while subjects' pain was reduced he and his colleagues "found that adverse events, such as sedation, dizziness and confusion were significantly higher among the cannabis smokers."<sup>163</sup>

- In response to this study, critics of smoked marijuana were quick to point out that while THC does have some medicinal benefits, smoked marijuana is a poor delivery mechanism. Citing evidence that marijuana smoke is harmful, Dr. David Murray, chief scientist at the Office of National Drug Control Policy, noted that "People who smoke marijuana are subject to bacterial infections in the lungs...Is this really what a physician who is treating someone with a compromised immune system wants to prescribe?"<sup>164</sup>
  - Dr. Murray also said that the findings are "not particularly persuasive" because of the small number of subjects and the possibility that subjects knew they were smoking marijuana and had an increased expectation of efficacy. He expressed the government's support for pain relief for HIV-affected individuals and said that while "We're very much supportive of any effort to ameliorate the suffering of AIDs patients, the delivery mechanism for THC should be pills, and not smoked marijuana, which can cause lung damage and deliver varying dosages of THC."<sup>165</sup>
  - Researchers involved with the University of California San Francisco project admitted that there may be a problem with efforts to gauge the effects of marijuana vs. the effects of a placebo. Some users were immediately able to acknowledge that their sample was indeed cannabis because of the effects of that substance. One participant, Diana Dodson said, "I knew immediately [that I received cannabis] because I could feel the effects."<sup>166</sup>
- Pro-marijuana advocates were encouraged by a medical study published in *Cancer Epidemiology, Biomarkers & Prevention*. The study, published in October 2006, was based on interviews with people in Los Angeles (611 who developed lung cancer, 601 who developed cancer of the head or neck regions, and 1,040 people without cancer who were matched [to other subjects] on age, gender, and neighborhoods). The study found that people who smoke marijuana do not appear to be at increased risk of developing lung cancer.<sup>167</sup> While this study's findings differed from previous studies and researchers' expectations, "[o]ther experts are warning that the study should not be viewed as a green light to smoke pot, as smoking marijuana has been associated with problems such as cognitive impairment and chronic bronchitis."<sup>168</sup> The National Institute on Drug Abuse (NIDA) continues to maintain that smoking marijuana is detrimental to pulmonary functions.
  - In its October, 2006, issue of *NIDA Notes*, mention is made of the most recent Tashkin study. "Biopsies of bronchial tissue provide evidence that regular marijuana smoking injures airway epithelial cells, leading to dysregulation of bronchial epithelial cell growth and eventually to possible malignant changes." Moreover, he adds, because marijuana smokers typically hold their breath four times as long as tobacco smokers after inhaling, marijuana smoking deposits significantly more tar and known carcinogens within the tar, such as polycyclic aromatic hydrocarbons, in the airways. In addition to precancerous changes, Dr. Tashkin found that marijuana smoking is associated with a range of damaging pulmonary effects, including inhibition of the,

tumor-killing and bactericidal activity of alveolar macrophages, the primary immune cells within the lung.”

- NIDA also comments on the Tashkin study in the *Director's Notes* from February 2007. While acknowledging that the study concluded “that the association of these cancers with marijuana, even long-term or heavy use, is not strong and may be below practically detectable limits...these results may have been affected by selection bias or error in measuring lifetime exposure and confounder histories.”<sup>169</sup>
- In October 2006, one of the study's authors, Dr. Hal Morgenstern, Chair of Epidemiology at the University of Michigan School of Public Health, said although the risk of cancer did not prove to be large in the recent study, “I wouldn't go so far as to say there is no increased cancer risk from smoking marijuana.”<sup>170</sup>

#### MARIJUANA AS A PRECURSOR TO ABUSE OF OTHER DRUGS

- Teens who experiment with marijuana may be making themselves more vulnerable to heroin addiction later in life, if the findings from experiments with rats are any indication. “Cannabis has very long-term, enduring effects on the brain,” according to Dr. Yamin Hurd of the Mount Sinai School of Medicine in New York, the study's lead author.<sup>171</sup>
- Marijuana is a frequent precursor to the use of more dangerous drugs and signals a significantly enhanced likelihood of drug problems in adult life. The *Journal of the American Medical Association* reported, based on a study of 300 sets of twins, “that marijuana-using twins were four times more likely than their siblings to use cocaine and crack cocaine, and five times more likely to use hallucinogens such as LSD.”<sup>172</sup>
- Long-term studies on patterns of drug usage among young people show that very few of them use other drugs without first starting with marijuana. For example, one study found that among adults (age 26 and older) who had used cocaine, 62 percent had initiated marijuana use before age 15. By contrast, less than one percent of adults who never tried marijuana went on to use cocaine.<sup>173</sup>
- Columbia University's National Center on Addiction and Substance Abuse (CASA) reports that teens who used marijuana at least once in the last month are 13 times likelier than other teens to use another drug like cocaine, heroin, or methamphetamine and almost 26 times likelier than those teens who have never used marijuana to use another drug.<sup>174</sup>
- In the March 2007 report on substance abuse at America's colleges and universities, CASA notes that between 1993 and 2005, the proportion of students who were daily marijuana users increased 110.5 percent, from 1.9 percent to 4.0 percent (approximately 310,000 students.)<sup>175</sup>
- Marijuana use in early adolescence is particularly ominous. Adults who were early marijuana users were found to be five times more likely to become dependent on any drug, eight times more likely to use cocaine in the future, and fifteen times more likely to use heroin later in life.<sup>176</sup>

- In 2009, an estimated 14.2 percent of past year marijuana users aged 12 or older used marijuana on 300 or more days within the past 12 months.<sup>177</sup>
- In 2009, 4 million Americans aged 12 or older used marijuana daily or almost daily in the past year.<sup>178</sup>
- In 2009, an estimated 36.7 percent or 6.1 million of past month users aged 12 or older used the drug on 20 or more days in the past month.<sup>179</sup>
- In 2009, there were 2.4 million persons who had used marijuana for the first time within the past 12 months; this averages to approximately 6,500 initiates per day.<sup>180</sup>
- On an average day in 2008, 3,695 adolescents 12 to 17 years of age used marijuana for the first time. On an average day in the past year, 563,182 used marijuana.<sup>181</sup>
- Healthcare workers, legal counsel, police and judges indicate that marijuana is a typical precursor to methamphetamine. For instance, Nancy Kneeland, a substance abuse counselor in Idaho, pointed out that "in almost all cases meth users began with alcohol and pot."<sup>182</sup>

## DEPENDENCY AND TREATMENT

- "The basic rule with any drug is if the drug becomes more available in the society, there will be more use of the drug," said Thomas Crowley, a University of Colorado psychiatry professor and director of the university's Division of Substance Dependence. "And as use expands, there will be more people who have problems with the drug."<sup>183</sup>
- A study of substance abuse treatment admissions in the United States between 1998 and 2008, found that although admission rates for alcohol treatment were declining, admission rates per 100,000 population for illicit drug use were increasing. One consistent pattern in every region was the increase in the admission rate for marijuana use which rose 30 percent nationally.<sup>184</sup>
- California, a national leader in 'medical' marijuana use, saw admission for treatment for marijuana dependence more than double over the past decade. Admissions grew from 52 admissions per 100,000 population in 1998 to 113 per 100,000 in 2008, an increase of 117 percent.<sup>185</sup>
- "[R]esearch shows that use of [marijuana] can lead to dependence. Some heavy users of marijuana develop withdrawal symptoms when they have not used the drug for a period of time. Marijuana use, in fact, is often associated with behavior that meets the criteria for substance dependence established by the American Psychiatric Association."<sup>186</sup>

- Of the 21.8 million Americans aged 12 or older who used illicit drugs in the past 30 days in 2009, 16.7 million used marijuana, making it the most commonly used illicit drug in 2009.<sup>187</sup>
- Adults who first started using marijuana at or before the age of 14 are most likely to have abused or been dependent on illicit drugs in the past year.<sup>188</sup>
- Adults who first used marijuana at age 14 or younger were six times more likely to meet the criteria for past year illicit drug abuse or dependence than those who first used marijuana when they were 18 or older (12.6 percent vs. 2.1 percent) and almost twice as likely as those who started between the ages of 15 and 17 (12.6 percent vs. 6.6 percent).<sup>189</sup>
- Among all ages, marijuana was the second most common illicit drug responsible for treatment admissions in 2008 after opioids, accounting for 17 percent of all admissions--outdistancing cocaine, the next most prevalent cause.<sup>190</sup>
- Marijuana dependency and abuse can be moderately improved by various psychotherapy treatments, but reduced use, rather than abstinence, may be the best clinicians can hope for at this time, a new review finds.<sup>191</sup>
- Of all the illicit drugs, marijuana had the highest level of past-year dependence or abuse (4.3 million) in 2009.<sup>192</sup>
- The proportion of admissions for marijuana as the primary substance of abuse increased from 13 percent in 1998 to 17 percent in 2008.<sup>193</sup>
- About four in five (79 percent) of adolescent treatment admissions involved marijuana as a primary or secondary substance.<sup>194</sup>

## DANGERS TO NON USERS

### DELINQUENT BEHAVIORS

Marijuana use is strongly associated with juvenile crime.

- In a 2008 paper entitled *Non-Medical Marijuana III: Rite of Passage or Russian Roulette*, CASA reported that in 2006 youth who had been arrested and booked for breaking the law were four times likelier than those who were never arrested to have used marijuana in the past year.<sup>195</sup>
- According to CASA in their report on *Criminal Neglect: Substance Abuse, Juvenile Justice and the Children Left Behind*, youth who use marijuana are likelier than those who do not to be arrested and arrested repeatedly. The earlier an individual begins to use marijuana, the likelier he or she is to be arrested.

- Marijuana is known to contribute to delinquent and aggressive behavior. A June 2007 report released by the White House Office of National Drug Control Policy (ONDCP) reveals that teenagers who use drugs are more likely to engage in violent and delinquent behavior. Moreover, early use of marijuana, the most commonly used drug among teens, is a warning sign for later criminal behavior. Specifically, research shows that the instances of physically attacking people, stealing property, and destroying property increase in direct proportion to the frequency with which teens smoke marijuana.<sup>196</sup>

In a report titled *The Relationship between Alcohol, Drug Use, and Violence among Students*, the Community Anti-Drug Coalitions of America (CADCA) reported that according to the 2006 Pride Surveys, during the 2005-2006 school year:

- Of those students who report carrying a gun to school during the 2005-2006 year, 63.9 percent report also using marijuana.
- Of those students who reported hurting others with a weapon at school, 68.4 percent had used marijuana.
- Of those students who reported being hurt by a weapon at school, 60.3 percent reported using marijuana.
- Of those students who reported threatening someone with a gun, knife, or club or threatening to hit, slap or kick someone, 27 percent reported using marijuana.
- Of those students who reported any trouble with the police, 39 percent also reported using marijuana.<sup>197</sup>
- According to ONDCP, the incidence of youth physically attacking others, stealing, and destroying property increased in proportion to the number of days marijuana was smoked in the past year.<sup>198</sup>
- ONDCP reports that marijuana users were twice as likely as non-users to report they disobeyed school rules.<sup>199</sup>

#### *DRUGGED DRIVERS*

- The principal concern regarding drugged driving is that driving under the influence of any drug that acts on the brain could impair one's motor skills, reaction time, and judgment. Drugged driving is a public health concern because it puts not only the driver at risk, but also passengers and others who share the road.<sup>200</sup>
- In Montana, where there has been an enormous increase in "medical" marijuana cardholders this past year, Narcotics Chief Mark Long told a legislative committee in April 2010 that "DUI arrests involving marijuana have skyrocketed, as have traffic fatalities where marijuana was found in the system of one of the drivers."<sup>201</sup>

- In 2009 there were 10.5 million persons aged 12 and older who reported driving under the influence of illicit drugs during the past year. The rate was highest among young adults aged 18 to 25.<sup>202</sup>
- The percentage of fatally injured drivers testing positive for drugs increased over the last five years according to data from the National Highway Traffic Safety Administration (NHTSA). In 2009, 33 percent of the 12,055 drivers fatally injured in motor vehicle crashes with known test results tested positive for at least one drug compared to 28 percent in 2005. In 2009, marijuana was the most prevalent drug found in this population – approximately 28 percent of fatally injured drivers who tested positive tested positive for marijuana.<sup>203</sup>
- Results from the Monitoring the Future survey indicated that in 2008 more than 12 percent of high school seniors admitted to driving under the influence of marijuana in the two weeks prior to the survey.<sup>204</sup>
- Recognizing that drugged driving is a serious health and safety issue, the National Organization for the Reform of Marijuana Laws (NORML) has called for a science-based educational campaign targeting drugged driving behavior. In January of 2008, Deputy Director Paul Armentano released a report titled, *Cannabis and Driving*, noting that motorists should be discouraged from driving if they have recently smoked cannabis and should never operate a motor vehicle after having consumed both marijuana and alcohol. The report also calls for the development of roadside, cannabis-sensitive technology to better assist law enforcement in identifying drivers who may be under the influence of pot.<sup>205</sup>
- In a 2007 National Roadside Survey of alcohol and drug use by drivers, a random sample of weekend nighttime drivers across the United States found that 16.3 percent of the drivers tested positive for drugs, compared to 2.2 percent of drivers with blood alcohol concentrations at or above the legal limit. Drugs were present more than 7 times as frequently as alcohol.<sup>206</sup>
- According to the National Institute of Drug Abuse (NIDA) funded study, a large number of American adolescents are putting themselves and others at great risk by driving under the influence of illicit drugs or alcohol. In 2006, 30 percent of high school seniors reported driving after drinking heavily or using drugs, or riding in a car whose driver had been drinking heavily or using drugs, at least once in the prior two weeks. Dr. Patrick O'Malley, lead author of the study, observed that "Driving under the influence is not an alcohol-only problem. In 2006, 13 percent of seniors said they drove after using marijuana while ten percent drove after having five or more drinks." "Vehicle accidents are the leading cause of death among those aged 15 to 20," added Dr. Nora Volkow, Director of NIDA. "Combining the lack of driving experience among teens with the use of marijuana and/or other substances that impair cognitive and motor abilities can be a deadly combination."<sup>207</sup>
- A June 2007 toxicology study conducted at the University of Maryland's Shock-Trauma Unit in Baltimore found that over 26 percent of injured drivers tested positive for marijuana. In an earlier study, the U.S. National Survey on Drug Use and Health estimated that 10.6 million Americans had driven a motor vehicle under the influence of drugs during the previous year.<sup>208</sup>

- In a study of seriously injured drivers admitted to a Maryland Level-1 shock-trauma center, 65.7 percent were found to have positive toxicology results for alcohol and/or drugs. Almost 51 percent of the total tested positive for illegal drugs. A total of 26.9 percent of the drivers tested positive for marijuana.<sup>209</sup>
- Driving under the influence of cannabis almost doubles the risk of a fatal road crash, according to a study published online by the *British Medical Journal* in December 2005. The study took place in France and involved 10,748 drivers who were involved in fatal crashes from October 2001 to September 2003. The risk of being responsible for a fatal crash increased as the blood concentration of cannabis increased. These effects were adjusted for alcohol and remained significant when also adjusted for other factors. The authors of this study assert that these results give credence to a causal relationship between cannabis and crashes.<sup>210</sup>
- A study of over 3000 fatally-injured drivers in Australia showed that when marijuana was present in the blood of the driver they were much more likely to be at fault for the accident. And the higher the THC concentration, the more likely they were to be culpable.<sup>211</sup>
- Drugged driving has become a significant problem in the United Kingdom, where almost 20 percent of drivers involved in fatal accidents had traces of drugs in their systems. The government is planning to issue roadside kits, known as “drugalysers,” which will test a motorist’s saliva and enable the police to identify drivers who are behind the wheel after taking illegal drugs, including marijuana.<sup>212</sup>
- A large shock trauma unit conducting an ongoing study found that 17 percent (one in six) of crash victims tested positive for marijuana. The rates were slightly higher for crash victims under the age of eighteen, 19 percent of who tested positive for marijuana.<sup>213</sup>
- The National Highway Traffic Safety Administration (NHTSA) has found that marijuana significantly impairs one’s ability to safely operate a motor vehicle. According to its report, “[e]pidemiology data from road traffic arrests and fatalities indicate that after alcohol, marijuana is the most frequently detected psychoactive substance among driving populations.” Problems reported include: decreased car handling performance, inability to maintain headway, impaired time and distance estimation, increased reaction times, sleepiness, lack of motor coordination, and impaired sustained vigilance.<sup>214</sup>

Some of the consequences of marijuana-impaired driving are startling:

- An off-duty Nevada Highway Patrol sergeant who caused a three-car crash killing a 47-year-old woman smoked marijuana a maximum of four hours before the accident. Tests showed that Sergeant Edward Lattin had 5.6 nanograms per milliliter of THC in his system before it metabolized and 26 nanograms per milliliter of THC in his blood after it was metabolized. State law allows drivers to have 2 nanograms per milliliter in their bodies before metabolizing and 5 nanograms per milliliter after it metabolizes to allow for issues such as secondhand exposure.<sup>215</sup>

- In Largo, Florida, a 54 year-old male driver high on marijuana struck and killed a pedestrian. A witness said that Karl Merl made no effort to avoid the 83 year old woman. Merl had 11 nanograms per milliliter of THC in his blood.<sup>216</sup>
- A 34 year-old male driver from Lower Paxton Township in Pennsylvania smoked marijuana and crashed his speeding car into another vehicle, killing an 87-year-old woman. Investigators of the February 2007 crash found marijuana in the driver's bloodstream, as well as partially smoked marijuana cigarettes in his car.<sup>217</sup>
- An 18 year-old was charged with reckless homicide in Jasper, Indiana after authorities said he crashed a pickup into a tree while under the influence of marijuana, killing his 16-year-old sister and two other teens. Authorities said the youth was under the influence of marijuana when he tried to pass another vehicle at high speed.<sup>218</sup>
- Police advised that a teen driver whose car veered into a school bus on August 22, 2006 in LaPorte, Michigan, was under the influence of marijuana. The teen was charged with operating while intoxicated, a Class A misdemeanor. Police said tests conducted at LaPorte Hospital detected marijuana in his bloodstream; however, since the drug can remain in the body for several weeks, the results did not show when he had used marijuana. While the teen was taken to the intensive care unit with a fracture to the upper left leg or hip, along with head injuries, none of the students on the bus were hurt.<sup>219</sup>
- The driver of a charter bus, whose 1999 accident resulted in the death of 22 people, had been fired from bus companies in 1989 and 1996 because he tested positive for marijuana four times. A federal investigator confirmed a report that the driver "tested positive for marijuana when he was hospitalized Sunday after the bus veered off a highway and plunged into an embankment."<sup>220</sup>
- In April 2002, four children and the driver of a van died when the van hit a concrete bridge abutment after veering off the freeway. Investigators reported that the children had nicknamed the driver "Smokey" because he regularly smoked marijuana. The driver was found at the crash scene with marijuana in his pocket.<sup>221</sup>
- A former nurse's aide was convicted in 2003 of murder and sentenced to 50 years in prison for hitting a homeless man with her car and driving home with his mangled body "lodged in the windshield." The incident happened after a night of drinking and taking drugs, including marijuana. After arriving home, the woman parked her car, with the man still lodged in the windshield, and left him there until he died.<sup>222</sup>
- In 2005, an eight year-old boy was killed when he was run over by an unlicensed 16-year-old driver who police believed had been smoking marijuana just before the accident.<sup>223</sup>
- Duane Baehler, 47, of Tulsa, Oklahoma was "involved in a fiery crash that killed his teenage son" in 2003. Police reported that Baehler had methamphetamine, cocaine and marijuana in his system at the time of the accident.<sup>224</sup>



## OTHER CONSEQUENCES OF MARIJUANA USE

- In Massachusetts in 2009 the possession of one ounce of marijuana went from a criminal charge to a civil fine. Police and District Attorneys want residents to know that smoking weed is not a victimless crime. Middlesex District Attorney Gerard T. Leone Jr. says that he fears that “decriminalization has created a booming ‘cottage industry’ for dope dealers to target youths no longer fearing the stigma of arrest or how getting high could affect their already dicey driving. What we’re seeing now is an unfortunate and predictable outcome. It’s a cash and carry business. With more small-time dealers operating turf encroachment is inevitable. This tends to make drug dealers angry.” Wellesly Deputy Police Chief William Brooks III, speaking on behalf of the Massachusetts Chiefs of Police Association said “the whole thing is a mess. The perception out there among a lot of people is it’s ok to do it now, so there’s an uptick in the number of people wanting to do it...Most of the drug-related violence you see now – the shootings, murders – is about weed.” Several 2010 high-profile killings have been linked by law enforcement to the increased market:
  - The May fatal shooting of a 21-year-old inside a Harvard University dorm, allegedly in a bid to rob him of his pot and cash.
  - The June murder of a 17-year-old in Callahan State Park, where he was lured by two men seeking revenge in a fight over marijuana.
  - The September massacre of four people in Mattapan, including a 21-year-old woman and her 2-year-old son, over an alleged pot-dealing turf dispute.
  - The September fatal shooting of a 29-year-old man, by four men, one a high school senior, in connection with robbery and murder of a drug dealer.<sup>225</sup>
- Children often bear the consequences of actions engaged in by parents or guardians involved with marijuana.
  - In Bradenton, Florida a Highway Patrol officer tried to stop a man speeding on I-75. The driver did not stop until he ran up on the median and crashed into a construction barrel. In the car the troopers found three small children, forty pounds of marijuana and several thousand dollars in cash.<sup>226</sup>
  - A Hamilton, Montana man put his three toddlers in the back seat of his one ton Chevy pickup and then partied with a friend as he drove along the highway. At 50 miles an hour he swerved into another car killing the owner. While partying with his friend in the vehicle he had smoked two bowls of pot.<sup>227</sup>
  - An Ohio mother is accused of teaching her two-year-old daughter smoke pot and recording the incident on her cell phone.<sup>228</sup>

- A Virginia mother and her roommate were charged with reckless child endangerment after her two-year-old daughter ingested an unknown amount of marijuana in a motel room.<sup>229</sup>
- A California couple was arrested after a video surfaced of them allowing their 23-month-old son to use a marijuana pipe. The video showed the child smoking the pipe. The pipe was tested and found to have marijuana residue in it. Both parents said they had medical marijuana cards, but could not explain why they would give it to their child and then videotape the incident.<sup>230</sup>
- Cincinnati, Ohio police arrested a woman for allegedly giving her three children, ages seven, four and one marijuana. The seven-year-old told the school counselor that she had been forced to smoke marijuana. All three children tested positive for marijuana.<sup>231</sup>
- In Stockton, California a two-year-old girl was in critical condition after ingesting marijuana resin. Although four adults were home at the time, none were supervising the child when she found a jar lid containing resin.<sup>232</sup>
- Two toddlers in Louisiana were hospitalized after ingesting marijuana and amphetamines. A search warrant of the home found several unsecured bottles of prescription medication and a hand-rolled cigar containing marijuana.<sup>233</sup>
- In Santa Clara, California, in one week in December, four dispensaries and one marijuana grower were hit by vandals, burglars, or armed robbers. At one location four suspects robbed the victim by throwing him to the floor, holding a piece of metal to his throat, and demanding marijuana and money. At one dispensary, the owner, who is paralyzed and in a wheelchair, was closing up the shop when armed robbers knocked him over and barged in. The robbers tied him up and took marijuana and cash.<sup>234</sup>

- The Los Angeles Police Department is investigating a series of robberies and shootings at marijuana dispensaries. Over a one week period in June 2010 a Northridge dispensary robbery left one employee in critical condition after being shot in the face; the shooting was the second at that business that year and the third dispensary to be targeted in three days. Two people were fatally shot in a pot shop robberies in Echo Park and Hollywood, and a third person was wounded.<sup>235</sup>
- On March 4, 2010, a California man was killed after opening fire on two Pentagon Police Officers. In a story on MSNBC, the Friday before the incident, John Patrick Bedell's parents had warned local authorities that his behavior had become erratic and that he was unstable and had a gun. Bedell was diagnosed as bipolar and had been in and out of treatment programs for years. His psychiatrist, J. Michael Nelson, said "Bedell tried to self-medicate with marijuana, inadvertently making his symptoms more pronounced."<sup>236</sup> Bedell had been given a prescription for medical use of marijuana in 2006 for chronic insomnia. According to long-time friend Reb Monaco "he was not a person who should have been issued a medical clearance to use marijuana, but he was."<sup>237</sup>
- A marijuana dealer kidnapped and murdered a 15 year-old boy after he got angry at the teen's half-brother for owing him a \$2,500 drug debt.<sup>238</sup>
- A 27-year-old lawyer, Oxford educated, fell to his death from the top floor of a London building following years of treatment for cannabis-induced mental illness. The February 2007 inquest revealed that he had been suffering from bi-polar affective disorder-manic depression, which "may have been triggered by cannabis use."<sup>239</sup>
- Marijuana also creates hazards that are not always predictable. In August 2004, two Philadelphia firefighters died battling a fire that started because of tangled wires and lamps used to grow marijuana in a basement closet.<sup>240</sup>
- All six people aboard a Piper Cherokee were killed when it crashed soon after take-off on Hamilton Island in North Queensland, Australia on September 2002. Toxicologist Professor Olaf Drummer told the inquest that blood tests on the 27-year-old pilot indicated that he had used marijuana either in the hours leading up to the crash or he could have been a regular user.<sup>241</sup>
- Grant Everson and three friends armed with box cutters and a shot-gun slipped into Everson's parents' Chaska, Minnesota home demanding money to open a coffeehouse in the marijuana-friendly City of Amsterdam. Although Grant lost his nerve, his friends proceeded to shoot and kill his mother. All four were arrested. Their alibi was that they had been sleeping in the same Burnsville apartment after a night of smoking marijuana and playing video games.<sup>242</sup>
- The National Transportation Safety Board investigation of a small plane crash near Walnut Ridge, Arkansas, killing a passenger and the pilot, was a result of pilot error. Pilot Jason Heard failed to fly high enough and maintain enough airspeed to avoid a stall. The report notes that Pilot Jason Heard had enough marijuana in his system to have contributed to the accident.<sup>243</sup>

## MARIJUANA AND INCARCERATION

Federal marijuana investigations and prosecutions usually involve hundreds of pounds of marijuana. Few defendants are incarcerated in federal prison for simple possession of marijuana.

- In 2008, according to the United States Sentencing Commission (USSC), 25,337 people were sentenced in federal court for drug crimes under six offense categories. Marijuana accounted for 6,337 (25 percent). Looking even further, of the 6,337 people sentenced, only 99 people or 1.6 percent, were sentenced for “simple possession” of marijuana.<sup>244</sup>
- According to a Bureau of Justice Statistics survey of state and federal prisoners published in October 2006, approximately 12.7 percent of state prisoners and 12.4 percent of federal prisoners were serving time for a marijuana-related offense. This is a decrease from 1997 when these figures were 12.9 percent and 18.9 percent respectively.<sup>245</sup>
- Between October 1, 2005 and September 30, 2006, there were 6,423 federal offenders sentenced for marijuana-related charges in the U.S. Courts. Approximately 95.9 percent of the cases involved trafficking.<sup>246</sup>
- In Fiscal Year 2006, there were 25,814 offenders sentenced in federal court on drug charges. Of those, only 1.6 percent (406 people) were sentenced for simple possession.<sup>247</sup>
- According to the White House Office of National Drug Control Policy, “Many inmates ultimately sentenced for marijuana and possession were initially charged with more serious crimes but were able to negotiate reduced charges or lighter sentences through plea agreements with prosecutors. Therefore the ... figure for simple possession defendants may give an inflated impression of the true numbers, since it also includes these inmates who pled down from more serious charges.”<sup>248</sup>
- Findings from the 2008 Arrestee Drug Abuse Monitoring System (ADAM II), which surveys drug use among booked male arrestees in ten major metropolitan areas across the country, shows the majority of arrestees in each city test positive for illicit drug use, with as many as 87 percent of arrestees testing positive for an illegal drug. Marijuana is the most commonly detected drug at the time of the arrest. In seven of the ten sites arrestees who are using marijuana are using it on the average of every other day for the past 30 days.<sup>249</sup>

## *THE FOREIGN EXPERIENCE WITH MARIJUANA*

Many European countries are re-thinking their liberal marijuana policies in the face of evidence that cannabis use has significant mental and physical consequences and may lead to higher crime rates, increased social costs and degradation of their quality of life. "Few adults in Europe believe marijuana should be readily available for personal consumption," according to the Eurobarometer conducted by NS Opinion and Social in September - October, 2006. "Only 26 percent of respondents in 30 countries believe cannabis should be legalized."<sup>250</sup>

There is no uniform drug policy in Europe. Some countries have liberalized their laws, while others have instituted strict drug control policies, which mean that the so called "European Model" is a misnomer. Like America, the various countries of Europe are looking for new ways to combat the worldwide problem of drug abuse.

In recent years the European Monitoring Center for Drugs and Drug Addiction (EMCDDA) has reported a tendency among European countries to make a stronger distinction between those who use drugs and those who sell or traffic drugs. This distinction is reflected in the reduction of penalties for drug use in some countries, though others have not changed or increased penalties. EMCDDA reports that recently, the penalties for drug offenses in Europe have generally increased. "Most of the reported drug law offenses are related to use and possession for use rather than supply, and whereas offenses related to supply increased by 12 percent, those related to possession have increased by over 50 percent." Cannabis continued to be the drug most often associated with drug law offenses. The view expressed by some that in Europe you are unlikely to be charged with a drug offense if caught using marijuana is not supported by the data.<sup>251</sup>

In the Annual Report for 2010, the EMCDDA has noted the increase in domestic cannabis production and its resulting negative effects. According to Wolfgang Götz, "Organized crime gangs have woken up to the profits that can accrue from the large-scale cultivation of cannabis near its intended market. The collateral damage of this development is the rising level of violence and criminality within urban communities, which is now triggering new action by the national and European law-enforcement bodies."<sup>252</sup>

### Australia

- On October 11, 2009 Premier Colin Barnett announced that the Government "would introduce legislation to repeal the Cannabis Control Act 2003 and make changes to the Misuse of Drugs Act 1981 and the Young Offenders Act 1994, sending a clear message that the current State Government did not endorse illicit drug use." "The new anti-cannabis laws will mark the start of the Liberal-National Government's fight to turn around eight years of a soft-on-drugs approach by the previous Labor government which has left lives ruined."<sup>253</sup>
- In a reversal of their 2006 official position, the Australian Medical Association has called on the state government of Western Australia to introduce harsher marijuana laws. The AMA cited a recent review of international research on the links between marijuana and mental illness. AMA president Dr. Rosanna Capolingua said that "soft marijuana laws certainly do not help support the message that marijuana is not a soft drug."<sup>254</sup>

- Drug Free Australia official Craig Thompson is urging the community, young people in particular, to change their thinking about cannabis because of its serious effects on health. “The road fatalities caused by cannabis-intoxicated drivers, links to cannabis and psychosis, birth defects and greater potency of the drug are just a few issues of enormous concern,” Mr. Thompson said.<sup>255</sup>

### Canada

- In August 2006, Ontario gave new powers to police, utilities and municipalities to crack down on marijuana grow operations and methamphetamine labs running from residential locations. The province’s anti-drug legislation was toughened to protect communities and allows police to work more effectively with citizens in identifying and uprooting marijuana operations. New provisions to the law include allowing water and power utilities officials to inspect buildings suspected to house marijuana grow operations.<sup>256</sup>
- After a large decline in the 1980s, marijuana use among teens increased during the 1990s as young people became “confused about the state of federal pot law” in the wake of an aggressive decriminalization campaign, according to a special adviser to Health Canada’s Director General of Drug Strategy. Several Canadian drug surveys show that marijuana use among Canadian youth has steadily climbed to surpass its 26-year peak, rising to 29.6 percent of youth in grades 7-12 in 2003.<sup>257</sup>

### Germany

- As The Netherlands cracks down on cannabis cultivation, it is pushing its drug gangs into Germany. Since 2004, 30 “cannabis plantations” have been shut down near the Dutch border. In addition, the Dutch government has forced a number of “coffee shops” that sell illegally produced hash and marijuana to move their operations out of city centers and closer to the Dutch-German border. Demand for marijuana among German youth is higher than ever, and investigators in Krefeld estimate that the coffee shops attract 54,000 customers each month, with 50,000 coming from Germany.<sup>258</sup>

### The Netherlands

- The Netherlands has led Europe in the liberalization of drug policy. “Coffee shops” began to emerge throughout The Netherlands in 1976, offering marijuana products for sale. Possession and sale of marijuana are not legal, but coffee shops are permitted to operate and sell marijuana under certain restrictions, including a limit of no more than 5 grams sold to a person at any one time, no alcohol or hard drugs, no minors, and no advertising. In The Netherlands it is illegal to sell or possess marijuana products. So coffee shop operators must purchase their marijuana products from illegal drug trafficking organizations.
- On January 2, 2007, the majority of the City Council in Amsterdam voted in favor of introducing a city-wide ban on smoking marijuana in public in areas where young people smoking joints have been causing a public nuisance. Their decision was based upon the success of the experimental ban in DeBaarsjes.<sup>259</sup>

- According to a *New York Times* article, “The mayor (of Maastricht) wants to move most of the city’s 16 licensed cannabis clubs to the edge of town, preferably close to the border” (with Belgium and Germany). Mayor Gerd Leers is reacting to growing concerns among residents who “complain of traffic problems, petty crime, loitering and public urination. There have been shootings between Balkan gangs. Maastricht’s small police force...is already spending one-third of its time on drug-related problems.” Cannabis clubs have drawn “pushers of hard drugs from Amsterdam, who often harass people on the streets.” The clubs have also attracted people looking to buy marijuana in quantity. Piet Tans, the police spokesman also stated that “People who come from far away don’t just come for the five grams you can buy legally over the counter...They think pounds and kilos; they go to the dealers who operate in the shadows.”<sup>260</sup>
- Moving the clubs did not prove to be an effective strategy to deal with the problem. As of January 1, 2010, coffee shops in the province of Limburg (which includes Maastricht) will be accessible only to registered members. Justice Minister Ernst Hirsch Ballin also stated that “it would become easier to keep minors out of the coffee shops.”<sup>261</sup>
- Although the Dutch government regulated what goes on in coffee shops, they have never legalized or regulated how the shops got their marijuana supply. The volume of sales generated by customers from bordering countries and tourists have made these shops regional suppliers. This has resulted in the creation of an illegal cultivation industry involving organized crime and money laundering.
- Paul Schnabel, director for the Social and Cultural Planning Office, a government advisory board, said that the move reflects a growing view that the tolerance policies have not controlled the ills associated with drugs and prostitution. “There’s a strong tendency in Dutch society to control things by allowing them...” “Dutch society is less willing to tolerate than before.”<sup>262</sup>
- Due to international pressure on permissive Dutch cannabis policy and domestic complaints over the spread of marijuana “coffee shops,” the Government of the Netherlands has reconsidered its legalization measures. After marijuana became normalized, consumption nearly tripled – from 15 percent to 44 percent – among 18 to 20 year-old Dutch youth.<sup>263</sup> As a result of stricter local government policies, the number of cannabis “coffeehouses” in the Netherlands was reduced – from 1,179 in 1997<sup>264</sup> to 737 in 2004, a 37 percent decrease in 7 years.<sup>265</sup>
- About 70 percent of Dutch towns have a zero-tolerance policy toward cannabis cafes.<sup>266</sup>
- Dr. Ernest Bunning, formerly with Holland’s Ministry of Health and a principal proponent of that country’s liberal drug philosophy, has acknowledged that, “[t]here are young people who abuse soft drugs . . . particularly those that have [a] high THC [content]. The place that cannabis takes in their lives becomes so dominant they don’t have space for the other important things in life. They crawl out of bed in the morning, grab a joint, don’t work, smoke another joint. They don’t know what to do with their lives.”<sup>267</sup>

- “Contrary to what is often claimed by supporters of the Dutch drug policy, cannabis usage by young people in The Netherlands is not lower but actually higher than average in Europe,” according to the findings of the 2007 European School Survey on Alcohol and Other Drugs (ESPAD). “The Netherlands scores above the European average. Over one-quarter (28 percent) of the youngsters aged 15 and 16 surveyed said they have used cannabis sometime in their life, compared with an average of 19 percent in Europe. Current Cannabis usage (at least once in the month prior to the survey) is more than double the European average in The Netherlands (15 percent versus 7 percent).”<sup>268</sup>
- An article published in April 2009 summarizes the challenge now faced by the Dutch as a result of their drug policies. “The Netherlands has risen in the ranking order of 35 European countries from number 12 in 2003 to number 5 on recent cannabis usage... The Dutch youngsters, possibly due to the liberal climate, widely believe that cannabis is innocent. The proportion of school children that thinks regular cannabis usage involves big risks is the lowest in the Netherlands (50 percent) of all countries surveyed.”<sup>269</sup>

## Portugal

- In July 2001, Portugal decriminalized all drugs, increased drug education efforts, and expanded the drug treatment programs. Drug possession for personal use and drug usage are still legally prohibited, although treated through an administrative process rather than a criminal one. Instead of being placed in the judicial system they are sent to dissuasion commissions run by the government. The commissions, made up of doctors, lawyers, and social workers, encourage addicts to undergo treatment and stop recreational users from becoming addicts.
- Anyone having enough drugs to exceed a ten day supply can be arrested, sentenced to jail, or given a criminal record. Drug trafficking is still a criminal offense.
- There is still much debate upon the success of this initiative. Those on each side of the legalization debate argue as to whether or not things improved in Portugal as a result of the decriminalization of use or as a result of the prevention efforts and accessibility of treatment programs. There are many different views on the measurement of the successes or failures of this initiative. Would the same results have happened if Portugal offered the emphasis of drug education and the accessibility of drug treatment without decriminalizing drug use? Would treating drug use and addiction as a health problem rather than a criminal justice problem have produced similar results?
- Clearly there is still plenty of work that needs to be done. The latest EMCDDA report reveals that drug use among the general population is still rising. The number of Portuguese aged 15 to 64 who have ever tried drugs has climbed from 7.8 percent in 2001 to 12 percent in 2007. Cannabis use went up from 7.6 percent to 11.7 percent.<sup>270</sup>
- What is clear is that Portugal believes that it is a combination of prevention, education, treatment and law enforcement that is needed to address the drug situation – no one aspect alone can effectively eradicate drug use and the problems it causes. This is the same strategy that is used by the United States.



## Singapore

- As of August 1, 2007, marijuana users caught in Singapore face mandatory treatment in Drug Rehabilitation Centers. However, people who undergo the treatment and subsequently get arrested again for marijuana use face a mandatory minimum five-year prison sentence, plus three strokes of the cane. Three-time offenders get seven years in prison plus six strokes.<sup>271</sup>

## Switzerland

- In December 2008, 63 percent of Swiss voters voted against an initiative to decriminalize marijuana. The government, which opposed the proposal, feared that liberalizing marijuana would cause problems from neighboring countries. "This could lead to a situation where you have some sort of cannabis tourism in Switzerland because of something that is illegal in the EU would be legal in Switzerland," a government spokesman said.<sup>272</sup>
- Liberalization of marijuana laws in Switzerland has likewise produced damaging results. After liberalization, Switzerland became a magnet for drug users from many other countries. In 1987, Zurich permitted drug use and sales in a part of the city called Platzpitz, dubbed "Needle Park." By 1992, the number of regular drug users at the park reportedly swelled from a "few hundred at the outset in 1987 to about 20,000." The area around the park became crime-ridden, forcing closure of the park. The experiment has since been terminated.<sup>273</sup>

## United Kingdom

- A 2009 Scottish Social Attitudes Survey on public attitudes toward illegal drugs and misuse in Scotland found a reversal in the tolerant attitudes toward cannabis. Support for legalization fell from 37 percent in 2001 to 24 percent in 2009. Even among those that had tried cannabis, support for legalization fell from 70 percent in 2001 to 47 percent in 2009. Attitudes for prosecution for possession hardened during the same time period. In 2001, 51 percent felt that people should not be prosecuted for possession of a small amount of cannabis for personal use, but in 2009 only 34 percent concurred. Most startling was the fact that the shifts were most prevalent among 18-24 year-olds. In 2001 62 percent of this age group was in favor of legalization; in 2009, only 24 percent felt that way.<sup>274</sup>
- In a statement to the press, Home Secretary Jacqui Smith announced on May 8, 2008 that cannabis is being reclassified back to a Class B drug, sending a strong message that the drug is harmful. Addressing the House of Commons, Secretary Smith cited the need to update public policies to match recent scientific evidence about the serious harms of marijuana use; "the enforcement response must reflect the danger that the drug poses to individuals, and in turn, to communities."<sup>275</sup>
- A major newspaper in England, *The Independent on Sunday*, reversed its very public stance in support of marijuana. After a pro-cannabis editorial appeared in 1997, 16,000 people marched on London's Hyde Park. The editorial and the subsequent march were credited with forcing the government to downgrade the legal status of cannabis to class C. However, an editorial in the

March 18, 2007 issue, titled "Cannabis: An Apology," states that the paper is reversing its decision. "In 1997, when this paper called for decriminalization, 1,600 people were being treated for cannabis addiction. Today, the number is 22,000." Concerns such as the record number of teenagers requiring drug treatment as a result of smoking skunk (a highly potent cannabis strain) and the growing proof that skunk causes mental illness were cited among the reasons for this reversal.<sup>276</sup>

- In March 2005, British Home Secretary Charles Clarke took the unprecedented step of calling "for a rethink on Labour's legal downgrading of cannabis" from a Class B to a Class C substance. Mr. Clarke requested that the Advisory Council on the Misuse of Drugs complete a new report, taking into account recent studies showing a link between cannabis and psychosis and also considering the more potent cannabis referred to as "skunk."<sup>277</sup>
- In 2005, during a general election speech to concerned parents, British Prime Minister Tony Blair noted that medical evidence increasingly suggests that cannabis is not as harmless as people think and warned parents that young people who smoke cannabis could move on to harder drugs.<sup>278</sup>

### **2006 World Drug Report**

- The *2006 World Drug Report* outlines significant global progress achieved in reducing the threat of drugs over 2005 and also highlights challenges to international efforts to stem the trafficking, use and production of dangerous, addictive drugs. Among the key findings of this report is that drug traffickers have invested heavily in increasing the potency of cannabis, which has produced devastating effects. As a result, the characteristics of cannabis are no longer that different from those of other plant-based drugs, such as cocaine and heroin. This report contends that differing messages as well as legislative changes by various governments regarding marijuana leave young people confused as to just how dangerous cannabis is.<sup>279</sup>

## **OTHER CONSIDERATIONS**

### ***MARIJUANA USE AMONG YOUTH IS RISING AS PERCEPTION OF RISK DECREASES***

- In December 2010, the Monitoring the Future Report indicated that after watching marijuana use have a gradual and steady decline in the last decade this trend has changed.
- Marijuana use rose for all prevalence periods this year – lifetime, past year, past 30-days, and daily in the past 30-days – for all three grades.
- Daily or near-daily use of marijuana (use on 20 or more occasions in the prior 30 days) increased significantly: for 8<sup>th</sup> (1.2 percent), 10<sup>th</sup> (3.3 percent) and 12<sup>th</sup> (6.1 percent) graders. This means that for 12<sup>th</sup> graders one in sixteen use marijuana on a daily or near-daily basis.

- One possible explanation for the resurgence in marijuana use is that in recent years fewer teens report seeing much danger associated with its use, even regular use. Both perceived risk and disapproval continued to decline in all three grades this year.<sup>280</sup>
- The perception that regular marijuana smoking is harmful decreased for 10<sup>th</sup> graders (down from 59.4 percent in 2009 to 57.2 percent in 2010) and 12<sup>th</sup> graders (from 52.4 percent in 2009 to 46.8 percent in 2010). Moreover disapproval of smoking marijuana decreased significantly among 8<sup>th</sup> graders.
- For 12<sup>th</sup> graders, declines in cigarette use accompanied by recent increase in marijuana use have put marijuana ahead of cigarette smoking in some measures. In 2010, 21.4 percent of high school seniors used marijuana in the past 30 days, while 19.2 percent smoked cigarettes.
- “We should examine the extent to which the debate over medical marijuana and marijuana legalization for adults is affecting teens’ perceptions of risk,” said NIDA Director Dr. Nora Volkow. We must also find better ways to communicate to teens that marijuana use can harm their short-term performance as well as their long-term potential.”<sup>281</sup>
- The 2009 National Survey on Drug Use and Health shows that among youth aged 12 to 17, the current illicit drug use rate increased from 2008 (9.3 percent) to 2009 (10 percent) and increased for marijuana use from 6.7 percent to 7.3 percent.<sup>282</sup>
- The percentage of youths aged 12 to 17 indicating great risk in smoking marijuana once a month decreased from 33.9 percent in 2008 to 30.7 percent in 2009.<sup>283</sup>
- The rate of youths aged 12 to 17 perceiving great risk in smoking marijuana once or twice a week also decreased from 33.9 percent in 2008 to 30.7 percent in 2009.<sup>284</sup>
- The 2009 Partnership Attitude Tracking Study (PATS), an annual survey of teens in grades 9 through 12 also shows a reversal in the declines in teen abuse and alcohol that hasn’t been seen since 1998. Past year use of marijuana shows a 19 percent increase (from 32 percent in 2008 to 38 percent in 2009). Between 1998-2008 marijuana use had decreased by 30 percent. Underlying these increases are negative shifts in teen attitudes, particularly a growing belief in the benefits and acceptability of drug use and drinking.<sup>285</sup>

#### *INCREASED ERADICATION*

- During 2009, DEA’s Domestic Cannabis Eradication/Suppression Program supported the eradication of 9,474,867 plants in the top seven marijuana producing states (California, Kentucky, Oregon, Tennessee, Utah, Washington, and West Virginia). This is an increase of 2,325,335 eradicated plants over the previous year.<sup>286</sup>
- During the 2009 eradication season, a total of over 10.3 million marijuana plants were eradicated across the United States. This is a 2.38 million plant increase over 2008.<sup>287</sup>

## IN THEIR OWN WORDS

“We created Prop. 215 so patients would not have to deal with the black market profiteers. But today it is all about the money. Most of the dispensaries operating in California are a little more than dope dealers with store fronts.”

- **Reverend Scott T. Imler**, co-author of Proposition 215, the 1996 ballot initiative that legalized medical marijuana in California, *Alternatives Magazine*, Fall 2006, issue 39.

“When we wrote Proposition 215, we were selling it to the public as something for seriously ill people... It’s turned into a joke. I think a lot of people have medicalized their recreational use.”

- **Reverend Scott T. Imler**, in an interview with Sandy Mazza, *San Gabriel Valley Tribune*, February 15, 2007.

“No reasonable person would have gathered that they were voting on setting up marijuana stores back in 1996.”

- **Mark A.R. Kleinman**, Professor of Public Policy, UCLA, December 27, 2006.

“Quitting cannabis has been an important part of my recovery from mental illness. Marijuana can trigger psychosis. Every time I was hospitalized it was preceded by heavy marijuana use.”

- **Margaret Trudeau**, ex-wife of former Canadian Prime Minister Pierre Trudeau, at the Canadian Mental Health Conference in Vancouver, February 15, 2007.

“Many [people] subscribe to the vague, laissez-faire tolerance of cannabis which is increasingly prevalent among educated people in Western countries. That consensus needs to be challenged. Evidence of the damage to mental health caused by cannabis use is mounting and cannot be ignored.” “It is time to explode the myth of cannabis as a “soft” drug.”

- **Antonio Maria Costa**, Executive Director, United Nations Office on Drugs and Crime, March 2007.

“Traditional 1960s herbal cannabis contained about 2-3 percent of the active ingredient tetrahydrocannabinol (THC); but today’s skunk varieties may contain 15 or 20 percent THC, and new resin preparations have up to 30 percent. Skunk is to old-fashioned hash as whiskey is to lager. You can become an alcoholic just by drinking lager; but you have to drink a lot more lager than whiskey. Similarly, you can go psychotic if you smoke enough traditional marijuana, but you have to consume a lot more for a longer time than with skunk.”

- **Professor Robin Murray**, London’s Institute of Psychiatry, *The Independent on Sunday*, March 21, 2007.

“I’ve been astonished by the way medical marijuana has become a commercial business... The energy is in medical marijuana for the younger generation, and there’s an actual economy of it.”

- **Dale Gieringer**, Director of California NORML and a Proposition 215 author, in an interview with Vanessa Grigoriadis, *Rolling Stone* magazine, February 7, 2007.

“Our current experience with legal, regulated prescription drugs like Oxycontin shows that legalizing drugs is not a panacea. In fact, its legalization widens its availability and misuse, no matter what controls are in place.”

- **Gil Kerlikowske**, Director, ONDCP, *Why Marijuana Legalization Would Compromise Public Health and Safety*, Annotated Remarks to the California Police Chiefs Association Conference, March 4, 2010.

## APPENDIX

### ACRONYMS USED IN "THE DEA POSITION ON MARIJUANA"

AAP	American Academy of Pediatrics
ACS	American Cancer Society
ADAM	Arrestee Drug and Alcohol Monitoring
AMA	American Medical Association
BBC	British Broadcasting Company
BMA	British Medical Association
CADCA	Community Anti-Drug Coalitions of America
CB1	Cannabinoid Receptor 1: one of two receptors in the brain's endocannabinoid (EC) system associated with the intake of food and tobacco dependency.
CBD	Cannabidiol, one of the cannabinoids found in marijuana
CMCR	Center for Medicinal Cannabis Research
DASIS	Drug and Alcohol Services Information System
DEA	Drug Enforcement Administration
EMCDDA	European Monitoring Center for Drugs and Drug Addiction
FDA	Food and Drug Administration
HIV	Human Immunodeficiency Virus
INCB	International Narcotics Control Board
IOM	Institute of Medicine
IOP	Intraocular Pressure
LSD	Diethylamide-Lysergic Acid
MS	Multiple Sclerosis
MTF	<i>Monitoring the Future</i> , an annual survey conducted by the University of Michigan on youth drug use
NHTSA	National Highway Traffic Safety Administration
NIDA	National Institute on Drug Abuse
NMSS	National Multiple Sclerosis Society
NORML	National Organization for the Reform of Marijuana Laws
NSDUH	National Survey of Drug Use and Health
ONDCP	Office of National Drug Control Policy
TEDS	Treatment Episode Data Set
THC	Tetrahydrocannabinol, the main psychoactive substance found in the marijuana plant
USSC	United States Sentencing Commission

## ENDNOTES

- <sup>1</sup> As of December 31, 2010, the 15 states that have decriminalized certain marijuana use are Alaska, Arizona, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington. In addition, Maryland has enacted legislation that recognizes a "medical marijuana" defense and Massachusetts replaced criminal penalties for adult possession of less than one ounce of marijuana with civil penalties. In Washington D.C. the Legalization of Marijuana for Medical Treatment Amendment Act of 2010 became law in July 2011.
- <sup>2</sup> Memorandum from Deputy Attorney General David W. Ogden to the United States Attorneys, "Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana." October 19, 2009 and Department of Justice Press Release 09-1119, October 19, 2009.
- <sup>3</sup> "Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine." *U.S. Food and Drug Administration*, April 20, 2006.  
<<http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2006/ucm/108643.htm>>.
- <sup>4</sup> "INCB: US Supreme Court Decision on Cannabis Upholds International Law." Professor Hamid Ghodse, President of the INCB. Press Release. June 8, 2005.
- <sup>5</sup> "Policy H-95.952 'Medical Marijuana.'" American Medical Association, Report 3 of the Council on Science and Public Health (I-09) Use of Cannabis for Medicinal Purposes.
- <sup>6</sup> ASAM Public Policy on "Medical Marijuana." (April 23, 2010) <http://www.wfad.se/latest-news/1-articles/213-asam-public-policy-statement-on-qmedical-marijuanag>.
- <sup>7</sup> "Experts: Pot Smoking Is Not Best Choice to Treat Chemo Side-Effects." *American Cancer Society*. May 22, 2001. [http://www.cancer.org/docroot/NWS/content/update/NWS\\_1\\_1xU\\_Experts\\_\\_Pot\\_Smoking\\_Is\\_Not\\_Best\\_Choice\\_to\\_Treat\\_Chemo\\_Side\\_Effects.asp](http://www.cancer.org/docroot/NWS/content/update/NWS_1_1xU_Experts__Pot_Smoking_Is_Not_Best_Choice_to_Treat_Chemo_Side_Effects.asp) ( March 9, 2005).
- <sup>8</sup> "American Glaucoma Society Position Statement: Marijuana and the Treatment of Glaucoma." Jampel, Henry MD. *MHS, Journal of Glaucoma*: February 2010- Volume 19-Issue 2 –pp.75-76 doi:10.1097/IJG.obo13e3181d12e39. also [www.glaucomaweb.org](http://www.glaucomaweb.org).
- <sup>9</sup> Committee on Substance Abuse and Committee on Adolescence. "Legalization of Marijuana: Potential Impact on Youth." *Pediatrics* Vol. 113, No. 6 ( June 6, 2004): 1825-1826. See also, Joffe, Alain, MD, MPH, and Yancy, Samuel, MD. "Legalization of Marijuana: Potential Impact on Youth." *Pediatrics* Vol. 113, No. 6 ( June 6, 2004): e632-e638h.
- <sup>10</sup> "Recommendations Regarding the Use of Cannabis in Multiple Sclerosis: Executive Summary." *National Clinical Advisory Board of the National Multiple Sclerosis Society*, Expert Opinion Paper, Treatment Recommendations for Physicians, April 2, 2008. <http://www.nationalmssociety.org>.
- <sup>11</sup> "Doctors' Fears at Cannabis Change." *BBC News*. January 21, 2004.
- <sup>12</sup> *Manchester Online*. "Doctors Support Drive Against Cannabis." *Manchester News*. January 21, 2004.  
<[http://www.manchesteronline.co.uk/news/s/78/78826\\_doctors\\_support\\_drive\\_against\\_cannabis.html](http://www.manchesteronline.co.uk/news/s/78/78826_doctors_support_drive_against_cannabis.html)> ( March 25, 2005).
- <sup>13</sup> *Institute of Medicine*. "Marijuana and Medicine: Assessing the Science Base." (1999). Summary.  
<<http://www.nap.edu/html/marimed>> (April 12, 2005).
- <sup>14</sup> Id.
- <sup>15</sup> *Institute of Medicine*. "Marijuana and Medicine: Assessing the Science Base." (1999). Executive Summary.  
<<http://www.nap.edu/html/marimed>> (January 11, 2006).
- <sup>16</sup> *Institute of Medicine*. "Marijuana and Medicine: Assessing the Science Base." (1999). Summary.  
<<http://www.nap.edu/html/marimed>> (January 11, 2006).
- <sup>17</sup> *Institute of Medicine*. "Marijuana and Medicine: Assessing the Science Base." (1999). Summary.  
<<http://www.nap.edu/html/marimed>> (January 11, 2006).
- <sup>18</sup> Benson, John A., Jr. and Watson, Stanley J., Jr. "Strike a Balance in the Marijuana Debate." *The Standard-Times*. 13 April 1999.
- <sup>19</sup> DEA, Office of Diversion Control, December 28, 2010.
- <sup>20</sup> GW Announces UK Launch of World's First Prescription Medicine, Press Release, June 21, 2010.  
<http://www.gwpharma.com/release-sativex-launch.aspx>. see also "The Development of Modern Cannabis-Based Medications: Myth and Facts." PowerPoint presentation to the 2010 Oregon Summit: The Impact of Marijuana, April 27, 2010, Mead, Alice, Director, U.S. Professional Relations, GW Pharmaceuticals.

- 21 Stannard, Matthew B. "Ecstasy Victim Told Friends She Felt Like She Was Going to Die." *The San Francisco Chronicle*, May 4, 2004. The Chronicle reported that Ms. Perez was given ibuprofen and "possibly marijuana," but the DEA has confirmed that the drug given to her was indeed marijuana.
- 22 Marijuana Policy Project's Vision and Mission Statement. [www.mpp.org](http://www.mpp.org).
- 23 From a videotape recording of Mr. Rosenthal's speech, as shown in "Medical Marijuana: A Smoke Screen."
- 24 "A Guide to Drug Related State Ballot Initiatives." *National Families in Action*. April 23, 2002. <http://www.nationalfamilies.org/guide/california215.html> ( March 31, 2005).
- 25 Wren, Christopher S. "Small But Forceful Coalition Works to Counter U.S. War on Drugs." *The New York Times*, January 2, 2000.
- 26 Craig, Tim. "Md. Starts to Allow Marijuana Court Plea; Penalty Can be Cut for Medicinal Use." *The Washington Post*. October 1, 2003, sec B.
- 27 Brant, Tataboline. "Marijuana Campaign Draws in \$857,000." *The Anchorage Daily News*. October 30, 2004.
- 28 Gathright, Alan. "Pot Backers Can't Stoke Hickenlooper." *Rocky Mountain News*. October 27, 2005.
- 29 Marijuana Initiatives: November 2006. *Marijuana Policy Project*. [www.mpp.org](http://www.mpp.org).
- 30 Ibid.
- 31 Ibid.
- 32 "Court Action Filed by Hailey City Officials on Voter Adopted Marijuana and Hemp Ordinances." Hailey City Hall Press Release, May 13, 2008. [http://www.haileycityhall.org/news\\_event/news/2008/MarijuanaCourtActionPressRelease.pdf](http://www.haileycityhall.org/news_event/news/2008/MarijuanaCourtActionPressRelease.pdf).
- 33 "Hailey changes course on pot initiatives: Council decides to litigate rather than amend policies." Idaho Mountain Express. January 30, 2008. <http://www.mtexpres.com/index2.php?ID=2005119141>.
- 34 "Judge Neuters Hailey Pot Initiatives." Terry Smith, Idaho Mountain Express, March 27, 2009. <http://www.mtexpress.com/index2.php?ID=2005125415>.
- 35 2008 Ballot Initiatives, Marijuana Policy Project, <http://www.mpp.org/library/2008-ballot-initiatives.html>.
- 36 Ibid.
- 37 Ibid.
- 38 Ibid.
- 39 Ibid.
- 40 "Medical Marijuana Bill Vetoed." Karen Langley, Concord Monitor, July 13, 2009. <http://www.concordmonitor.com/apps/pbcs.dll/article?AID=/20090711/FRONTPAGE/907110312/1001/NEWS01>.
- 41 "RI Assembly overrides veto on marijuana compassion centers." Donita Naylor and Cynthia Needham, the Providence Journal, June 17, 2009.
- 42 "Medical marijuana grower to begin distribution." Jeremy Jojola and Matthew Kappus, June 3, 2009. <http://www.kob.com/article/stories/5961683.shtml>.
- 43 "Medical Marijuana Expansion Approved by a Wide Margin." Meg Haskell, MPBN, Maine Public Broadcasting Network, November 4, 2009. <http://www.mpbn.net/Home/tabid/36/ctl/ViewItem/mid/3478/ZItemid/9642/Default.aspx>.
- 44 "Colorado Town Will Decriminalize Possession as Medical Marijuana Movement Gains Steam." CBS news, November 4, 2009.
- 45 "N.J. Medical Marijuana Law Overlooks Many In Pain." Susan Donaldson James, January 18, 2010, <http://www.abcnnews.go.com/Health/wellness/nj-medical-marijuana-law-ignores-chronic-pain-sufferers/story?id=95744509>.
- 46 "N.J. Medical Marijuana Law Deadline to be Delayed to Next Year." [http://www.nj.com/news/index.ssf/2010/06/nj\\_medical\\_marijuana\\_law\\_could.html](http://www.nj.com/news/index.ssf/2010/06/nj_medical_marijuana_law_could.html).
- 47 "Marijuana Questions on Some Massachusetts Ballots." Phillip Smith. September 29, 2010. [http://stopthedrugwar.org/chronicle/2010/sep/29/marijuana\\_questions\\_some\\_massach](http://stopthedrugwar.org/chronicle/2010/sep/29/marijuana_questions_some_massach). "The Victories That Got Overlooked – and Still Lie Ahead." Rob Kampia. November 4, 2010. [http://www.huffingtonpost.com/rob-kampia/the-mj-victories-t-b\\_778945.html](http://www.huffingtonpost.com/rob-kampia/the-mj-victories-t-b_778945.html).
- 48 "Arizona voters approve medical marijuana measure." <http://www.cbsnews.com/storeis/2010/11/12/national/main/7052327.html>. Mark deBernardo "Arizona Passes 'Medical-Marijuana' Initiative," Legislative Update. Institute for a Drug-Free Workplace. November 17, 2010.
- 49 "South Dakota voters say no to medical marijuana." Lynn Taylor Rick. Rapid City Journal. November 3, 2010. [http://www.rapidcityjournal.com/news/article\\_1ae826c6-e6f2-11df-8018-001cc4c002eo.html](http://www.rapidcityjournal.com/news/article_1ae826c6-e6f2-11df-8018-001cc4c002eo.html).
- 50 "Oregon Voters See Folly in Expanding Medi-Pot Program." Press Release. S.O.S. and the Drug Free American Foundation, Inc. November 2, 2010. <http://www.saveoursociety.org/issues-legislation-o>.



51 "Measure to Legalize Marijuana Loses in California." AOL news. November 3, 2010.  
<http://www.aolnews.com/2010/11/03/california-voters-reject-legalization-of-marijuana/>.

52 This Year's Top 10 Domestic Drug Policy Stories." Phillip Smith. Drug War Chronicles, Issue #664. December 22,  
 2010. [http://stopthedrugwar.org/chronicle/2010/dec/22/years\\_top\\_10\\_domestic\\_drug\\_polic](http://stopthedrugwar.org/chronicle/2010/dec/22/years_top_10_domestic_drug_polic).

53 Press Statement of Former DEA of Former DEA Administrators Robert C. Bonner and Peter Bensinger. October 15,  
 2010. <http://www.theiacp.org/About/PressCenter/MarijuanaLegalizationIssue/tabid/756/Default.aspx>

54 Ibid.

55 "CQ Floor Votes." *Congressional Quarterly, Inc.* July 25, 2007.  
[www.nctimes.com/artoc/es/2005/11/02/news/top\\_stories/21\\_52\\_3711\\_1\\_05.txt](http://www.nctimes.com/artoc/es/2005/11/02/news/top_stories/21_52_3711_1_05.txt).

56 David C. Lipscomb, "D.C. Officials Cautious on Legal Marijuana," *Washington Times*, December 10, 2009.

57 Representative Barr (GA). "Amendment offered by Mr. Barr of Georgia." *Congressional Record*, 105<sup>th</sup> Congress, 1<sup>st</sup>  
 Sess., September 17, 1997, p. H7388.

58 "Medical Marijuana Now Legal." Tim Craig. D.C. Wire, Washington Post. July 27, 2010.  
[http://voices.washingtonpost.com/dc/2010/07/medical\\_marijuana\\_now\\_legal.html](http://voices.washingtonpost.com/dc/2010/07/medical_marijuana_now_legal.html). "Liquor regulators may help  
 oversee D.C. medical marijuana program." Mike DeBonis. Washington Post. August 7, 2010.  
[http://www.washingtonpost.com/wp-dyn/content/article/2010/08/06/AR2010080606308\\_pf.html](http://www.washingtonpost.com/wp-dyn/content/article/2010/08/06/AR2010080606308_pf.html).  
<http://www.nbcwashington.com/news/local-beat/Medical-Marijuana-Makes-It-Into-Law-in-the-District.html>.

59 Wade, Jerry, "A Comparison of Medical Marijuana Programs in California and Oregon." *Alternatives Magazine*, Fall,  
 2006, Issue 39.

60 "Medical Pot Dispensaries Under Scrutiny." Sandy Mazza. *San Gabrielle Valley Tribune*. February 15, 2007.

61 "L.A.'s Marijuana Stores Take Root." William M. Welch, *USA Today*. March 8, 2007.

62 "Pot-Friendly California: Amsterdam in America?" Richard Gonzales, npr, August 13, 2009.  
<http://www.npr.org/templates/story/story.php?storyId=111784495&ps=rs>.

63 Dinkelspiel, Frances, "Berkeley Cannabis Collectives Slapped With Huge Tax Bills." *Berkeleyside*. February 3,  
 2011. Retrieved from <http://www.berkeleyside.com/2011/02/03/berkeley-cannabis-collectives-slapped-with-huge-tax-bills/>

64 Chairman Jerome E. Horton. California State Board of Equalization. (2010, February 3). *Tax Board Vice  
 Chairperson Jerome Horton Proposes Taxing Marijuana Manufacturers* [Press Release]. Retrieved from  
<http://www.boe.ca.gov/news/2010/16-10-H.pdf>

65 Dinkelspiel, Frances, "Berkeley Cannabis Collectives Slapped With Huge Tax Bills." *Berkeleyside*. February 3,  
 2011. Retrieved from <http://www.berkeleyside.com/2011/02/03/berkeley-cannabis-collectives-slapped-with-huge-tax-bills/>

66 U.S. Drug Enforcement Administration. (2008, May 16). *Modesto Marijuana Collective Owners Convicted* [Press  
 Release]. Retrieved from <http://www.justice.gov/dea/pubs/states/newrel/sanfran051608.html>

67 Korn, Peter, "Medical marijuana: a broken system." *Portland Tribune*. April 25, 2010.

68 Jacklet, Ben "Marijuana goes mainstream in Southern Oregon," *Oregon Business*, May 2010. p 35.

69 Ibid.

70 Thurstone, Christian, "Smoke and mirrors: Colorado teenagers and marijuana." *Denver Post*, February 1, 2010.  
[http://www.denverpost.com/opinion/ci\\_14289807?source=email](http://www.denverpost.com/opinion/ci_14289807?source=email).

71 "Medical pot laws result in increased teen drug use." *White Mountain Independent*. January 15, 2011.  
[http://www.wmicentral.com/news/latests\\_news/medical-pot-laws-result-in-increased-teen-drug-use/article-a6622a0c-1f42-11e0-a38e-001cc4c002e0.html](http://www.wmicentral.com/news/latests_news/medical-pot-laws-result-in-increased-teen-drug-use/article-a6622a0c-1f42-11e0-a38e-001cc4c002e0.html).

72 "AP Enterprise: Docs help make pot available in CA." November 1, 2010.  
<http://www.cbs8.com/Global/story.asp?S=13423097>

73 "Much Better Choices than Marijuana for Medical Uses." Jeff Stone, Doctor of Pharmacology. *North County Times*.  
 February 23, 2006.

74 "Renters turn Brevard homes into pot farms." January 11, 2010.  
<http://www.floridatoday.com/article/20100111/NEWS01/1110315?Renters-turn-Brevard-homes-into-pot-farms-%7c-video>.

75 "Vendors Reefer Sadness," Eric Bailey. *Los Angeles Times*. December 27, 2006.

76 "City Reconsiders Pot Ban." Claudia Reed. *The Willits News*. October 27, 2006.  
[http://www.willitsnews.com/localnews/ci\\_4561613](http://www.willitsnews.com/localnews/ci_4561613).

77 Marijuana 'grow houses' are creating problems in Arcata, California." *Los Angeles Times*, May 31, 2008.  
<http://www.latimes.com/news/local/la-me-pot31-2008may31.0.2034882.story>.

78 Ibid.

- 79 Move over meth: Marijuana 'grow houses' an increasing menace." MSN Real Estate. January 3, 2011.  
<http://realestate.msn.com/article.aspx?cp-documentid=26924092>.
- 80 "Marijuana grows involved water diversion; Fish and Game called in". Tiffany Revelle. The Daily Journal. October  
 13, 2010. <http://www.ukiahdailyjournal.com/fdcp?1287008819062>.
- 81 "Educators see rise in student drug use, blame medical marijuana." Great Falls Tribune, May 30, 2010.  
<http://www.greatfallstribune.com/article/20100530/NEWS01/5300301/Educators-see-rise-in-student-drug-use-blame-medical-marijuana>.
- 82 "Owner of six L.A. - area medical marijuana dispensaries is arrested." *Los Angeles Times*, May 28, 2008.  
<http://www.latimes.com/news/local/la-me-medpot28-2008may28.0.6101689.story>.
- 83 "The Great California Weed Rush: How Medical Marijuana is Turning L.A. Pot Dealers into Semilegit Businessmen  
 - No Beeper Required." Vanessa Grigoriadis. *Rolling Stone Magazine*. February 7, 2007.
- 84 "Santa Cruz Pot Users, Sellers, Find Loopholes in State's Medical Marijuana Laws." Shanna McCord. *Santa Cruz  
 Sentinel*. January 28, 2007.
- 85 "Teens at California School Getting High on Medical Marijuana." *KNSD-TV*, March 10, 2007.
- 86 "A Primer on Selling Pot Legally in California." Andrew Glazer. Associated Press. March 10, 2007.
- 87 "The Great California Weed Rush: How Medical Marijuana is Turning L.A. Pot Dealers into Semilegit Businessmen  
 - No Beeper Required." Vanessa Grigoriadis. *Rolling Stone Magazine*. February 7, 2007.
- 88 "Santa Cruz Pot Users, Sellers, Find Loopholes in State's Medical Marijuana Laws." Shanna McCord. *Santa Cruz  
 Sentinel*. January 28, 2007.
- 89 "Drug overdose: Medical marijuana facing a backlash." The Associated Press, May 21, 2010.  
<http://www.msnbc.com/id/37282436>.
- 90 Ibid.
- 91 "Montana and Other States Struggle to Contain Medical Marijuana Boom, Related Violence." Medical News Today,  
 May 27, 2010. <http://www.medicalnewstoday.com/articles/190074.hph>.
- 92 "Educators see rise in student drug use, blame medical marijuana." Great Falls Tribune, May 30, 2010.  
<http://www.greatfallstribune.com/article/20100530/NEWS01/5300301/Educators-see-rise-in-student-drug-use-blame-medical-marijuana>.
- 93 Ibid.
- 94 "Great Falls bans medical marijuana businesses outright." Richard Ecker. Great Falls Tribune. June 2, 2010.  
<http://www.gratfallstribune.com/article/20100602/NEWS01/6020302/Geat-Falls-bans-medical-marijuana-businesses-outright>.
- 95 "Cannabis Caravans Fuel Medical Pot Boom." Matt Volz. June 3, 2010.  
[http://www.msnbc.com/id/37494656/ns/health-alternative\\_medicine/](http://www.msnbc.com/id/37494656/ns/health-alternative_medicine/).
- 96 Ibid.
- 97 "Montana Board Bans Video Exams for Medical Marijuana." November 20, 2010.  
[http://www.flatheadbeacon.com/articles/article/montana\\_board\\_bans\\_video\\_exams\\_for\\_medical\\_marijuana/20735/](http://www.flatheadbeacon.com/articles/article/montana_board_bans_video_exams_for_medical_marijuana/20735/).
- 98 "Ritter signs bill regulating medical-marijuana industry." John Ingold. Denver Post. June 8, 2010.  
[http://www.denverpost.com/ci\\_15248235](http://www.denverpost.com/ci_15248235).
- 99 Colorado official works to regulate, legitimize medical marijuana industry. Michael W. Savage. The Washington Post.  
 July 25, 2010. [http://www.washingtonpost.com/wp-dyn/content/article/2010/07/24/AR2010072402559\\_pf.html](http://www.washingtonpost.com/wp-dyn/content/article/2010/07/24/AR2010072402559_pf.html).
- 100 "Don't call it pot; it's "medicine" now. Dealers are caregivers, and buyers are patients...How Marijuana Got  
 Mainstreamed.: Andrew Ferguson. Time Magazine. November 11, 2010.  
<http://www.time.com/nation/article/0,8599,2030768,00.html>.
- 101 "Colorado Medical Marijuana: State Supreme Court Rejects Challenge to Regulation." Huffington Post. January 11,  
 2011. [http://www.huffingtonpost.com/2011/01/11/colorado-medical-marijuan\\_6\\_n\\_807444.html](http://www.huffingtonpost.com/2011/01/11/colorado-medical-marijuan_6_n_807444.html).
- 102 "Pruning pot spots." Editorial, July 30, 2009. <http://www.latimes.com/news/opinion/la-ed-marijuana30-2009jul30.0.5752313.story>.
- 103 "DA, DEA, US Attorney, IRS, Sheriff, SDPD Serve Warrants at Illegal Marijuana Dispensaries." Press Release,  
 Office of the District Attorney, County of San Diego, September 10, 2009.
- 104 "L.A. submits new draft ordinance on medical marijuana." John Hoeffel, November 14, 2009.  
<http://www.latimes.com/news/local/la-me-pot14-2009nov14.0.6360273.story>.
- 105 D.A. chides L.A. Council, says he'll target pot dispensaries." John Hoeffel, LA Times, November 18, 2009.  
<http://www.latimes.com/news/local/la-me-medical-marijuana18-2009nov18.0.5278631.story>.
- 106 "Judge proposes injunction on sales of pot at Eagle Rock dispensary." John Hoeffel, LA Times, December 2, 2009.  
<http://www.latimes.com/news/local/la-me-medical-marijuana2-2009dec02.0.1.1283296>.

107 Richard Gonzales, "Los Angeles Officials Crack Down on Pot Clinics." NPR. February 25, 2010.  
 108 "Los Angeles City Council passes medical marijuana dispensary ordinance." John Hoeffel, Los Angeles Times,  
 109 January 19, 2010. <http://www.latimes.com/news/local/la-me-medical-marijuana20-2010jan20.0.6270825.story>.  
 110 "LA orders 439 medical marijuana dispensaries to close." John Hoeffel, Los Angeles Times, May 5, 2010.  
 111 <http://www.latimes.com/news/local/la-me-0505-medical-marijuana-20100505.0.7354914.story>.  
 112 "Marijuana Hotbed Retreats on Medicinal Use." The New York Times. June 9, 2008.  
 113 <http://www.nytimes.com/2008/06/09us/09pot.html>.  
 114 Americans for Safe Access, January 21, 2011. <http://www.safeaccess.org/article/php?id=3165>.  
 115 "California's Awash in 'legal' Marijuana," Bill O'Reilly, *Post Bulletin*. March 27, 2007.  
 116 "New Report Finds Highest Levels of THC in U.S. Marijuana to Date." *Office of National Drug Control Policy Press Release*. May 14, 2009.  
 117 "Study Finds Highest Levels of THC in U.S. Marijuana to Date: 20 Year Analysis of Marijuana Seizures Reveals a  
 118 Doubling in Pot Potency Since Mid-80's." *Office of National Drug Control Policy Press Release*. April 25, 2007.  
 119 "Teenage Schizophrenia Is the Issue, Not Legality." Robin Murray. *Independent on Sunday*. March 18, 2007.  
 120 [www.independent.co.uk](http://www.independent.co.uk).  
 121 "The Debate Over the Drug is No Longer about Liberty. It's about Health." Antonio Maria Costa. March 27, 2007.  
 122 *Independent on Sunday*, United Kingdom.  
 123 "Why Marijuana Legalization Would Compromise Public Health and Safety." ONDCP Director Gil Kerlikowske,  
 124 Speech Delivered at the California Police Chiefs Association Conference. March 4, 2010.  
 125 "Nearly One in Ten First-Year College Students at One University Have a Cannabis Use Disorder; At-Risk Users  
 126 Report Potentially Serious Cannabis-Related Problems." CESAR FAX, Vol. 17, Issue 3, January 21, 2008.  
 127 [www.cesar.umd.edu](http://www.cesar.umd.edu).  
 128 "Teen Marijuana Use Worsens Depression: An Analysis of Recent Data Shows "Self Medication" Could Actually  
 129 Make Things Worse." *Office of National Drug Control Policy*, May 2008.  
 130 [http://www.whitehousedrugpolicy.gov/news/press08/marij\\_mental\\_health.pdf](http://www.whitehousedrugpolicy.gov/news/press08/marij_mental_health.pdf).  
 131 "Marijuana Links with Psychosis." AM with Tony Eastley. February 8, 2011.  
 132 <http://www.abc.net.au/am/content/2011/s3132596.htm>.  
 133 "Cannabis increases risk of psychosis in teens." *Telegraph News*, June 2, 2008.  
 134 <http://www.telegraph.co.uk/news/uknews/2063199/Cannabis-increases-risk-of-psychosis-in-teens.html>.  
 135 "Marijuana May Shrink Parts of the Brain." Steven Reinberg. *U.S. News and World Report - Online*. June 2, 2008.  
 136 [http://health.usnews.com/articles/healthday/2008/06/02/marijuana\\_may\\_shrink\\_parts\\_of\\_the\\_brain.html](http://health.usnews.com/articles/healthday/2008/06/02/marijuana_may_shrink_parts_of_the_brain.html). "Long-term  
 137 Cannabis Users May Have Structural Brain Abnormalities." *Science Daily*. June 3, 2008.  
 138 <http://www.sciencedaily.com/releases/2008/06/080602160845.htm>.  
 139 Kate Benson, "Dope smokers not so mellow." *The Sydney Morning Herald*, July 30, 2009.  
 140 <http://www.smh.com.au/news/health/dope-smokers-not-so-mellow-20090407-9yOi.html>.  
 141 "Prenatal Marijuana Exposure and Intelligence Test Performance at Age 6." Abstract, *Journal of the American  
 142 Academy of Child & Adolescent Psychiatry*. 47(3):254-263, March 2008. Goldschmidt, Lidush Ph.D. et al.  
 143 "A Functional MRI Study of the Effects of Cannabis on the Brain." Prof. Phillip McGuire, UK, May 1, 2007. 2<sup>nd</sup>  
 144 International Cannabis and Mental Health Conference, London, UK.  
 145 "Study: Marijuana may Affect Neuron Firing." November 29, 2006. UPI.  
 146 Laucius, Joanne. "Journal Articles Link Marijuana to Schizophrenia" August 28, 2006 [www.Canada.com](http://www.Canada.com)  
 147 "Memory, Speed of Thinking and Other Cognitive Abilities Get Worse Over Time With Marijuana Use" March 15,  
 148 2006. <http://www.news-medical.net>  
 149 "Drug Abuse; Drug Czar, Others Warn Parents that Teen Marijuana Use Can Lead to Depression." *Life Science  
 150 Weekly*. May 31, 2005.  
 151 Kearney, Simon. "Cannabis is Worst Drug for Psychosis." *The Australian*. November 21, 2005.  
 152 Curtis, John. "Study Suggests Marijuana Induces Temporary Schizophrenia-Like Effects." *Yale Medicine*.  
 153 Fall/Winter 2004.  
 154 "Neurotoxicology; Neurocognitive Effects of Chronic Marijuana Use Characterized." *Health & Medicine Week*. 16  
 155 May 2005.  
 156 "Teenage Schizophrenia is the Issue, Not Legality." Robin Murray. *Independent on Sunday*. March 18, 2007.  
 157 [www.independent.co.uk](http://www.independent.co.uk).  
 158 "UN Warns of Cannabis Dangers as it Backs 'IoS' Drugs 'Apology'." Jonathan Owen. *Independent on Sunday*.  
 159 March 25, 2007. [www.independent.co.uk](http://www.independent.co.uk). and "Cannabis-related Schizophrenia Set to Rise, Say Researchers."  
 160 *Science Daily*. March 26, 2007. [www.sciencedaily.com/releases/2007/03/070324132832.htm](http://www.sciencedaily.com/releases/2007/03/070324132832.htm).

- 135 "Long-term pot use can double risk of psychosis." March 1, 2010. <http://www.msnbc.com/id/35642202/ns/health-addictions/?ns=health-addictions>. Also McGrath J, et al "Association between cannabis use and psychosis-related outcomes using sibling pair analysis in a cohort of young adults" *Arch Gen Psych* 2010; DOI: 10.1001/archgenpsychiatry.2010.6.
- 136 "Quitting Pot Important Part of Trudeau's Recovery." Denise Ryan, *Vancouver Sun*, February 12, 2007.
- 137 "Marijuana Use Affects Blood Flow in Brain Even After Abstinence." *Science Daily*, February 12, 2005. [www.sciencedaily.com/releases/2005/02/050211084701.htm](http://www.sciencedaily.com/releases/2005/02/050211084701.htm); *Neurology*, February 8, 2005, 64:488-493.
- 138 "Marijuana Use Takes Toll on Adolescent Brain Function, Research Finds." *Science Daily*, October 15, 2008. <http://www.sciencedaily.com/releases/2008/10/081014111156.htm>.
- 139 State of California, Environmental Protection Agency, Office of Environmental Health Hazard Assessment, Safe Drinking Water and Toxic Enforcement Act of 1986, "Chemicals Known to the State to Cause Cancer or Reproductive Toxicity, September 11, 2009. [http://www.oehha.ca.gov/prop65\\_list/files/P65single091001.pdf](http://www.oehha.ca.gov/prop65_list/files/P65single091001.pdf).
- 140 "Pot smoking during pregnancy may stunt fetal growth." January 22, 2010. <http://www.reuters.com/article/id=Ustre60L55L20100122>.
- 141 "Heavy Marijuana Use Linked to Gum Disease, Study Shows." *Science Daily*, February 6, 2008. <http://www.sciencedaily.com/releases/2008/02/080205161239.htm>; "Cannabis Smoking and Periodontal Disease Among Young Adults." *The Journal of the American Medical Association*, Vol. 299, No. 5, February 6, 2008. <http://www.jama.ama-assn.org/cgi/content/full/299/5/25>.
- 142 "Marijuana Smokers Face Rapid Lung Destruction – As Much As 20 Years Ahead of Tobacco Smokers." *Science Daily*, January 27, 2008. <http://www.sciencedaily.com/releases/2008/01/080123104017.htm>; "Bullous Lung Disease Due to Marijuana." *Respirology* (2008) 13, 122-127.
- 143 Marijuana Smoke Contains Higher Levels of Certain Toxins Than Tobacco Smoke." *Science Daily*, December 18, 2007. <http://www.sciencedaily.com/releases/2007/12/071217110328.htm>. "A Comparison of Mainstream and Sidestream Marijuana and Tobacco Smoke Produced Under Two Machine Smoking Conditions." *American Chemical Society, Chemical Research in Toxicology*, December 17, 2008.
- 144 "Marijuana Worsens COPD Symptoms in Current Cigarette Smokers." American Thoracic Society. *Science Daily*, May 23, 2007.
- 145 "How Smoking Marijuana Damages the Fetal Brain." Karolinska Institute. *Science Daily*, May 29, 2007.
- 146 "Cannabis Linked to Lung Cancer Risk." Martin Johnston. *New Zealand Herald*, March 27, 2007.
- 147 "Marijuana Use Linked to Increased Risk of Testicular Cancer." *Science Daily*, February 9, 2009. <http://www.sciencedaily.com/releases/2009/02/090209075631.htm>
- 148 Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. "Highlights of the 2009 Drug Abuse Warning Network (DAWN), Findings on Drug-related Emergency Department Visits." December 2010. P. 3.
- 149 Ibid. p.3.
- 150 "A Day in the Life of American Adolescents: Substance Use Facts Update." OAS Report, April 29, 2010. <http://www.oas.samhsa.gov>.
- 151 Tertraut, Jeannette M. MD, et. al., "Effects of Marijuana Smoking on Pulmonary Function Respiratory Complications: A Systematic Review" *Arch. Intern. Med.* 2007;167:221-228; *Science Daily*, "Long-term Marijuana Smoking Leads to Respiratory Complaints," [www.sciencedaily.com/releases/2007/02/070212184119.htm](http://www.sciencedaily.com/releases/2007/02/070212184119.htm).
- 152 "Marijuana Use Linked to Early Bladder Cancer." <http://www.medicalnewstoday.com/articles/36695.php>. January 26, 2006.
- 153 "Marijuana Tied to Precancerous Lung Changes" *Reuters*. July 13, 2006. <http://today.reuters.com/misc> See also: "The Association Between Marijuana Smoking and Lung Cancer" *Archives of Internal Medicine*. <http://archinte.ama-assn.org/cgi/content/full/166/12/1359?maxtoshow> July 10, 2006.
- 154 "Cannabis More Toxic than Cigarettes: Study," French National Consumers' Institute, *60 Million Consumers* (magazine) April 2006, [www.theage.com.au](http://www.theage.com.au).
- 155 "Conception and Pregnancy Put at risk by Marijuana Use" *News-Medical.Net* August 2, 2006 See also: "Fatty Acid Amide Hydrolase Deficiency Limits Early Pregnancy Events" Research Article. *Journal of Clinical Investigation*. Published March 22, 2006, revised May 23, 2006 <http://www.jci.org/cgi/content/full/116/8/2122>
- 156 In utero Marijuana Exposure Alters Infant Behavior. *Reuters*, January 17, 2007.
- 157 Metro, Michael J., MD. "Association Between Marijuana Use and the Incidence of Transitional Cell Carcinoma Suggested" <http://www.news.medical.net> June 28, 2006.
- 158 Tashkin, D.P., "Smoked Marijuana is a Cause of Lung Injury." *Monaldi Archives for Chest Disease* 63(2):93-100, 2005.

- 159 "Marijuana Associated with Same Respiratory Symptoms as Tobacco," *YALE News Release*. January 13, 2005.  
 <<http://www.yale.edu/opa/newsr/05-01-13-01.all.htm>> (14 January 2005). See also, "Marijuana Causes Same  
 160 Respiratory Symptoms as Tobacco," January 13, 2005, 14WFIE.com.
- 161 "What Americans Need to Know about Marijuana," page 9, ONDCP.
- 162 "Decreased Respiratory Symptoms in Cannabis Users Who Vaporize," *Harm Reduction Journal* 4:11, April 16,  
 2007.
- 163 "Marijuana Affects Brain Long-Term, Study Finds." *Reuters*. February 8, 2005. See also: "Marijuana Affects  
 Blood Vessels." *BBC News*. 8 February 2005; "Marijuana Affects Blood Flow to Brain." *The Chicago Sun-Times*.  
 February 8, 2005; Querna, Elizabeth. "Pot Head." *US News & World Report*. February 8, 2005.
- 164 Smith, Michael. *Medpage Today*. February 12, 2007.  
<http://www.medpagetoday.com/Neurology/GeneralNeurology/tb/5048>.
- 165 "HIV Patients: Marijuana Eases Foot Pain." *Associated Press*. February 13, 2007.
- 166 Weiss, Rick. "Research Supports Medicinal Marijuana." *Washington Post*. February 13, 2007.
- 167 Dahlbert, Carrie Peyton. "Marijuana Can Ease HIV-related Nerve Pain." *McClatchy Newspapers*. Feb. 13, 2007.
- 168 Hashibe M, Morgenstern H, Cui Y, et al. Marijuana use and the risk of lung and upper aerodigestive tract cancers:  
 results of a population-based case-control study. *Cancer Epidemiol Biomarkers Prev* 2006; 15:1829-1834.
- 169 "Heavy marijuana use not linked to lung cancer," *News-Medical.Net*, Wednesday, May 24, 2006.  
<http://www.nida.nih.gov/DirReports/DirRep207/DirectorReport8.html>.
- 170 <http://www.umich.edu/news/index.html?Releases/2006/Oct06/r101006a>.
- 171 Harding, Anne. "Pot May Indeed Lead to Heroin Use, Rat Study Shows" *Reuters*. July 12, 2006. See also: "Why  
 Teenagers Should Steer Clear of Cannabis" Vine, Gaia. [www.NewScientist.com](http://www.NewScientist.com)
- 172 "What Americans Need to Know about Marijuana." *Office of National Drug Control Policy*. October 2003.
- 173 Gfroerer, Joseph C., et al. "Initiation of Marijuana Use: Trends, Patterns and Implications." *Department of Health  
 and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies*. July  
 2002. Page 71.
- 174 "Non-Medical Marijuana II: Rite of Passage or Russian Roulette?" *CASA Reports*. April 2004. Chapter V, Page 15.
- 175 *The National Center on Addiction and Substance Abuse at Columbia University*, "Wasting the Best and the Brightest:  
 Substance Abuse at America's Colleges and Universities." March 2007. page 4.
- 176 "What Americans Need to Know about Marijuana," page 9, ONDCP.
- 177 *Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of  
 Applied Studies* "Results from the 2009 National Survey on Drug Use and Health: Vol. I. Summary of National  
 Findings." September 2010. Page 27.
- 178 Ibid.
- 179 Ibid.
- 180 Ibid. p.54.
- 181 "A Day in the Life of American Adolescents: Substance Use Facts Update." OAS Report, April 29, 2010.  
<http://www.oas.samhsa.gov>.
- 182 Furber, Matt. "Threat of Meth—the Devil's Drug—increases." *Idaho Mountain Express and Guide*. December 28,  
 2005.
- 183 "Medical pot laws result in increased teen drug use." *White Mountain Independent*. January 13, 2011.  
[http://www.wmicentral.com/news/atests\\_news/medical-pot-laws-result-in-increased-teen-drug-use/article\\_a6622a0c-1f42-11e0-a38e-001cc4c002e0.html](http://www.wmicentral.com/news/atests_news/medical-pot-laws-result-in-increased-teen-drug-use/article_a6622a0c-1f42-11e0-a38e-001cc4c002e0.html).
- 184 "New Study shows dramatic shifts in substance abuse treatment admissions among states between 1998 and 2008."  
 Department of Health and Human Services, Substance Abuse and Mental Health Administration, Office of Applied  
 Studies. Press Release. December 22, 2010. <http://www.samhsa.gov>.
- 185 California No. 1 in marijuana admissions." Cheryl Wetzstein. *The Washington Times*. December 30, 2010.  
<http://www.washingtontimes.com/news/2010/dec/30/>
- 186 "Marijuana Myths & Facts: The Truth Behind 10 Popular Misperceptions." *Office of National Drug Control Policy*.  
 <[http://www.whitehousedrugpolicy.gov/publications/marijuana\\_myths\\_facts/index.html](http://www.whitehousedrugpolicy.gov/publications/marijuana_myths_facts/index.html)> (January 12, 2006).
- 187 *Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of  
 Applied Studies*. "Results from the 2009 National Survey on Drug Use and Health: Vol. I. Summary of National  
 Findings." September 2009, page 1.
- 188 "Early Marijuana Use Related to Later Illicit Drug Abuse and Dependence." *CESARFAX*. Vol. 19, Issue 41. October  
 25, 2010. [www.cesar.umd.edu](http://www.cesar.umd.edu).
- 189 Ibid.

- 190 Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. "Treatment Episode Data Set (TEDS) 1998-2008, National Admissions to Substance Abuse Treatment Services". April 2010 Page 1. Table 1.1. [www.oas.samhsa.gov](http://www.oas.samhsa.gov).
- 191 "Psychotherapeutic Interventions for Cannabis Abuse" July 21, 2006 <http://www.news-medical.net> See also: Denis C, Lavie D, Fatseas M, Aurizcombe M. "Psychotherapeutic Interventions for Cannabis Abuse and/or Dependence in Outpatient Settings". *The Cochrane Collaboration*. <http://www.cochrane.org/reviews/en/ab005336.html>.
- 192 Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. "Results from the 2009 National Survey on Drug Use and Health: Vol. I. Summary of National Findings." September 2010. Page 74.
- 193 Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. "Treatment Episode Data Set (TEDS) 1998-2008. National Admissions to Substance Abuse Treatment Services." April 2010. Page 2. [www.oas.samhsa.gov](http://www.oas.samhsa.gov).
- 194 Ibid. Page 3. Table. 3.4.
- 195 "Non-Medical Marijuana III: Rite of Passage or Russian Roulette?" A CASA White Paper, June 2008. <http://www.casacolumbia.org>.
- 196 "Early Marijuana Use a Warning Sign For Later Gang Involvement," *ONDCP press release*, June 19, 2007.
- 197 "The Relationship Between Alcohol, Drug Use and Violence Among Students." Community Anti-Drug Coalitions of American (CADCA). [www.cadca.org](http://www.cadca.org). *Pride Surveys*, (2006) Questionnaire report for grades 6-12: 2006 National Summary. Page 184. <http://www.pridesurveys.com/customercenter/us05ns.pdf>.
- 198 Office of National Drug Control Policy. (2006) "Marijuana Myths and Facts: The Truth Behind 10 Popular Misperceptions." Page 10. [http://www.whitehousedrugpolicy.gov/publications/marijuana\\_myths\\_facts](http://www.whitehousedrugpolicy.gov/publications/marijuana_myths_facts).
- 199 Ibid.
- 200 NIDA InfoFacts: Drugged Driving, September 10, 2009, page 1. <http://drugabuse.gov/Infofacts/driving.html>.
- 201 Volz, Matt. "Drug overdose: Medical marijuana facing a backlash." <http://www.msnbc.msn.com/id/37282436>.
- 202 Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Results from the 2009 National Survey on Drug Use and Health: Vol. I. Summary of National Findings. September 2010. Page 28.
- 203 "One-third of Fatally Injured Drivers with Known Test Results Tested Positive for at Least one Drug in 2009. CESARFAX. Vol. 19, Issue 49. December 20, 2010. [www.cesar.umd.edu](http://www.cesar.umd.edu).
- 204 Ibid.
- 205 "Cannabis and Driving: A Scientific and Rational Review." Armentano, Paul. *NORML/NORML Foundation*. January 10, 2008. [http://normal.org/index.cfm?Group\\_ID=7475](http://normal.org/index.cfm?Group_ID=7475) for article and [http://normal.org/index.cfm?Group\\_ID=7459](http://normal.org/index.cfm?Group_ID=7459) for the full report.
- 206 DuPont, Robert. "National Survey Confirms that Drugged Driving is Significantly More Widespread than Drunk Driving." Commentary, Institute for Behavior and Health, July 17, 2009. page 1. <http://www.ibhinc.org>.
- 207 "Drug-Impaired Driving by Youth Remains Serious Problem." NIDA News Release, October 29, 2007. <http://www.drugabuse.gov/newsroom/07/NR10-29.html>.
- 208 "The Drugged Driving Epidemic," *The Washington Post*, June 17, 2007.
- 209 DuPont, Robert. "National Survey Confirms that Drugged Driving is Significantly More Widespread than Drunk Driving." Commentary, Institute for Behavior and Health, July 17, 2009. page 1. <http://www..ibhinc.org>.
- 210 "Cannabis Almost Doubles Risk of Fatal Crashes". December 2005. *BMJ.com*. [http://bmj.bmjournals.com/content/vol331/issue7528/press\\_release.shtml](http://bmj.bmjournals.com/content/vol331/issue7528/press_release.shtml).
- 211 Drummer, OH, Gerostamoulos J, Batziris H, Chu M, Caplehorn J, Robertson MD, Swann P. "The Involvement of drugs in drivers of motor vehicles killed in Australian road traffic crashes." *Accid Anal Prev* 36(2):229-48, 2004.
- 212 "Drug-Driving Test Kits Get Green Light" *Scotland on Sunday*, September 9, 2006. <http://www.mapinc.org/tlcnews/v06/n1013/a05.htm?134>.
- 213 "Drugged Driving Poses Serious Safety Risk to Teens; Campaign to Urge Teens to 'Steer Clear of Pot' During National Drunk and Drugged Driving (3D) Prevention Month." *PR Newswire*. December 2, 2004.
- 214 Couper, Fiona, J, and Logan, Barry *Drugs and Human Performance Fact Sheets* National Highway Traffic Safety Administration., page 11. April 2004.
- 215 "Pot Smoking Linked to Crash." *Las Vegas Review-Journal*. July 18, 2008. <http://www.lvjr.com/news/25610594.html>.
- 216 "Police: Man Was High on Pot When Car Fatally Stuck Woman." April 20, 2010. <http://www.msnbc.com/id/36669052/from/ET/>.
- 217 "Marijuana Blamed in Fatal Crash. *The Patriot News*. May 1, 2007.
- 218 "Ind. Teen Charged in Deadly Car Crash. *The New York Times*. August 2, 2006.

219 Maddux, Stan. "Teen Whose Car Hit Bus Allegedly on Marijuana." Post-trib.com. August 24, 2006.  
[http://www.post-trib.com/cgi-bin/pto-story/news/zl/08-24-06\\_zl\\_news\\_15.html](http://www.post-trib.com/cgi-bin/pto-story/news/zl/08-24-06_zl_news_15.html)

220 "Nation: Drug Test Positive for Driver in Deadly Crash." *Orange County Register*. May 14, 1999.

221 Edmondson, Aimee. "Drug Tests Required of Child Care Drivers – Fatal Crash Stirrs Change; Many Already Test Positive." *The Commercial Appeal*. July 2, 2003.

222 McDonald, Melody and Boyd, Deanna. "Jury Gives Mallard 50 Years for Murder; Victim's Son Forgives but Says 'Restitution is Still Required.'" *Fort Worth Star Telegram*. June 28, 2003.

223 "Boy, 8, Who Was Struck While Riding Bike Dies." *The Dallas Morning News*. April 25, 2005.

224 The Associated Press. "Police: Driver in Fatal Crash had Drugs in System." *The Associated Press*. June 1, 2003.

225 "New pot law blamed as violence escalates." Laurel J. Sweet and O'Ryan Johnson. Boston Herald. November 15, 2010. <http://www.bostonherald.com/news/politics/view.bg?articleid=1296392>.

226 "FHP: Man led trooper on chase with kids-and pot – in car." Bay News 9. February 3, 2011.  
<http://www.baynews9.com/article/news/2011/february/204034/FHP:-Man-led-trooper-on-chase-with-kids-in-car-?cid=rss>.

227 "Driving under influence of marijuana a growing problems." Gwen Florio. Missoulia.com January 16, 2011.  
[http://missoulia.com/news/local/article\\_1d9f6f8a-2137-11e0-a0be-001cc4c002e0.html](http://missoulia.com/news/local/article_1d9f6f8a-2137-11e0-a0be-001cc4c002e0.html).

228 "Jessica Gamble, Ohio Mom, Charged for Teaching 2-Year-Old Daughter to Smoke Marijuana." Caroline Black. CBS WKRC. September 16, 2010. [http://www.cbsnews.com/8301-504083\\_162-20016662-504083.html](http://www.cbsnews.com/8301-504083_162-20016662-504083.html).

229 "Va. Pair Charged After Toddler Eats Marijuana." Whz.com. October 8, 2010.  
<http://wjz.com/wireapnews/va/Manassas.pair.charged.2.1953794.html>.

230 "Video shows parents giving pot pipe to toddler." Beatriz Valenzuela. Daily Press. January 17, 2011.  
<http://www.vvdailypress.com/articles/parents-25426-pipe.pot.html>.

231 "Police: Mom gave pot to her 3 kids." Lance Berry. October 28, 2010.  
[http://www.wcpo.com/dpp/news/region/east\\_cincinnati/madisonville/police%3A-mom-gave-pot-to-3-kids](http://www.wcpo.com/dpp/news/region/east_cincinnati/madisonville/police%3A-mom-gave-pot-to-3-kids).

232 "Toddler in Critical Condition After Ingesting Marijuana." February 2, 2011.  
<http://losangeles.cbslocal.com/2011/02/02/toddler-in-critical-condition-after-ingesting-marijuana>.

233 "Mother charged after toddler hospitalized for eating marijuana, pills." Michelle Hunter. The Times-Picayune. October 13, 2008. [http://www.nola.com/news/index.ssf/2008/10/children\\_3\\_and\\_4\\_hospitalized.html](http://www.nola.com/news/index.ssf/2008/10/children_3_and_4_hospitalized.html).

234 "Police: Criminal targeting San Jose's medicinal marijuana clubs." Sean Webby. The Mercury News. December 16, 2010. <http://www.mercurynews.com/fdcp?1293042861859>.

235 "LAPD investigates third shooting at a medical marijuana dispensary." Andrew Blackstein, Los Angeles Times, July 1, 2010. <http://www.latimes.com/news/local/la-me-pot-shooting-20100701.0.4009176.story>.

236 "Pentagon shooter had a history of mental illness." March 5, 2010.  
[http://www.msnbc.com/id/35716821/ns/us\\_news\\_crime\\_and\\_courts/](http://www.msnbc.com/id/35716821/ns/us_news_crime_and_courts/)

237 Parents warned police of Pentagon shooter's bizarre mental state." Washington Post. March 5, 2010.  
[http://www.washingtonpost.com/wp-dyn/content/article/2010/03/05/AR2010030500957\\_2.html?hpid=dynamiclead](http://www.washingtonpost.com/wp-dyn/content/article/2010/03/05/AR2010030500957_2.html?hpid=dynamiclead).

238 "Calif. Drug dealer guilty of murdering 15-year-old." San Diego Union Tribune, July 9, 2008. [www.sandiego.com](http://www.sandiego.com).

239 "Lawyer Who Fell to Death... Was Driven Mad by Cannabis." *Daily Mail*, May 15, 2007.

240 The Associated Press. "Murder Charges Filed in Blaze that Killed Two Firefighters." *The Associated Press*. August 21, 2004.

241 "Pilot Used Marijuana before Fatal Plane Crash." ABC Newonline. February 7, 2006.  
[www.abc.net.au/news/newsitems/200602/s1564190.htm](http://www.abc.net.au/news/newsitems/200602/s1564190.htm).

242 "4 charged in Chaska Slaying." David Hanners. *Pioneer Press*. January 13, 2006. <http://www.twincities.com>.

243 "NTSB: Pilot Had Marijuana In His System." *KTHV Little Rock*. February 6, 2006. [www.todaysthv.com](http://www.todaysthv.com).

244 U.S. Sentencing Commission, "2008 Sourcebook of Federal Sentencing Statistics,": see:  
<http://www.ussc.gov/ANNRPT/2008/SBTOC08.htm>, Table 33.

245 Bureau of Justice Statistics, "Drug Use and Dependence", *State and Federal Prisoners*, 2004, October 2006.

246 United States Sentencing Commission, "2006 Sourcebook of Federal Sentencing Statistics," June 2007.

247 Ibid.

248 *Office of National Drug Control Policy*. "Who's Really in Prison for Marijuana?" May 2005 Page 22.

249 "New study Reveals Scope of Drug and Crime Connection: As Many as 87 Percent of People Arrested for Any Crime Test Positive for Drug Use." Office of National Drug Control Policy Press Release, May 28, 2009 and Fact Sheet 2008 ADAM II Report, [www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov).

250 Angus Reid Global Monitor, Polls & Research, December 23, 2006. [www.angus-reid.com/polls/index.cfm.fuseaction/viewItem/itemID/14189](http://www.angus-reid.com/polls/index.cfm.fuseaction/viewItem/itemID/14189).

- 251 European Monitoring Centre for Drugs and Drug Addiction, "2008 Annual Report: The State of the Drug Problem in Europe." Office of Official Publications of the European Communities, Luxembourg, June 2008, page 11. see also [www.emcdda.europa.eu](http://www.emcdda.europa.eu).
- 252 "Europe faces new challenges posed by changes in drug supply and use." European Monitoring Centre for Drugs and Drug Addiction, Annual Report 2010: Highlights. October 11, 2010. [www.emcdda.europa.eu](http://www.emcdda.europa.eu).
- 253 "Liberal-National Government to overturn soft-on-drugs legislation." Government Media Office, Ministerial Media Statements, Government of Western Australia, October 11, 2009. <http://www.mediastatements.wa.gov.au>.
- 254 "Australia: Doc Group Lobbies for Tougher Western Australia Marijuana Laws, Cites Mental Health Threat." May 24, 2008. *The Western Australia*. <http://www.thewest.com.au/default.aspx?MenuID=158&ContentID=74974>.
- 255 "Warning Marijuana is 'Not a Soft Drug,'" *Australian Associated Press*. August 1, 2006. <http://www.theage.com.au/news/National/Warning-marijuana-is-not-a-soft-drug/2006>.
- 256 Burman, John. "Ontario Toughens Rules to Uproot Grow-ops" *The Hamilton Spectator*, August 4, 2006 <http://www.hamiltonspectator.com/NASAPP/cs/ContentServer?pagename=hamilton/Layout> See also: CTV Toronto, August 3, 2006.
- 257 Adlaf, Edward M. and Paglia-Boak, Angela, Center for Addiction and Mental Health, *Drug Use Among Ontario Students, 1977-2005*, CAMH Research Document Series No. 16. The study does not contain data on marijuana use among 12<sup>th</sup> graders prior to 1999. See also: *Canadian Addiction Survey, Highlights* (November 2004) and *Detailed Report* (March 2005), produced by Health Canada and the Canadian Executive Council on Addictions; *Youth and Marijuana Quantitative Research' 2003 Final Report*, Health Canada; Tibbetts, Janice and Rogers, Dave. "Marijuana Tops Tobacco Among Teens, Survey Says: Youth Cannabis Use Hits 25-Year Peak," *The Ottawa Citizen*, October 29, 2003.
- 258 Kleinhubbert, Guido. "Germany's 'McDope' Problem." *Spiegel Online*. 17, August 2006. <http://www.service.spiegel.de/cache/international/spiegel/0,1518,432078,00.html>.
- 259 "Amsterdam Bans Smoking of Marijuana in Some Public Places." *Expatica's* January 29, 2007. [www.expatica.com/actual/article.asp?subchannel\\_id=19&story\\_id=5804](http://www.expatica.com/actual/article.asp?subchannel_id=19&story_id=5804).
- 260 *The New York Times*, August 20, 2006.
- 261 "Cannabis Bars in Limburg to be for Members Only," NIS News Bulletin, May 13, 2009, see: [http://www.nisnews.nl/public/103509\\_1.htm](http://www.nisnews.nl/public/103509_1.htm).
- 262 "Amsterdam's cannabis-selling coffee shops face crackdown." Stanley Pignal. *The Washington Post*. October 8, 2010. [http://www.washingtonpost.com/wp-dyn/content/article/2010/10/08/AR2010100806139\\_pf.html](http://www.washingtonpost.com/wp-dyn/content/article/2010/10/08/AR2010100806139_pf.html).
- 263 "What Americans Need to Know about Marijuana," *ONDCP*, Page 10.
- 264 Dutch Health, Welfare and Sports Ministry Report. April 23, 2004.
- 265 INTRAVAL Bureau for Research & Consultancy. "Coffeeshops in the Netherlands 2004." *Dutch Ministry of Justice*. June 2005. <<http://www.intraval.nl/en/b/b45.html>>.
- 266 Id.
- 267 Collins, Larry. "Holland's Half-Baked Drug Experiment." *Foreign Affairs* Vol. 73, No. 3. May-June 1999: Pages 87-88.
- 268 Hibell, B; Guttormsson, U, Ahlstrom, S, Balakireva, O., Bjarnason, T., Kokkevi, A., Kraus, L., "The 2007 ESPAD AReport-Substance Use Among Students in 35 European Countries," the Swedish Council for information on Alcohol and Other Drugs (CAN), Stockholm, Sweden, 2009.
- 269 "Netherlands from 12<sup>th</sup> to 5<sup>th</sup> Place in Europe on Cannabis Usage," NIS News Bulletin, April 4, 2009, see: [http://www.nisnews.nl/public/040409\\_1.htm](http://www.nisnews.nl/public/040409_1.htm).
- 270 European Monitoring Centre for Drugs and Drug Addiction, Situation Summary for Portugal, November 2010. <http://www.emcdda.europa.eu/publications/country-overviews/pt>.
- 271 "Singapore Gives Treatment Option to Marijuana, Cocaine Users." *Drug War Chronicle*, Issue 495, July 27, 2007.
- 272 "Swiss approve heroin scheme but vote down marijuana law." *The Guardian*, December 1, 2008. <http://www.guardian.co.uk/world/2008/dec/01/switzerland-drugs-heroin/>
- 273 Cohen, Roger. "Amid Growing Crime, Zurich Closes a Park it Reserved for Drug Addicts." *The New York Times*. February 11, 1992.
- 274 Ormston, Rachel, Bradshaw, Paul and Anderson, Simon, *Scottish Social Attitudes Survey 2009, Public Attitudes to Drugs and Drug Use in Scotland*, Scottish Government Social Research, 2010. Page 1.
- 275 "UK: Cannabis To Be Reclassified As A Class B Drug." May 8, 2008. <http://www.scoop.co.nz/stories/WO0805/S00105.htm>.
- 276 "Cannabis: An Apology." *The Independent on Sunday*. March 18, 2007. [www.news.independent.co.uk/uk/health\\_medical/article2368994.ece](http://www.news.independent.co.uk/uk/health_medical/article2368994.ece).



- 277 Koster, Olinka, Doughty, Steve, and Wright, Stephen. "Cannabis Climbdwn." *Daily Mail (London)*. March 19, 2005. See also. Revill, Jo, and Bright, Martin. "Cannabis: the Questions that Remain Unanswered." *The Observer*. 20 March 2005; Steele, John and Helm, Toby. "Clarke Reviews "Too Soft" Law on Cannabis." *The Daily Telegraph (London)*. 19 March 2005; Brown, Colin. "Clarke Orders Review of Blunkett Move to Downgrade Cannabis." *The Independent (London)*. March 19, 2005.
- 278 "Blair's 'Concern' on Cannabis." *The Irish Times*. May 4, 2005. See also, Russell, Ben. "Election 2005: Blair Rules Out National Insurance Rise." *The Independent (London)*. May 4, 2005.
- 279 "Top U.S. and United Nations Anti-Drug Officials Warn About Increasing Threat of Marijuana." Press Release. June 26, 2006. ONDCP. <http://www.whitehousedrugpolicy.gov/news/press/06/062606.html>.
- 280 Johnston, L.D., O'Malley, P.M., Bachman, J.G. & Schulenberg, J.E. (December 14, 2010.) "Marijuana use is rising: ecstasy use is beginning to rise; and alcohol use is declining among U.S. Teens." University of Michigan News Service, Ann Arbor, MI. December 14, 2010. <http://www.monitoringthefuture.org>.
- 281 U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, "Teen marijuana use increase, especially among eighth-graders." Press Release, December 14, 2010.
- 282 Department of Health And Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, "Results From The 2009 National Survey On Drug Use And Health: Volume I. Summary of National Findings." September 2010. Pages 1-2.
- 283 Ibid. p. 65.
- 284 Ibid. p. 66.
- 285 Partnership for a Drug Free America and the MetLife Foundation, *2009 Partnership Attitude Tracking Study*, March 2, 2010. <http://www.drugfree.org>
- 286 DEA Domestic Cannabis Eradication/Suppression Program, 2009 eradication season. This information can also be found at <http://www.albany.edu/sourcebook/pdf/t4382009.pdf>.
- 287 Id.

The experts in Maine readily admit they have found cannabis to be a gateway drug, that is they have a large volume of reports of hard drug using addicts were able to escape the capture of meth, cocaine and heroin by using medical marijuana. On the other hand the users report street dealers often inadvertently increase drug problems when they offer whatever drug they have on hand to the street customer.

Recreational use of marijuana has decreased in states with medical marijuana programs. The executive director of the Maine dispensaries we visited noted with satisfaction the cooperation and lack of interest by state and local law enforcement. The chief of police in one dispensing community said he has stopped observing the dispensary as he is satisfied there is no problem with the stores. In 2012 Maine fell victim to fifty-four opiate robberies in Pharmacies in Maine while during the same period there were zero robberies of cannabis dispensaries, another source of relief for law enforcement.

Who are the patients? Sufferers of pain or chronic debilitating diseases, Alzheimer patients who are severely agitated, Multiple Sclerosis patients, HIV sufferers, and of course cancer patients and many others who are chronically nauseated and are dying from malnutrition. Malnutrition in cancer patients is a leading contributor to final demise. Cancer Treatment Centers of America learned while developing their own protocols for treatment of persons cursed with cancer that the normal ration of hospital nutritionists to patients is about fifteen to one, they saw malnutrition serious enough a treatment conundrum to demand one nutritionist for every three patients. The use of medical cannabis increases appetite allowing maintenance of weight and better outcomes along with other therapies.

Education is the cornerstone of the project in Maine and every effort is made to educate the patient, the staff and the communities involved on the proper and most efficacious use of the medicine. Patients are further cautioned to not divert their allotment of cannabis. Diversion results in expulsion from the program.

The parochial (narrowly restricted in scope or outlook) condemnation by New Hampshire law enforcement is to be expected once again. If they find their curiosity piqued they could actually investigate the experience of other states and communities in states now among the seventeen states using medical cannabis to relieve pain, suffering and malnutrition.

Study of data from the US Center for Disease Control leads to a conclusion nationally we can expect a reduction in the suicide rate of about five percent in the general population and a 9 to 11 percent

decrease in some selected populations.. The relationship between reduced alcohol abuse and use of cannabis is documented in several studies. This is of great importance to those of us who serve as members of the suicide prevention council. There is a correlation between reduced alcohol abuse and use of cannabis. The reduction in SLEs, stressful life events, sees a reduction in the rate of suicide. The positive to the cannabis use is the reduction on physiological stressor chemicals, these chemicals are made worse by alcohol ingestion. Cannabis causes less reliance on alcohol.

The gateway bugaboo is being proven untrue according to anecdotal and survey result among hard drug users. The hard drug, heroin, cocaine, methamphetamine, users report the easing of symptoms of withdrawal thru the use of cannabis. It is a pleasant addition to the drug abuse counselors tool box to have a medicine with no side effects to ease the pain of withdrawal.

If you are aware of the rise in psychotic behaviors especially among young males you should welcome a reduction in the use of those prescription drugs that have led to the bizarre episodes sometimes tragically resulting in mass murder. We have all been receiving emails and phone calls from constituents suggesting an increase in mental health care might better protect the general public from the ill or untreated population seeking entry and treatment in an over burdened mental health system. To deny physicians, counselors and other mental health care providers a medicine guaranteed to reduce agitation in patients, reducing anxiety with sometimes a reduction in alcohol self medication is to deny progress to the system of in community mental health possibilities.

SO we have endless opportunities to make possible the use of a plant, produced at low cost, benefitting many, how can we refuse our citizens availability because of an scurrilous policy of the federal government. Even the federal government has a wait and watch policy in states with legalized medical cannabis. It is our chance in New Hampshire to join seventeen other states in a proven policy of benefit to our most ill citizens. I urge the committee to recommend ought to pass on HB 573.

Maine has recognized the medical use of marijuana since 1999 allowing medical cannabis users to grow their own. Ten years later Maine, seeing the inability of so many very sick patients but very inept gardeners authorized the creation of 8 dispensaries in eight different geographical regions of the state.

There are three legal and acceptable methods sick persons to obtain medical cannabis. *in maine*

A patient may grow their own cannabis and are allowed to nurture up to six plants for their own use. These self supplying sick persons do not have to register with anybody.

A caregiver is a grower for those unable to grow their own cannabis and are not proximal to a dispensary. Each caregiver can grow six plants for their own medical treatment and can grow six plants for each of five other medically physician recommended sufferers. Care givers also do not register with the state of Maine.

The third avenue for obtaining medical cannabis is through a dispensary. A dispensary must be a registered non-profit corporation. To purchase medicine at a dispensary the patient must have an ID card and their physicians original letter of recommendation or a Maine Medical Cannabis Program Card issued by the department of health and human services.

Patients can use a dispensary, signing an agreement with the dispensary of their choosing and can simultaneously grow their own. The dual supply is to guarantee a supply when so many growers are unsuccessful at propagating their own plants.

The pricing is left to the individual dispensaries who must determine the competitive price between the dispensary and the street price offered on the street market. There is an eighteen year old entry age for patients. Minors need be accompanied by an adult.

Quality and purity is a selling point for competing with the street market. The dispensaries are self supplying operations. The product is sold as tinctures, ointments, salves, edibles, vaporizer additives and of course the ever familiar smokeable weed.

The legal limit for purchase is 2.5 ounces (70 grams) every fifteen days. Median patient age is 46. The average purchase is \$100. My wife's final year saw us purchasing out of pocket about one thousand dollars of oxy this and oxy that. Pain relief was inconsistent but the side effects were constant and miserable.

Matt Simon  
Legislative Analyst, Marijuana Policy Project  
Feb. 21, 2013

**Testimony in support of HB 573, allowing marijuana for medical purposes, for the House Committee on Health, Human Services, and Elderly Affairs**

Overview of Written Testimony:

1. Brief overview of historical timeline.
2. Excerpts from DEA Administrative Law Judge Francis Young's 1988 ruling in favor of moving marijuana out of Schedule I.
3. Excerpts from the Institute of Medicine's 1999 report "Marijuana as Medicine: Assessing the Science Base."
4. "Study Finds No Cancer-Marijuana Connection." *The Washington Post*, May 26, 2006.
5. Handout: "Do medical marijuana laws lead to increased rates of teen marijuana use?" Additionally on that topic, a quote by Dr. Seth Ammerman writing in the winter 2011 edition of *California Pediatrician*: "the data are very reassuring that in almost all cases medical marijuana legalized for adults does not lead to an increase in recreational use of marijuana by adolescents."
6. Handout: "How HB 573 Differs from California's Prop 215."
7. Written testimony of John Tommasi, retired police sergeant and former member of the NH Drug Task Force.
8. "Lynch drove me out of state." This 2012 editorial was published by Ron Mitchell, who planned to testify in person but had to attend a funeral in another state. Mr. Mitchell and his wife now live in Vermont, away from family in New Hampshire, so he can follow his doctor's recommendation without fearing the police.
9. Written testimony of Richard Vincent, MS patient and head of multiple sclerosis support group in Concord.
10. "Legalize marijuana for medical use in NH." *Nashua Telegraph* editorial board: December 17, 2013.
11. "Medical marijuana law overdue in New Hampshire." *Portsmouth Herald* editorial board: February 16, 2013.
12. "Report to the Legislature and Governor of the State of California," University of California Center for Medicinal Cannabis Research, 2010 (submitted one copy for the committee file).

## **Cannabis/Marijuana: A Glance at History**

1753 – The plant now generally known in the United States by the Mexican slang term *marijuana* was classified *Cannabis sativa* by Linneaus<sup>1</sup>.

Mid-1800's – Doctors in the U.S. became aware that cannabis was being successfully used by doctors in India and elsewhere to treat various illnesses. Despite difficulties creating consistent medicines from the plant, it was widely used without reports of serious side-effects and many favorable articles were published in medical journals<sup>2</sup>.

1870 – Cannabis was added to the U.S. pharmacopoeia.

Late 1800's and early 1900's – Cigarette smoking became more popular, and at some point the first "joint" was rolled. "Marijuana" smoking caught on in Mexico, and immigrants brought the practice with them to Texas and New Mexico around the turn of the century. Meanwhile, cannabis was being introduced in New Orleans and other port cities by Caribbean sailors and West Indian immigrants<sup>3</sup>. From New Orleans, it traveled up the Mississippi River.

1914 – Harrison Act became federal law, restricting narcotics. Cannabis was not included.

1931 – Texas became the first state to prohibit possession of marijuana.

1933 – With Alcohol Prohibition repealed, prohibitionists set their sights on marijuana. Under Harry Anslinger, who served as "drug czar" from 1930-1962, the word *cannabis* was discarded from use and marijuana was held to have no medicinal properties whatsoever.

July 10, 1937 -- The American Medical Association submitted a letter in opposition to the "Marihuana Tax Act of 1937." Here is a section of the letter:

*Since the medicinal use of cannabis has not caused and is not causing addiction, the prevention of the use of the drug for medicinal purposes can accomplish no good end whatsoever. How far it may serve to deprive the public of the benefits of a drug that on further research may prove to be of substantial value, it is impossible to foresee.*

1937 – The Marijuana Tax Act passed into law, partly because the AMA's position was falsely represented on the floor of the Senate as being in support of the bill.

---

<sup>1</sup> *The Marijuana Conviction: A History of Marijuana Prohibition in the United States*. Bonnie, Richard and Charles Whitebread. Originally published in 1974, republished in 1999 by the Lindesmith Center, New York.

<sup>2</sup> *ibid*

<sup>3</sup> *ibid*

1942 – All references to medical use of cannabis were removed from the U.S. pharmacopoeia.

1964 – Delta-9 Tetrahydrocannabinol (THC) was identified as the primary active ingredient in marijuana.

1970 – The Controlled Substances Act (CSA) passed, creating “schedules” for drugs and empowering the Justice Department to enforce drug laws. Marijuana was provisionally placed in Schedule I pending a recommendation from President Nixon’s National Commission on Marijuana and Drug Abuse, chaired by former Pennsylvania Governor Raymond Shafer (a Republican and former prosecutor).

1972 – The Shafer Commission published its report “Marijuana: A Signal of Misunderstanding,” which recommended that marijuana use should be discouraged, but not criminalized. The report was ignored by federal authorities, but eleven state legislatures took action in the 1970’s to “decriminalize” marijuana.

1976 – Glaucoma patient Robert Randall sued in federal court for his right to use marijuana to prevent blindness. The court found in his favor, and this led to the Compassionate Investigative New Drug (IND) Program, under which four patients still receive marijuana directly from the federal government. (The IND program was closed to new applicants in 1991, as it became increasingly obvious that AIDS patients were benefiting from marijuana.)

1980’s – “War on Drugs” was escalated, with politicians promising to create a “Drug-free America” by adopting zero-tolerance policies, increasing penalties and enforcement budgets, and waging a high-profile propaganda campaign.

1988 – After hearings, DEA Administrative Law Judge Francis Young ruled that the scheduling standards established in CSA “permit and require the transfer of marijuana from Schedule I to Schedule II.” He added: “Marijuana, in its natural form, is one of the safest therapeutically active substances known. It would be unreasonable, arbitrary, and capricious for the DEA to continue to stand between those sufferers and the benefits of the substance.” Judge Young’s ruling was promptly overturned by DEA administrator Scott Lawn.

1994– A federal court upheld Lawn’s authority to overturn Judge Young’s ruling.

1996 to 2012 – 18 states and the District of Columbia passed laws protecting patients from arrest if their doctors recommend medical use of marijuana.

***"[W]e concluded that there are some limited circumstances in which we recommend smoking marijuana for medical uses."***

— from Principal Investigator Dr. John Benson's opening remarks at IOM's 3/17/99 news conference

## **Questions about medical marijuana answered by the Institute of Medicine's report Marijuana and Medicine: Assessing the Science Base\***

**Excerpts compiled by the Marijuana Policy Project**

### **What conditions can marijuana treat?**

"The accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation." [p. 3]

"[B]asic biology indicates a role for cannabinoids in pain and control of movement, which is consistent with a possible therapeutic role in these areas. The evidence is relatively strong for the treatment of pain and, intriguing although less well established, for movement disorders." [p. 70]

"For patients such as those with AIDS or who are undergoing chemotherapy and who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad-spectrum relief not found in any other single medication. The data are weaker for muscle spasticity but moderately promising." [p. 177]

"The most encouraging clinical data on the effects of cannabinoids on chronic pain are from three studies of cancer pain." [p. 142]

### **Why can't patients use medicines that are already legal?**

"[T]here will likely always be a subpopulation of patients who do not respond well to other medications." [Pp. 3, 4]

"The critical issue is not whether marijuana or cannabinoid drugs might be superior to the new drugs, but whether some group of patients might obtain added or better relief from marijuana or cannabinoid drugs." [p. 153]

"The profile of cannabinoid drug effects suggests that they are promising for treating wasting syndrome in AIDS patients. Nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana. Although some medications are more effective than marijuana for these problems, they are not equally effective in all patients." [p. 159]

### **What about Marinol®, the major active ingredient in marijuana in pill form?**

"It is well recognized that Marinol's oral route of administration hampers its effectiveness because of slow absorption and patients' desire for more control over dosing." [Pp. 205, 206]

### **Why not wait for more research before making marijuana legally available as a medicine?**

"[R]esearch funds are limited, and there is a daunting thicket of regulations to be negotiated at the federal level (those of the Food and Drug Administration, FDA, and the Drug Enforcement Administration, DEA) and state levels." [p. 137]

"Some drugs, such as marijuana, are labeled Schedule I in the Controlled Substance Act, and this adds considerable complexity and expense to their clinical evaluation." [p. 194]

"[O]nly about one in five drugs initially tested in humans successfully secures FDA approval for marketing through a new drug application." [p. 195]

"From a scientific point of view, research is difficult because of the rigors of obtaining an adequate supply of legal, standardized marijuana for study." [p. 217]

\*Copyright 1999 by the National Academy of Sciences (ISBN 0-309-07155-0)

**Marijuana Policy Project ■ P.O. Box 77492 ■ Capitol Hill ■ Washington, D.C. 20013  
tel 202-462-5747 ■ fax 202-232-0442 ■ MPP@MPP.ORG ■ <http://www.mpp.org>**



"In short, development of the marijuana plant is beset by substantial scientific, regulatory, and commercial obstacles and uncertainties." [p. 218]

"[D]espite the legal, social, and health problems associated with smoking marijuana, it is widely used by certain patient groups." [p. 7]

### **Do the existing laws really hurt patients?**

"G.S. spoke at the IOM workshop in Louisiana about his use of marijuana first to combat AIDS wasting syndrome and later for relief from the side effects of AIDS medications. ... [He said,] 'Every day I risk arrest, property forfeiture, fines, and imprisonment.'" [Pp. 27, 28]

### **Why shouldn't we wait for new drugs based on marijuana's components to be developed, rather than allowing patients to eat or smoke natural marijuana right now?**

"Although most scientists who study cannabinoids agree that the pathways to cannabinoid drug development are clearly marked, there is no guarantee that the fruits of scientific research will be made available to the public for medical use." [p. 4]

"[I]t will likely be many years before a safe and effective cannabinoid delivery system, such as an inhaler, is available for patients. In the meantime there are patients with debilitating symptoms for whom smoked marijuana might provide relief." [p. 7]

"[W]hat seems to be clear from the dearth of products in development and the small size of the companies sponsoring them is that cannabinoid development is seen as especially risky." [Pp. 211, 212] [IOM later notes that it could take more than five years and cost \$200-300 million to get new cannabinoid drugs approved—if ever.]

"Cannabinoids in the plant are automatically placed in the most restrictive schedule of the Controlled Substances Act, and this is a substantial deterrent to development." [p. 219]

### **Isn't marijuana too dangerous to be used as a medicine?**

"[E]xcept for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications." [p. 5]

"Until the development of rapid onset antiemetic drug delivery systems, there will likely remain a subpopulation of patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. It is possible that the harmful effects of smoking marijuana for a limited period of time

might be outweighed by the antiemetic benefits of marijuana, at least for patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. Such patients should be evaluated on a case-by-case basis and treated under close medical supervision." [p. 154]

"Terminal cancer patients pose different issues. For those patients the medical harm associated with smoking is of little consequence. For terminal patients suffering debilitating pain or nausea and for whom all indicated medications have failed to provide relief, the medical benefits of smoked marijuana might outweigh the harm." [p. 159]

### **What should be done to help the patients who already benefit from medical marijuana, prior to the development of new drugs and delivery devices?**

"Patients who are currently suffering from debilitating conditions unrelieved by legally available drugs, and who might find relief with smoked marijuana, will find little comfort in a promise of a better drug 10 years from now. In terms of good medicine, marijuana should rarely be recommended unless all reasonable options have been eliminated. But then what? It is conceivable that the medical and scientific opinion might find itself in conflict with drug regulations. This presents a policy issue that must weigh—at least temporarily—the needs of individual patients against broader social issues. Our assessment of the scientific data on the medical value of marijuana and its constituent cannabinoids is but one component of attaining that balance." [p. 178]

"Also, although a drug is normally approved for medical use only on proof of its 'safety and efficacy,' patients with life-threatening conditions are sometimes (under protocols for 'compassionate use') allowed access to unapproved drugs whose benefits and risks are uncertain." [p. 14]

"Until a nonsmoked rapid-onset cannabinoid drug delivery system becomes available, we acknowledge that there is no clear alternative for people suffering from chronic conditions that might be relieved by smoking marijuana, such as pain or AIDS wasting. One possible approach is to treat patients as n-of-1 clinical trials (single-patient trials), in which patients are fully informed of their status as experimental subjects using a harmful drug delivery system and in which their condition is closely monitored and documented under medical supervision. ..." [p. 8] [The federal government's "compassionate use" program, which currently provides marijuana to seven patients nationwide, is an example of an n-of-1 study.]

**The IOM report doesn't explicitly endorse state bills and initiatives to simply remove criminal penalties for bona fide medical marijuana users. Does that mean that we should keep the laws exactly as they are and keep arresting patients?**

"This report analyzes science, not the law. As in any policy debate, the value of scientific analysis is that it can provide a foundation for further discussion. Distilling scientific evidence does not in itself solve a policy problem." [p. 14]

**If patients were allowed to use medical marijuana, wouldn't overall use increase?**

"Finally, there is a broad social concern that sanctioning the medical use of marijuana might increase its use among the general population. At this point there are no convincing data to support this concern. The existing data are consistent with the idea that this would not be a problem if the medical use of marijuana were as closely regulated as other medications with abuse potential. ... [T]his question is beyond the issues normally considered for medical uses of drugs and should not be a factor in evaluating the therapeutic potential of marijuana or cannabinoids." [Pp. 6, 7]

"No evidence suggests that the use of opiates or cocaine for medical purposes has increased the perception that their illicit use is safe or acceptable." [p. 102]

"Thus, there is little evidence that decriminalization of marijuana use necessarily leads to a substantial increase in marijuana use." [p. 104]  
*[Decriminalization is defined as the removal of criminal penalties for all uses, even recreational.]*

**Doesn't the medical marijuana debate send children the wrong message about marijuana?**

"[T]he perceived risk of marijuana use did not change among California youth between 1996 and 1997. In summary, there is no evidence that the medical marijuana debate has altered adolescents' perceptions of the risks associated with marijuana use." [p. 104]

"Even if there were evidence that the medical use of marijuana would decrease the perception that it can be a harmful substance, this is beyond the scope of laws regulating the approval of therapeutic drugs. Those laws concern scientific data related to the safety and efficacy of drugs for individual use; they do not address perceptions or beliefs of the general population." [p. 126]

**Isn't marijuana too addictive to be used as a medicine?**

"Some controlled substances that are approved medications produce dependence after long-term use; this, however, is a normal part of patient management and does not generally present undue risk to the patient." [p. 98]

"Animal research has shown that the potential for cannabinoid dependence exists, and cannabinoid withdrawal symptoms can be observed. However, both appear to be mild compared to dependence and withdrawal seen with other drugs." [p. 35]

"A distinctive marijuana and THC withdrawal syndrome has been identified, but it is mild and subtle compared with the profound physical syndrome of alcohol or heroin withdrawal." [Pp. 89, 90]

Drug Category	Proportion Of Users That Ever Became Dependent (%)	
Alcohol	15	
Marijuana (including hashish)	9	[p. 95]

"Compared to most other drugs ... dependence among marijuana users is relatively rare." [p. 94]

"In summary, although few marijuana users develop dependence, some do. But they appear to be less likely to do so than users of other drugs (including alcohol and nicotine), and marijuana dependence appears to be less severe than dependence on other drugs." [p. 98]

**Doesn't the use of marijuana cause people to use more dangerous drugs?**

"[I]t does not appear to be a gateway drug to the extent that it is the *cause* or even that it is the most significant predictor of serious drug abuse; that is, care must be taken not to attribute cause to association." [p. 101]

"There is no evidence that marijuana serves as a stepping stone on the basis of its particular physiological effect." [p. 99]

"Instead, the legal status of marijuana makes it a gateway drug." [p. 99]

**Shouldn't medical marijuana remain illegal because it is bad for the immune system?**

"The short-term immunosuppressive effects are not well established; if they exist at all, they are probably not great enough to preclude a legitimate medical use. The acute side effects of marijuana use are within the risks tolerated for many medications." [p. 126]

### **Doesn't marijuana cause brain damage?**

"Earlier studies purporting to show structural changes in the brains of heavy marijuana users have not been replicated with more sophisticated techniques." [p. 106]

### **Doesn't marijuana cause amotivational syndrome?**

"When heavy marijuana use accompanies these symptoms, the drug is often cited as the cause, but no convincing data demonstrate a causal relationship between marijuana smoking and these behavioral characteristics." [Pp. 107, 108]

### **Doesn't marijuana cause health problems that shorten the life span?**

"[E]pidemiological data indicate that in the general population marijuana use is not associated with increased mortality." [p. 109]

### **Isn't marijuana too dangerous for the respiratory system?**

"Given a cigarette of comparable weight, as much as four times the amount of tar can be deposited in the lungs of marijuana smokers as in the lungs of tobacco smokers." [p. 111]

"However, a marijuana cigarette smoked recreationally typically is not packed as tightly as a tobacco cigarette, and the smokable substance is about half that in a tobacco cigarette. In addition, tobacco smokers generally smoke considerably more cigarettes per day than do marijuana smokers." [Pp. 111, 112]

"There is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use. ... More definitive evidence that habitual marijuana smoking leads or does not lead to respiratory cancer awaits the results of well-designed case control epidemiological studies." [p. 119]

### **Don't the euphoric side effects diminish marijuana's value as a medicine?**

"The high associated with marijuana is not generally claimed to be integral to its therapeutic value. But mood enhancement, anxiety reduction, and mild sedation can be desirable qualities in medications—particularly for patients suffering pain and anxiety. Thus, although the psychological effects of marijuana are merely side effects in the treatment of some symptoms, they might contribute directly to relief of other symptoms." [p. 84]

### **What other therapeutic potential does marijuana have?**

"One of the most prominent new applications of cannabinoids is for 'neuroprotection,' the rescue of neurons from cell death associated with trauma, ischemia, and neurological diseases." [p. 211]

"There are numerous anecdotal reports that marijuana can relieve the spasticity associated with multiple sclerosis or spinal cord injury, and animal studies have shown that cannabinoids affect motor areas in the brain—areas that might influence spasticity." [p. 160]

"High intraocular pressure (IOP) is a known risk factor for glaucoma and can, indeed, be reduced by cannabinoids and marijuana. However, the effect is too and [sic] short lived and requires too high doses, and there are too many side effects to recommend lifelong use in the treatment of glaucoma. The potential harmful effects of chronic marijuana smoking outweigh its modest benefits in the treatment of glaucoma. Clinical studies on the effects of smoked marijuana are unlikely to result in improved treatment for glaucoma." [p. 177] *[Note that IOM found that marijuana does work for glaucoma, but was uncomfortable with the amount that a person needs to smoke. Presumably, it would be an acceptable treatment for glaucoma patients to eat marijuana. Additionally, MPP believes that IOM would not support arresting patients who choose to smoke marijuana to treat glaucoma.]*

### **Do the American people really support legal access to medical marijuana, or were voters simply tricked into passing medical marijuana ballot initiatives?**

"Public support for patient access to marijuana for medical use appears substantial; public opinion polls taken during 1997 and 1998 generally report 60-70 percent of respondents in favor of allowing medical uses of marijuana." [p. 18]

### **But shouldn't we keep medical marijuana illegal because some advocates want to "legalize" marijuana for all uses?**

"[I]t is not relevant to scientific validity whether an argument is put forth by someone who believes that all marijuana use should be legal or by someone who believes that any marijuana use is highly damaging to individual users and to society as a whole." [p. 14]

The full report by the National Academy of Sciences can be viewed on-line at  
<http://bob.nap.edu/books/0309071550/html/>

# The Washington Post

## Study Finds No Cancer-Marijuana Connection

Advertisement

By Marc Kaufman  
Washington Post Staff Writer  
Friday, May 26, 2006

Go gle

The largest study of its kind has unexpectedly concluded that smoking marijuana, even regularly and heavily, does not lead to lung cancer.

The new findings "were against our expectations," said Donald Tashkin of the University of California at Los Angeles, a pulmonologist who has studied marijuana for 30 years.

"We hypothesized that there would be a positive association between marijuana use and lung cancer, and that the association would be more positive with heavier use," he said. "What we found instead was no association at all, and even a suggestion of some protective effect."

Federal health and drug enforcement officials have widely used Tashkin's previous work on marijuana to make the case that the drug is dangerous. Tashkin said that while he still believes marijuana is potentially harmful, its cancer-causing effects appear to be of less concern than previously thought.

Earlier work established that marijuana does contain cancer-causing chemicals as potentially harmful as those in tobacco, he said. However, marijuana also contains the chemical THC, which he said may kill aging cells and keep them from becoming cancerous.

Tashkin's study, funded by the National Institutes of Health's National Institute on Drug Abuse, involved 1,200 people in Los Angeles who had lung, neck or head cancer and an additional 1,040 people without cancer matched by age, sex and neighborhood.

They were all asked about their lifetime use of marijuana, tobacco and alcohol. The heaviest marijuana smokers had lighted up more than 22,000 times, while moderately heavy usage was defined as smoking 11,000 to 22,000 marijuana cigarettes. Tashkin found that even the very heavy marijuana smokers showed no increased incidence of the three cancers studied.

"This is the largest case-control study ever done, and everyone had to fill out a very extensive questionnaire about marijuana use," he said. "Bias can creep into any research, but we controlled for as many confounding factors as we could, and so I believe these results have real meaning."

Tashkin's group at the David Geffen School of Medicine at UCLA had hypothesized that marijuana would raise the risk of cancer on the basis of earlier small human studies, lab studies of animals, and the fact that marijuana users inhale more deeply and generally hold smoke in their lungs longer than tobacco smokers -- exposing them

to the dangerous chemicals for a longer time. In addition, Tashkin said, previous studies found that marijuana tar has 50 percent higher concentrations of chemicals linked to cancer than tobacco cigarette tar.

While no association between marijuana smoking and cancer was found, the study findings, presented to the American Thoracic Society International Conference this week, did find a 20-fold increase in lung cancer among people who smoked two or more packs of cigarettes a day.

The study was limited to people younger than 60 because those older than that were generally not exposed to marijuana in their youth, when it is most often tried.

[View all comments](#) that have been posted about this article.

© 2006 The Washington Post Company

# Do medical marijuana laws lead to increased rates of teen marijuana use?

Some opponents claim that New Hampshire should not allow medical use of marijuana for seriously ill patients because to do so would “send the wrong message” to young people about marijuana use. They assume teen marijuana use in New Hampshire will increase if the state passes a medical marijuana law.

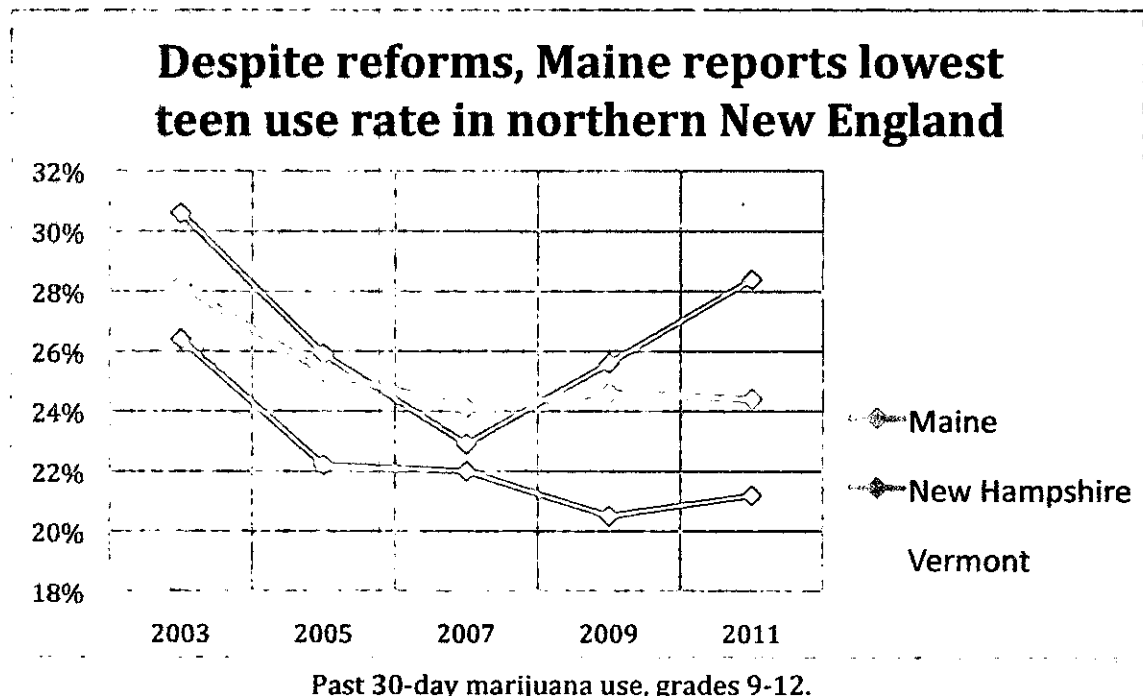
Rather than accepting this assumption at face value, we should first examine the relevant data from Vermont, Maine, and New Hampshire to determine if these states’ contrasting policies have demonstrated any effect on rates of teen use.

**VERMONT** passed a medical marijuana law in 2004 and expanded the list of qualifying conditions in 2007.

**MAINE** passed a medical marijuana law in 1999. Furthermore, marijuana has been “decriminalized” in Maine since 1976, meaning that possession of small amounts for personal use has been treated as a civil violation with no threat of jail time. The qualifying conditions for Maine’s medical marijuana law are less restrictive than Vermont’s law, and Maine’s law allows patients to cultivate medical marijuana without registering with the state.

In **NEW HAMPSHIRE**, all marijuana possession and use remains criminalized.

So, according to government surveys, which state has the lowest rate of teen use in northern New England? If opponents of HB 573 are correct, it can’t be Maine, right?



Source: US Centers for Disease Control and Prevention, Youth Risk Behavioral Surveillance System (YRBSS), <http://apps.nccd.cdc.gov/youthonline/App/Default.aspx>



**Marijuana Policy Project**  
P.O. Box 77492 • Capitol Hill  
Washington, D.C. 20013  
p: (202) 462-5747 • f: (202) 232-0442  
info@mpp.org • www.mpp.org

## **How HB 573 Differs From California's Prop. 215**

When people think about medical marijuana, chances are the first law that comes to mind is California's. It's little surprise California has gotten the most attention since it's the most populous medical marijuana state, and its law is the oldest, broadest, and most vague. But Prop. 215 is hardly the norm. Other states like Vermont and Maine have been protecting patients for several years with modest medical marijuana laws that haven't created controversy. These laws have simply received much less national media attention. Here's a look at some key ways HB 573 differs from California's law.

### **Qualifying, Serious Medical Conditions Required Under HB 573**

Until Jan. 1, 2013, when Massachusetts' Question 3 became law, California was the only state where a physician could recommend medical marijuana for *any* medical condition. In the other 16 states where medical marijuana is legal, the laws are limited to specific qualifying conditions and symptoms, as they would be in New Hampshire. The qualifying conditions in New Hampshire are similar to those in Vermont and Maine. Patients aren't required to register in Maine, so it's impossible to know how many patients benefit from Maine's program, but in Vermont there are only about 559 patients, a far cry from the more than 500,000 California patients. New Hampshire's bill is also more restrictive than most medical marijuana laws by only allowing severe pain as a qualifying condition if other treatments have not been effective for three months or longer or if they have caused serious side effects.

### **Required Provider-Patient Relationship**

HB 573 requires doctors to perform a full assessment of a patient's medical history and current condition. They must also have a "provider-patient relationship" with the patient to whom they recommend medical marijuana as defined in RSA 126-W:1, IX. Unless the condition had a sudden onset, the relationship would have to be established for at least three months prior to the certification. This contrasts starkly with California, where physicians often provide recommendations within minutes of meeting a patient.

### **Patients and Caregivers Must Register**

In California, patients and caregivers do not have to register with the state. HB 573 would include a mandatory registry of patients, caregivers, and cultivation locations. This would allow for police to verify a patient's status and also would make it possible to revoke the right to use marijuana if a patient broke the rules.

### **Patient Access By Limited, Secure Home Cultivation and Regulated ATCs**

While California has hundreds of dispensaries, with varying levels of local regulations and in some cases none, New Hampshire's HB 573 would only authorize five Alternative Treatment Centers (ATC's), which would be regulated by the Department of Health and Human Services. Patients would be allowed to cultivate a limited supply of their own medicine or to designate a caregiver to do so, but unlike in California, all cultivation would have to occur in a locked, secure location registered with the state health department. Patients would be limited to four mature marijuana plants, which is a reasonable but limited amount. By contrast, California does not set a clear limit on how much marijuana patients and caregivers may grow.

### **Caregivers Would Be Volunteers**

Unlike California, where caregivers can receive compensation, caregivers would have to serve as volunteers under HB 573. They could receive compensation for actual costs, but not for their labor. Additionally, HB 573 would require caregivers to pass a criminal background check before being approved.

### **Sensible Restrictions**

California's voter initiative was one page and did not spell out any restrictions on the medical use of marijuana. By contrast, HB 573 contains many regulations and restrictions that have been agreed upon by New Hampshire legislative committees. For example, HB 573 specifies that marijuana can only be grown in a locked, enclosed location registered with DHHS, and it requires patients and caregivers to carry a state-issued ID card when possessing marijuana. It also limits patients to purchasing from one ATC, unlike in California, where patients can purchase from multiple unregulated dispensaries.

### **Class B Felony for Diversion**

HB 573 would impose a Class B felony conviction on any cardholder who sells marijuana to a non-patient, in addition to the usual felony penalty for selling marijuana. Class B felonies are punishable by one to seven years in prison. It would also require the card to be revoked in such a case. California's law does not include any enhanced penalties for patients or caregivers who divert marijuana.



John Tommasi  
Testimony Supporting HB 573  
House Health, Human Services, and Elderly Affairs Committee  
February 21, 2013

Honorable Committee Members:

I am sorry I can't be present for today's hearing, but I thank you for considering my testimony.

My name is John Tommasi and I am currently a part-time professor at the University of New Hampshire, Whittemore School of Business (Durham, NH) and a full-time professor at Bentley College. I hold a BA in Psychology, an MA in Business Administration and an MA in Economics from the University of New Hampshire.

Before I embarked on my career as a college and university professor, I served as a full-time police officer with the Salem Police Department from 1979 to 2002. I served on the Drug Task Force from 1987-1989, was promoted to sergeant in 1983, and retired in 2002. I continue to work as a part-time police officer in Hampton Beach during the summer.

I am not a medical professional, but I am very aware of the fact that some seriously ill patients benefit from the medical use of marijuana. If HB 573 becomes law, patients in New Hampshire would receive state-issued ID cards if their doctors recommend medical marijuana, and those patients and their caregivers would be protected from arrest as long as they are complying with the provisions of the law.

The alternative to passing HB 573 is to maintain the status quo, and the status quo is that all marijuana possession and use is considered criminal activity in New Hampshire – even for patients battling diseases such as cancer, multiple sclerosis, and glaucoma.

I suspect that many members of law enforcement would support this reform if they were in the legislature and had to cast a vote. Some New Hampshire police chiefs may disagree, but from my perspective HB 573 appears to be a responsibly-crafted bill that would protect patients and their families without leading to serious abuses.

I encourage the committee to vote "yes."

Thank you for your consideration.

Sincerely,

John Tommasi  
[jrtommasi@aol.com](mailto:jrtommasi@aol.com)

# **Lynch drove me out of state**

## **Medical marijuana made life bearable**

By Ronald Mitchell / For the Monitor

May 25, 2012

It was a tragedy for me and my family when Gov. John Lynch vetoed the medical marijuana bill in 2009. When an effort to override the veto passed the House but failed by two votes in the Senate, my hopes for a healthy future in New Hampshire were crushed.

Sixteen states plus the District of Columbia now offer legal protection for patients if their doctors recommend marijuana. Connecticut is on the verge of becoming the 17th state. Sadly, patients whose doctors recommend marijuana in New Hampshire have no choice but to sneak around, buying from the black market and living in constant fear of arrest.

I can attest to that fear. And now that I have moved from Manchester to Vermont, I can attest to the much more beneficial alternative, which is peace of mind. Legislators and Lynch should consider my story before casting final judgment on SB 409.

I am a U.S. Army combat veteran (1971-73). I then worked as a sheet metal man for almost 15 years, but one day back in 1987 I crushed my back at work. After two failed back surgeries, I was left with severe, debilitating pain.

Doctors have prescribed every prescription pain killer you can name, and in 2009, at age 57, I was taking more than 20 pills a day. I was in so much pain that I was rarely able to leave the house. The only way I could endure the pain was to keep swallowing the pills.

But I hated the pills. I kept needing more and more of them, and they turned me into a zombie. I was afraid my wife was going to leave me. My life seemed like it was going down the tubes.

One option that never occurred to me was medical marijuana, so imagine my shock when my doctor suggested it. He told me about the law that was being considered in the Legislature, and he said marijuana might make it possible for me to take fewer pills and become more active.

I was amazed at this advice, but since nothing else was working, what did I have to lose? Well, only my freedom, I guessed.

Anyway, it seemed worth the risk, so I made a few calls and found somebody who could get me some marijuana.

When I tried it, I couldn't believe how much better it made me feel. For the first time in years, I was able to sleep more than four hours at a time!

over  
↙

I began using it daily, despite my fear of being arrested, and I quickly found that I was able to take fewer pills. Given how toxic those pills are, this was a major victory in itself. Unfortunately, Lynch vetoed the bill, and the override effort fell short by a mere two votes.

With no choice but to continue using medical marijuana, I found a small apartment in Vermont. Several months later, my wife found a job nearby and was able to join me, although she had to take a significant pay cut to do so, and she was very sad to move away from her family.

On the positive side, I now have a small, legal, indoor garden that provides me with a consistent supply of medical marijuana, and I don't have to live in fear of my state or local police. Most amazingly, I'm now down to two pills a day, one in the morning and one in the evening, and my ability to get around has improved dramatically! So it's not an exaggeration for me to say that Lynch drove me and my wife out of New Hampshire. If Lynch manages to kill the medical marijuana bill again in 2012, he'll be killing the hopes of many patients in New Hampshire, and he'll also be making it impossible for my wife and me to move back home where we belong.

*(Ronald Mitchell lives in White River Junction, Vt.)*

To whom it may concern:

I run the Multiple Sclerosis Support Group at the HealthSouth Rehabilitation Hospital in Concord, New Hampshire for the National MS Society.

Multiple Sclerosis can happen to anyone no matter what the age. While Multiple Sclerosis has the potential to cause several different symptoms, the specific symptoms each person experiences vary greatly. When experiencing one or more of these symptoms, an individual should consult his or her physician. Medications are available to treat many MS symptoms. These may include over-the-counter drugs as well as prescribed medications and if approved, medical marijuana. Diet and exercise may also be helpful with managing certain symptoms. All treatments, including medical marijuana or changes in diet or exercise should only be done under the guidance of a qualified physician.

When recovering from a symptom flare-up or learning to cope with a change in mobility, rehabilitation through physical therapy and occupational therapy can be of great value. Speech therapy, therapeutic exercise, and certain medical devices may also be useful in dealing with the symptoms of MS. Some of those who have a physically demanding or highly stressful job may choose to make a career change, in which case vocational training is helpful.

When a family member is diagnosed with MS, participating in some type of counseling program is often of benefit to everyone involved. Individuals may be affected in different ways, both physically and emotionally. Seeking professional assistance helps to ensure that MS does not disrupt one's family and happiness. Medical marijuana can be a new tool to help somebody cope with their difficulty. Please pass HB 573. The suffering should be finished with, this year.

Best Regards,

Richard Vincent  
20 Country Hill Road  
Loudon, NH 03307

# The Telegraph

It's Your Community.

This is a printer friendly version of an article from [www.nashuatelegraph.com](http://www.nashuatelegraph.com)

To print this article if a print dialogue does not open automatically, open the File menu and choose Print.

[Back](#)

---

Published: Monday, December 17, 2012

## Legalize marijuana for medical use in NH

And then there was one.

Effective Jan. 1, New Hampshire will be the only New England state in which patients cannot receive safe, legal access to medical marijuana.

Last month, Massachusetts joined Connecticut, Maine, Rhode Island, Vermont and a growing number of other states by voting to protect seriously ill patients from arrest when their doctors recommend marijuana for treatment.

So much for "Live Free or Die."

As residents of New Hampshire, we've heard the motto a million times. But when we look at the states around us, and the actions they are taking to allow their residents to live more freely than we do, we start to wonder if we're losing our "live free or die" spirit.

We wonder what it means to live in a state in which our seriously ill cannot legally receive relief from a natural plant when recommended by their doctor.

If you're older than 18, you don't have to wear a seat belt. If you're a motorcycle rider, and want to feel the breeze through your hair, no helmet is required.

We reduce cigarette taxes, better enabling our population – and our nearby neighbors – to smoke more affordably. (Never mind that smokers make up 20 percent of the adult population and cause \$564 million in annual health care costs.)

But if you are ill, your doctor can't prescribe marijuana, because New Hampshire is not quite "free" enough.

We're not talking about Cheech and Chong-style smoking for fun and silly antics. We're talking about allowing medical board certified doctors to prescribe the medicinal usage of marijuana for patients who physicians feel are best treated by cannabis.

Sure, marijuana has side effects like most medical treatments, but doctors should have the opportunity to determine if the benefits outweigh the risks, as they do with other treatments.

Advocates tried twice recently to push through medical marijuana bills in New Hampshire –

in 2009 and 2012 – only to have the bills vetoed by Gov. John Lynch.

This year, in a true bipartisan effort, the Legislature nearly had the two-thirds support needed to override the veto, with 10 of the 19 Senate Republicans voting in favor of the bill, as well as 62 percent of Republicans in the House.

Looking ahead at 2013, the prospect of passing a medical marijuana bill looks brighter.

Gov.-elect Maggie Hassan voted three times in favor of the medical marijuana bill as Senate majority leader in 2009, and in November, residents voted in a Legislature with a more equal balance between Republicans and Democrats.

New Hampshire is well known for its independence, but being unique by not allowing the medicinal use of marijuana is not something we should be proud of.

In order to protect our most seriously ill residents, we must legalize medicinal marijuana so doctors can use it to offer relief. Our most vulnerable residents are counting on it.

---

© 2012, Telegraph Publishing Company, Nashua, New Hampshire

## **Medical marijuana law overdue in New Hampshire**

**By Portsmouth Herald Editorial Board**

February 16, 2013 2:00 AM

New Hampshire is very likely to become the 19th state to allow citizens suffering from pain and illness to responsibly use medical marijuana, and to this we say: It's about time.

Last year, the New Hampshire House and Senate passed a limited medical marijuana law by wide margins. It was then vetoed by Gov. John Lynch and an override attempt failed.

Today, Gov. Lynch has been replaced by Gov. Maggie Hassan, who supports medical marijuana and even voted to override a Lynch veto when she was a state senator.

The question now is not whether New Hampshire will legalize medical marijuana but rather when the state will allow it and what the rules and regulations will be.

Last year's Senate Bill 409 empowered doctors and registered nurses to authorize seriously ill patients to grow up to four mature marijuana plants for their own medicinal use. Patients would not be allowed to sell the pot they grow and could never be in possession of more than six ounces at a time. The bill also prohibited public use of marijuana and driving under its influence. This year's legislative proposals also include five highly regulated dispensaries, which would be useful to those who, for any number of reasons, cannot grow their own marijuana.

While we strongly support use of marijuana for medicinal purposes, the Herald editorial board has not yet debated or taken a position of legalizing it entirely. And full legalization does not inevitably follow legalization for medical uses. Maine has allowed medical marijuana since 1999, and in 2009 the Pine Tree State passed a law allowing dispensaries, and yet full legalization is not likely anytime soon.

And Granite Staters nervous about medical marijuana can look across the river and see that allowing sick people to relieve their pain and maintain their appetites through marijuana use did not turn Mainers into 1970s stoners Cheech and Chong.



# CENTER FOR MEDICINAL CANNABIS RESEARCH

*Report to the Legislature and Governor of the State of California  
presenting findings pursuant to SB847 which created the CMCR and provided state funding*

*Director:*

**Igor Grant, M.D.**

*University of California, San Diego*

*Co-Directors:*

**J. Hampton Atkinson, M.D.**

**Andrew Mattison, Ph.D.\***

*University of California, San Diego*

**Thomas J. Coates, Ph.D.**

*University of California, Los Angeles*

*\*Deceased*





# Objective

---

In 1999, the California legislature passed and Governor Gray Davis signed SB847, which commissioned the University of California to establish a scientific research program to expand the public scientific knowledge on purported therapeutic usages of marijuana.

We hereby submit this report of our scientific findings pursuant to this objective.

# Table of Contents

---

<b>Executive Summary .....</b>	<b>2</b>
<i>Summary of Results to Date .....</i>	<i>2</i>
<i>Other CMCR Activities .....</i>	<i>3</i>
<i>Conclusion .....</i>	<i>4</i>
<b>Mission Statement .....</b>	<b>4</b>
<b>Scientific and Legislative Precursors of the CMCR.....</b>	<b>5</b>
<i>Discovery of Cannabis Receptors in the Brain.....</i>	<i>5</i>
<i>Scientific Reports.....</i>	<i>5</i>
<i>Legislative Origins.....</i>	<i>5</i>
<b>CMCR Review Process.....</b>	<b>6</b>
<b>CMCR Vision for Cannabis Therapeutics Research.....</b>	<b>7</b>
<i>Stage I: Smoked Cannabis.....</i>	<i>7</i>
<i>Stage II: Non-Smoked Preparations.....</i>	<i>7</i>
<i>Stage III: Molecules To Target Endocannabinoid System .....</i>	<i>7</i>
<b>Overview of Research Program .....</b>	<b>8</b>
<i>Studies in Pain and Other Neurologic Conditions.....</i>	<i>8</i>
<b>Synopsis of CMCR Published Clinical Study Results.....</b>	<b>10</b>
<i>"The Effect of Cannabis on Neuropathic Pain in HIV-Related Peripheral Neuropathy" .....</i>	<i>10</i>
<i>"Placebo-Controlled, Double Blind Trial of Medicinal Cannabis in Painful HIV Neuropathy" .....</i>	<i>10</i>
<i>"A Double-Blind, Placebo-Controlled Crossover Trial of the Antinociceptive Effects of Smoked Marijuana on Subjects with Neuropathic Pain" .....</i>	<i>11</i>
<i>"Analgesic Efficacy of Smoked Cannabis" .....</i>	<i>11</i>
<i>"Short-Term Effects of Cannabis Therapy on Spasticity in Multiple-Sclerosis" .....</i>	<i>12</i>
<i>"Vaporization as a 'Smokeless' Cannabis Delivery System" .....</i>	<i>12</i>
<b>Recently Completed And Ongoing Studies.....</b>	<b>13</b>
<i>"Sleep and Medicinal Cannabis" .....</i>	<i>13</i>
<i>"Impact of Repeated Cannabis Treatments on Driving Abilities" .....</i>	<i>13</i>
<i>"Efficacy of Inhaled Cannabis in Diabetic Painful Peripheral Neuropathy" .....</i>	<i>13</i>
<i>"The Analgesic Effect of Vaporized Cannabis on Neuropathic Pain" .....</i>	<i>13</i>
<b>Completed Pre-Clinical Studies .....</b>	<b>14</b>
<i>"Mechanisms of Cannabinoid Analgesia" .....</i>	<i>14</i>
<i>"Cannabinoids in Fear Extinction" .....</i>	<i>14</i>
<i>"Effects of Cannabis Therapy on Endogenous Cannabinoids" .....</i>	<i>14</i>
<i>"Effects of Medicinal Cannabis on CD4 Immunity in AIDS" .....</i>	<i>15</i>
<b>Discontinued Studies.....</b>	<b>15</b>
<b>Summary And Future Directions .....</b>	<b>16</b>
<b>CMCR Roster.....</b>	<b>17</b>
<b>CMCR Supported Publications .....</b>	<b>18</b>
<i>Results of CMCR Studies .....</i>	<i>18</i>
<i>Published Abstracts .....</i>	<i>18</i>
<i>Other CMCR-Supported Publications.....</i>	<i>19</i>

**"Research should continue into the physiological effects of synthetic and plant-derived cannabinoids and the natural function of cannabinoids found in the body."**

*~ Institute of Medicine, 1999*

**"The question of whether marijuana has any legitimate medical purpose should be determined by sound science and medicine."**

*~ Asa Hutchinson, Former DEA Administrator, 2001*

**"The scientific community, the medical community in particular, is divided on the real therapeutic effectiveness of marijuana. Some are quick to say that opening the door to medical marijuana would be a step toward outright legalization of the substance. But none of that should matter to physicians or scientists. It is not a question of defending general public policy on marijuana or even all illegal drugs. It is not a question of sending a symbolic message about "drugs". It is not a question of being afraid that young people will use marijuana if it is approved as a medicine. The question, and the only question, for physicians as professionals is whether, to what extent and in what circumstances, marijuana serves a therapeutic purpose."**

*~ Canadian Senate Special Committee On Illegal Drugs. Cannabis: Summary Report, 2002.*

**"Although the indications for some conditions (e.g., HIV wasting and chemotherapy-induced nausea and vomiting) have been well documented, less information is available about other potential medical uses. Additional research is needed to clarify marijuana's therapeutic properties and determine standard and optimal doses and routes of delivery."**

*~ American College of Physicians, 2008*

**"The Center for Medicinal Cannabis Research is currently conducting scientific studies to determine the efficacy of marijuana in treating various ailments. Until that research is concluded, however, most of what the public hears from marijuana activists is little more than a compilation of anecdotes."**

*~ John Walters, Former Director of the White House Office of National Drug Control Policy, 2002*

# Executive Summary

The Center for Medicinal Cannabis Research (CMCR) at the University of California was created in 2000 to conduct clinical and pre-clinical studies of cannabinoids, including smoked marijuana, to provide evidence one way or the other to answer the question "Does marijuana have therapeutic value?" To accomplish this objective, the CMCR issued calls for applications from researchers at leading California institutions, developed a close working relationship with state and federal agencies to gain regulatory approvals, established panels of nationally-recognized experts to rigorously review the merit of applications, and funded carefully designed studies that have now been published in high impact scientific journals, making significant contributions to the available literature on cannabis and the cannabinoids.

## Summary of Results to Date

In total, the CMCR has approved fifteen clinical studies, including seven clinical trials, of which five have completed and two are in progress. The CMCR has also approved four pre-clinical studies, all of which have completed.

By design CMCR clinical studies focused on conditions identified by the Institute of Medicine for which cannabis might have potential therapeutic effects, based on current scientific knowledge (Institute of Medicine, 1999). To date, four CMCR-funded studies have demonstrated that cannabis has analgesic effects in pain conditions secondary to injury (e.g. spinal cord injury) or disease (e.g. HIV disease, HIV drug therapy) of the nervous system. This result is particularly important because three of these CMCR studies utilized cannabis as an add-on treatment for patients who were not receiving adequate benefit from a wide range of standard pain-relieving medications. This suggests that cannabis may provide a treatment option for those individuals who do not respond or respond inadequately to currently available therapies. The efficacy of cannabis in treatment-refractory patients also may suggest a novel mechanism of action not fully exploited by current therapies. In addition to nerve pain, CMCR has also supported a study on muscle spasticity in Multiple Sclerosis (MS). Such spasticity can be painful and disabling, and some patients do not benefit optimally from existing treatments. The results of the CMCR study suggest that cannabis reduces MS spasticity, at least in the short term, beyond the benefit available from usual medical care.

**Table 1. Clinical Studies Published or Submitted for Publication**

<b>Donald Abrams, M.D.</b> UC San Francisco	Cannabis for Treatment of HIV-Related Peripheral Neuropathy
<b>Donald Abrams, M.D.</b> UC San Francisco	Vaporization as a Smokeless Cannabis Delivery System
<b>Jody Corey-Bloom, M.D., Ph.D.</b> UC San Diego	Short-Term Effects of Cannabis Therapy on Spasticity in MS
<b>Ronald Ellis, M.D., Ph.D.</b> UC San Diego	Placebo-controlled, Double Blind Trial of Medicinal Cannabis in Painful HIV Neuropathy
<b>Mark Wallace, M.D.</b> UC San Diego	Analgesic Efficacy of Smoked Cannabis
<b>Barth Wilsey, M.D.</b> UC Davis	Double Blind, Placebo Controlled Trial of Smoked Marijuana on Neuropathic Pain

To date, six of the studies have published (or are in the process of publishing) results in respected medical journals, garnering national and international attention from other researchers, media outlets, governmental agencies, and the general public (see Table 1). These results have helped to bring together accomplished international experts on cannabis and cannabinoids and foster scientific dialog on the possible utility of cannabis as a therapeutic agent.

Adverse side effects experienced by participants included cough, nausea, dizziness, sedation and changes in cognition. However, these effects were typically mild and resolved rapidly after treatment. Currently approved analgesics are not without side effects, and the effects observed in CMCR studies tended to be no worse than would be expected with other potent analgesics. Following the conclusion of the two studies currently in progress, CMCR will have exhausted its available funding for clinical work, though the CMCR will continue to maintain a sample bank and to consult with researchers and policy-makers as needed.

The majority of CMCR studies that have been discontinued were cancer studies that experienced difficulty in recruiting participants. Many severely ill individuals were reluctant to volunteer for a rigorous research protocol where the experimental treatment addressed disease symptoms (i.e. nausea, pain) but did not affect tumor growth directly. Other factors, such as requirement that patients have stable pain scores over a period of time leading into the study, prohibition from driving for the duration of the study, and difficulty in providing cannabis for home administration may also have played a role in the lack of success in recruiting this population. A further impediment to participation in CMCR studies, particularly in cancer patients, was the inability of CMCR to continue to provide study drug beyond the study period to patients who find active treatment beneficial. Additionally, some individuals already were using cannabis to treat pain or other symptoms, and so had less incentive to participate in research.

The CMCR portfolio also included basic science studies in animals and in human cells (pre-clinical research). This research was supported because it had the potential to provide insights into therapeutic use of cannabinoids in human disease. One study provided evidence, by way of recordings of nerve cell activity and in awake animals, of analgesic effects of cannabis-like compounds on head and facial pain, suggesting that clinical trials of cannabis might be warranted in patients with headache or other facial pain. Another study reported that cannabis did not interfere with the function of blood cells involved with immunity, an important finding considering potential therapeutic use of cannabis compounds will be in persons with chronic illnesses.

## Other CMCR Activities

In addition to the research, CMCR has also functioned as a catalyst for discussion and examination of the potential development of cannabis as medicine. In July, 2002, CMCR sponsored a workshop "Future Directions in Cannabinoid Therapeutics" featuring presentations by intellectual and scientific leaders in the field of cannabinoid science from around the world. CMCR hosted a second meeting in summer 2004 to address recent progress in science that would be likely to lead to clinical trials of new cannabinoid compounds. "Future Directions in Cannabinoid Therapeutics II: From the Bench to the Clinic" brought together the major stakeholders in the development of cannabinoid therapeutics in order to survey laboratory compounds that are most promising for testing in human trials and to confront potential stumbling blocks to testing and development of these compounds. A special issue of the journal *Neuropharmacology* (2005) was dedicated to publishing the research presented at this meeting.

## *Executive Summary (cont.)*

---

CMCR researchers have also published two literature reviews on the neuropsychological effects of cannabis use in order to better understand the potential hazards of cannabis use in short and long-term treatment settings (Grant, et al., 2003 & Gonzalez, et. al, 2002 – see reference list).

### **Conclusion**

As a result of the vision and foresight of the California State Legislature Medical Marijuana Research Act (SB847), the CMCR has successfully conducted the first clinical trials of smoked cannabis in the United States in more than 20 years. As a result of this program of systematic research, we now have reasonable evidence that cannabis is a promising treatment in selected pain syndromes caused by injury or diseases of the nervous system, and possibly for painful muscle spasticity due to multiple sclerosis. Obviously more research will be necessary to elucidate the mechanisms of action and the full therapeutic potential of cannabinoid compounds. Meanwhile, the knowledge and new findings from the CMCR provide a strong science-based context in which policy makers and the public can discuss the place of these compounds in medical care.

## **Mission Statement**

---

“The Center for Medicinal Cannabis Research (CMCR) will conduct high quality scientific studies intended to ascertain the general medical safety and efficacy of cannabis products and examine alternative forms of cannabis administration. The Center will be seen as a model resource for health policy planning by virtue of its close collaboration with federal, state, and academic entities.”

# Scientific and Legislative Precursors of the CMCR

---

## Discovery of Cannabis Receptors in the Brain

During the late 1980's and early 1990's, a series of significant scientific breakthroughs revealed an in-built system of cannabinoid receptors and cannabinoid signaling molecules in the human brain. Cannabinoid receptors are located throughout the central nervous system and peripheral tissues and are implicated in nervous system excitability, movement, analgesia, neuroprotection, and feeding behaviors, including newborn suckling.

## Scientific Reports

Following this period of scientific discovery and expanded understanding of the physiological basis of cannabinoid action, there was renewed interest in potential therapeutic applications of cannabinoid chemicals. The National Institutes of Health Ad Hoc Group of Experts and the Institute of Medicine, following thorough review of the existing scientific literature, identified medical conditions warranting further research regarding the possible therapeutic effects of marijuana. Medical evidence for likely therapeutic benefit was identified in the areas of appetite stimulation, neurological and movement disorders, analgesia, and nausea and vomiting.

**1997:** National Institutes of Health, Workshop on the Medical Utility of Marijuana

**1999:** Institute of Medicine Report, "Marijuana and Medicine: Assessing the Science Base"

(Available through the CMCR website at: <http://cmcr.ucsd.edu/geninfo/marijuana.htm>)

## Legislative Origins

The triggering event which led to the creation of the CMCR was the passage by the people of California in 1996 of Proposition 215, the Compassionate Use Act, which approved the medical use of marijuana (although at that time the exact role the substance should play in patient care remained ambiguous). Following that, in 1999, the Legislature of California passed Senate Bill (SB) 847, authored by then Assemblyman, later Senator John Vasconcellos, after extensive negotiations with then Attorney General Dan Lungren, providing the bipartisan legitimacy that enabled this bill to obtain the required two-thirds vote in each house of the California legislature. SB847 proposed (subject to the approval of the Board of Regents of the University of California) to create a three-year program overseeing objective, high quality medical research that would "...enhance understanding of the efficacy and adverse effects of marijuana as a pharmacological agent," stressing that the project "should not be construed as encouraging or sanctioning the social or recreational use of marijuana." In August 2000, the Center for Medicinal Cannabis Research was established at the University of California to carry out this mission. In 2003, after CMCR had demonstrated its ability to carry out the proposed program of research, SB295 was approved to remove the 3-year program limitation included in the founding legislation.

**1996:** California voters pass the Compassionate Use Act of 1996.

**1999:** California State Legislature passes the Medical Marijuana Research Act of 1999 (SB847).

**2000:** Center for Medicinal Cannabis Research is established as a state-funded research center at the University of California to solicit, review, and support clinical and limited preclinical research

**2000:** CMCR issued its first call for proposals

**2003:** SB295 is passed, re-authorizing the CMCR to continue indefinitely



In order to evaluate the scientific validity of the proposals submitted, the CMCR engaged TFO PST D FOU JUT SPN BSVCE U F CBUPOUP TFS/F BTB4DFCJ D3FWFX #PBE 43# 4UVEFT SFDPN N FCFE GSSVCEJCH CZU F 4DFCJ D3FWFX #PBE XFSF U FOTVONJWE GSSFWFX UP U F3FTFBD "EWIPSZ1BCFMPSBMPSQB 3"1 \$ U F0 DFPGIVOM) FBM BCE4DFCJPG U FCFPSBM/FCBSN FOU PG FBM BCE) VNBO4FSWFT %) 4 U F' PPE BCE %SM" ENJDTJUB LPO ' % U F/ BUPOBMOTUJUFPO %SM" CVTF / % BCE U F %SMH8CPSFN FOU' ENJDTJUB LPO %&" 6CPO CBMCCBPVMSPN FED PGJ FBCPVF BHFCDFT TUEFTXFSF BUI PSJ FE UP PSEFSDBOBCJTDJBFUFT SPN / % BCE UP CFHOSFDB/JCHCBJFOUT 5I JTCSPDFTJT described in Figures 1 and 2.

```
graph TD; A[Application reviewed internally] --> B[Application assigned 3 SPB reviewers for detailed critique]; B --> C[Application sent to full SPB]; C --> D[SPB members submit critiques to CMCR to circulate to entire SPB]; D --> E[Telephone meeting of entire SPB. Each protocol is reviewed and scored. Necessary modifications (including budget) are discussed]; E --> F[CMCR Director communicates review to Investigators]; F --> G[Recommended<br/>Invite Investigator revisions]; F --> H[Deferred<br/>Suggest major revisions for next round]; F --> I[NOT Recommended<br/>Proposal Declined];
```

Application reviewed internally

Application assigned 3 SPB reviewers for detailed critique

Application sent to full SPB

SPB members submit critiques to CMCR to circulate to entire SPB

Telephone meeting of entire SPB. Each protocol is reviewed and scored. Necessary modifications (including budget) are discussed

CMCR Director communicates review to Investigators

Results

Recommended  
Invite Investigator revisions

Deferred  
Suggest major revisions for next round

NOT Recommended  
Proposal Declined

```

graph TD
    CMC_Review[CMC Review] --> SFB_Approval[SFB Approval]
    SFB_Approval --> Revisions1[Revisions]
    Revisions1 --> DHHS[DHHS]
    Revisions1 --> NIDA[NIDA]
    DHHS --> NIDA
    NIDA --> Revisions2[Revisions]
    Revisions2 --> Revised_Proposals[Revised Approved Proposals]
    Revised_Proposals --> FDA[FDA]
    Revised_Proposals --> DEA_HQ[DEA HQ]
    FDA --> IND#[IND#]
    IND# --> DEA_HQ
    DEA_HQ --> DEA_Local[DEA Local]
    DEA_Local --> Inspection[Inspection]
    Inspection --> Approval[Approval]
    Approval --> Order_Product[Order Product]
    Order_Product --> Begin_Studies[Begin Studies]
  
```

The flowchart illustrates the New Drug Application (NDA) Review Process, organized into four main review stages:

- CMC Review:** Starts with **SFB Approval**, which leads to **Revisions** (dashed box).
- State of California Review:** **Revisions** leads to **RAPC**, which leads to **Revisions** (dashed box).
- DHHS Review:** **Revisions** (dashed box) leads to **Revised Approved Proposals**. **Revised Approved Proposals** leads to **FDA** and **DEA HQ**.
- FDA Review:** **FDA** leads to **IND#**, which leads to **DEA HQ**.
- DEA Review:** **DEA HQ** leads to **DEA Local**, **Inspection**, and **Approval**.
- Final Steps:** **Approval** leads to **Order Product**, which leads to **Begin Studies**.

# CMCR Vision for Cannabis Therapeutics Research

---

CMCR envisions its role in the investigation of cannabis and cannabinoid compounds in three main research domains involving smoked cannabis, non-smoked preparations, and eventually new pharmaceutical drug candidates formulated to act directly on the endocannabinoid system.

## Stage I: Smoked Cannabis

Develop state and federal review process, and solicit proposals for initial studies.

Conduct well-designed, rigorously controlled clinical trials of smoked cannabis. Until alternative delivery systems and new molecules are available, smoked cannabis offers the most efficient delivery of cannabinoids for clinical trials.

Cannabis cigarettes are provided by the National Institute on Drug Abuse (NIDA).

### Work Accomplished

CMCR has developed the scientific and administrative infrastructure to support application, review, selection, and implementation of studies, and has developed a rigorous process of peer review of scientific proposals by independent Scientific Review Board. CMCR has also established a relationship with state and federal agencies (RAPC, DEA, FDA, DHHS, NIDA) to facilitate regulatory approval.

The CMCR first solicited applications in fall 2000, and has funded fifteen clinical and four pre-clinical studies throughout California. The CMCR has issued five calls for proposals, most recently in summer 2006.

## Stage II: Non-Smoked Preparations

Explore the safety and effectiveness of non-smoked forms of medicinal cannabis.

Expand trials to include alternative, non-smoked delivery of cannabis preparations.

Alternative delivery may include vaporization, patches, suppositories, and alternative oral forms.

### Work Accomplished

In the area of non-smoked routes of cannabis administration, Dr. Donald Abrams' study, "Vaporization as a 'Smokeless' Cannabis Delivery System," has been completed and the results published in the Journal of Clinical Pharmacology & Therapeutics. This study found that vaporization as a safe and effective mode of delivery. Two CMCR clinical trials are now in progress utilizing vaporization.

## Stage III: Molecules To Target Endocannabinoid System

Stage III represents long-term goals for cannabinoid research. If the CMCR were to continue, the long-term research objectives would be to:

Collaborate with laboratories around the world who are working on specific molecules (both natural and synthetic) to activate, modulate, or deactivate the body's in-built cannabinoid system.

Perform Phase I, II, and III clinical trials on new molecules targeting the endocannabinoid system.

# Overview of Research Program

---

## Studies in Pain and Other Neurologic Conditions

Chronic pain—pain on a daily or almost daily basis for six months or longer—is one of the most prevalent and disabling conditions in California and in the US generally. Whereas many types of pain are caused by stimulation of specialized pain receptors on nerve endings, due to injury of tissues, neuropathic pain is produced either by direct damage to the central (brain, spinal cord) or peripheral nervous system itself, or by abnormal functioning of these systems. Infections, diabetes, physical trauma, strokes, and many other diseases can injure the nervous system, with resulting pain, which persists even though pain receptors themselves are not directly activated. It is therefore not surprising that neuropathic pain is widespread, affecting 5-10% of the US population. Only a few classes of medications are approved for use as analgesics in these conditions (opioids, anticonvulsants, antidepressants), and many patients obtain only partial relief, even when using combinations of all available therapies. Among the most difficult to treat neuropathic pain conditions are those secondary to HIV, diabetes, and to physical trauma to the nervous system. Because these neuropathic disorders are so prevalent, and treatment alternatives are so limited, the CMCR focused on these conditions.

A distinguishing scientific feature of this program of pain research, made possible only by the coordinating function of the CMCR, is the commonality of measures and methods across the research studies. This allows for the distinctive advantage of comparability of results across studies. Additionally, when possible we studied treatment of the same type of pain condition (e.g., HIV neuropathy) in more than one geographic site. Finding comparable results at two or more sites studying the same disease is scientifically important, since this suggests that the results are generally valid, rather than being due to chance or the specific characteristics of a single sample of patients, or of a particular team of researchers.

This research used the gold standard design for assessment of therapeutic effects, the randomized clinical trial. In this approach participants are assigned by chance, like flipping a coin, to an experimental treatment, in this case cannabis, or to a placebo (an inactive treatment). The placebo in all of our studies was a marijuana (cannabis) cigarette, made with cannabis from which the “active” ingredients, for example delta-9-tetrahydrocannabinol (THC), had been removed. The cigarette therefore had the appearance and the aroma of a marijuana cigarette, but without the crucial chemical ingredients hypothesized to be therapeutically active. Randomization ensures factors which might skew the results (like age, duration or intensity of pain) are equally present in both the experimental and placebo condition. Placebo is essential, since the expectation of pain relief from any treatment is a powerful analgesic itself. All of our protocols used measures of pain recommended by expert consensus as standard in the field. For studies of smoked cannabis, the researchers used a standard, timed method of inhalation; research using vaporized cannabis used similar, state-of-the-art technology. Researchers measured blood concentrations of the primary active ingredient of cannabis (THC), allowing estimates of relationships between dose, concentration, and magnitude of pain relief.

To date, the CMCR has completed four studies in the treatment of neuropathic pain. Two studies have focused on neuropathic pain resulting from HIV infection or the drugs used to treat HIV, one has focused on neuropathic pain of varying causes, and one has used an experi-

---

mental model of neuropathic pain tested in healthy volunteers. The results from these four studies have been convergent, with all four demonstrating a significant decrease in pain after cannabis administration. The magnitude of effect in these studies, expressed as the number of patients needed to treat to produce one positive outcome, was comparable to current therapies. Two additional studies involving neuropathic pain are underway.

Multiple sclerosis (MS) is one of the most common chronic and disabling diseases of the nervous system. Caused by loss of the insulating sheath surrounding nerve fibers, the disease usually begins in young adulthood. Although it may initially wax and wane in intensity and be of mild severity, it often steadily progresses, causing fatigue, loss of balance, muscle weakness, and muscle spasticity. Affecting up to 70% of people with the disease, muscle spasms lead to pain, inability to walk, and difficulties with self-care, causing most of the everyday life disability from this disease. There is as yet no cure for MS. Treatments for muscle spasticity are only partially effective and have side effects which are not easily tolerated, making the search for new therapies of high importance. Given this background, the CMCR identified MS spasticity as an additional target for therapeutic research. As with all CMCR studies, the research used the most rigorous scientific approach to testing therapies, a randomized clinical trial, supplemented by modern measurement of muscle spasticity, everyday function, life quality, and side effects. Results to date have found a significant improvement in both an objective measure of spasticity and pain intensity in patients whose standard therapy had provided inadequate relief.

# Synopsis of CMCR Published Clinical Study Results

## **"The Effect of Cannabis on Neuropathic Pain in HIV-Related Peripheral Neuropathy"**

*Donald I. Abrams, M.D., University of California, San Francisco*

The primary objective of this study was to evaluate the efficacy of smoked cannabis when used as an analgesic in persons with neuropathic pain from HIV-associated distal sensory polyneuropathy (DSPN). In a double blind, randomized, five-day clinical trial patients received either smoked cannabis or placebo cannabis cigarettes. Patients continued on any concurrent analgesic medications (e.g., gabapentin, amitriptyline, narcotics, NSAIDs) which they were prescribed prior to the trial; the dose and amount of the medications were recorded daily.

The full results of this study appear in the journal *Neurology* (Abrams, et al., 2007– see reference list). In brief, 55 patients were randomized and 50 completed the entire trial. Smoked cannabis reduced daily pain by 34% compared to 17% with placebo. The study concluded that a significantly greater proportion of patients who smoked cannabis (52%) had a greater than 30% reduction in pain intensity compared to only 24% in the placebo group. This result is clinically important, since the threshold of a 30% reduction in pain intensity is associated with meaningful improvement in quality of life in other research on pain outcomes.

Cannabis appeared to be well-tolerated and there were no safety concerns raised. By design, all patients had smoking experience with cannabis. There were more side effects in those receiving cannabis than placebo, with the most frequent being sedation, anxiety, and dizziness, but these were all rated as "mild."

## **"Placebo-Controlled, Double Blind Trial of Medicinal Cannabis in Painful HIV Neuropathy"**

*Ronald J. Ellis, M.D., Ph.D., University of California, San Diego*

The primary objective of this study also was to evaluate the efficacy of smoked cannabis when used as an analgesic in persons with HIV-associated painful neuropathy. In a double-blind, randomized, clinical trial of the short-term adjunctive treatment of neuropathic pain in HIV-associated distal sensory polyneuropathy, participants received either smoked cannabis or placebo cannabis cigarettes. A structured dose escalation-titration protocol was used to find an individualized, effective, safe, and well-tolerated dose for each subject. Participants continued on their usual analgesic medications throughout the trial, with the dose and amount of these medications being recorded daily.

The full results of this study were published in the journal *Neuropsychopharmacology* (Ellis, et al., 2008 – see reference list). In brief, 34 eligible subjects enrolled and 28 completed both cannabis and placebo treatments. Among completers, pain relief was significantly greater with cannabis than placebo. The proportion of subjects achieving at least 30% pain relief was again significantly greater with cannabis (46%) compared to placebo (18%). It was concluded that smoked cannabis was generally well-tolerated and effective when added to concomitant analgesic therapy in patients with medically refractory pain due to HIV-associated neuropathy. Once again these results appeared to be relevant to everyday clinical practice, because the magnitude of pain relief is associated with that which improves life quality, and also because the benefit was above and beyond that conferred by the patients' usual analgesics.

As in the study described above, side effects were more frequent with cannabis than with placebo, with the most common being sleepiness or sedation, fatigue, and difficulty with concentration. These were "mild" for the most part and did not raise safety concerns.

## **“A Double-Blind, Placebo-Controlled Crossover Trial of the Antinociceptive Effects of Smoked Marijuana on Subjects with Neuropathic Pain”**

*Barth Wilsey, M.D., University of California, Davis*

This study's objective was to examine the efficacy of two doses of smoked cannabis on pain in persons with neuropathic pain of different origins (e.g., physical trauma to nerve bundles, spinal cord injury, multiple sclerosis, diabetes). In a double-blind, randomized clinical trial participants received either low-dose, high-dose, or placebo cannabis cigarettes. As customary in CMCR trials, participants were allowed to continue their usual regimen of pain medications (e.g., codeine, morphine, and others).

The full results of this study have been published in the *Journal of Pain* (Wilsey, et al., 2008 – see reference list). Thirty-eight patients underwent a standardized procedure for smoking either high-dose (7%), low-dose (3.5%), or placebo cannabis; of these, 32 completed all three smoking sessions. The study demonstrated an analgesic response to smoking cannabis with no significant difference between the low and the high dose cigarettes. The study concluded that both low and high cannabis doses were efficacious in reducing neuropathic pain of diverse causes.

Disagreeable or unpleasant side effects were significantly more likely with high dose cigarettes compared to low dose or placebo, whereas there was no difference in these effects between low dose and placebo sessions. There was no indication of mood changes (e.g., sadness, anxiety, fearfulness).

## **“Analgesic Efficacy of Smoked Cannabis”**

*Mark Wallace, M.D., University of California, San Diego*

This study used an experimental model of neuropathic pain to determine whether pain induced by the injection into the skin of capsaicin, a compound which is the “hot” ingredient in chili peppers, could be alleviated by smoked cannabis. Another aim of the study was to examine the effects of “dose” of cannabis, and the time course of pain relief. In a randomized double-blinded placebo controlled trial, volunteers smoked low, medium, and high dose cannabis (2%, 4%, 8% THC by weight) or placebo cigarettes.

The full results of this study were published in the journal *Anesthesiology* (Wallace, et al., 2007 – see reference list). Nineteen healthy volunteers were enrolled, and 15 completed all four smoking sessions. In brief, five minutes after cannabis exposure, there was no effect on capsaicin-induced pain at any dose. By 45 minutes after cannabis exposure there was a significant decrease in capsaicin-induced pain with the medium dose (4%) and a significant increase in pain with the high dose (8%). There was no significant effect seen with low dose (2%). There was a significant inverse relationship between pain perception and plasma THC. In summary, this study suggested that there may be a “therapeutic window” (or optimal dose) for smoked cannabis: low doses were not effective; medium doses decreased pain; and higher doses actually increased pain. These results suggest the mechanism(s) of cannabinoid analgesia are complex, in some ways like non-opioid pain relievers (e.g., aspirin, ibuprofen) and in others like opioids (e.g., morphine).

## *Synopsis of CMCR Published Clinical Study Results (cont.)*

---

### **"Short-Term Effects of Cannabis Therapy on Spasticity in Multiple-Sclerosis"**

*Jody Corey-Bloom, M.D., University of California, San Diego*

This objective of this study was to determine the potential for smoked cannabis to ameliorate marked muscle spasticity (chronic painful contraction of muscles), a severe and disabling symptom of multiple sclerosis. In a placebo-controlled, randomized clinical trial spasticity and global functioning was examined before and after treatment with smoked cannabis. Patients were allowed to continue their usual treatments for spasticity and pain while participating in the research.

The full results of this study are being submitted for publication. Initial results were presented at the meeting of the American College of Neuropsychopharmacology in 2007. Thirty patients with multiple sclerosis were enrolled. Compared to placebo cigarettes, cannabis was found to significantly reduce both an objective measure of spasticity, and pain intensity. This study concluded that smoked cannabis was superior to placebo in reducing spasticity and pain in patients with multiple sclerosis, and provided some benefit beyond currently prescribed treatments.

### **"Vaporization as a 'Smokeless' Cannabis Delivery System"**

*Donald Abrams, M.D., University of California, San Francisco*

The aim of this study was to evaluate the use of a vaporization system (the Volcano; VAPORMED® Inhalatoren; Tüttlingen, Germany) as a "smokeless" delivery system for inhaled cannabis. Because of concerns regarding the practicality and palatability of using cannabis cigarettes as a standard treatment, there has been an interest in developing alternative delivery systems. Participants were randomly assigned to receive low, medium, or high dose (1.7, 3.4, or 6.8% tetrahydrocannabinol) cannabis cigarettes delivered by smoking or by the vaporization system on six study days.

The full results of this study have been published in the journal *Clinical Pharmacology & Therapeutics* (Abrams, et al., 2007 – see reference list). Eighteen healthy volunteers were recruited to participate in the research. The analysis indicated that the blood levels of vaporized cannabis are similar to those of smoked cannabis over a six hour period. However, blood concentrations of THC at 30 and 60 minutes after inhalation were significantly higher in vaporized cannabis as compared to smoked cannabis. In addition, carbon monoxide levels were significantly reduced with vaporization compared with smoked cannabis. Fourteen participants preferred vaporization, 2 preferred smoking, and 2 reported no preference. In summary, vaporization of cannabis was found to be a safe mode of delivery, and participants had a preference for vaporization over smoking as a delivery system in this trial.

# Recently Completed And Ongoing Studies

---

## **"Sleep and Medicinal Cannabis"**

*Sean Drummond, Ph.D., University of California, San Diego*

The primary objective of this study was to determine the effects of cannabis on insomnia and poor sleep quality, which are experienced by up to 90% of HIV-infected individuals. Participants in this study were individuals enrolled in the UCSD randomized trial comparing cannabis and placebo as an analgesic in painful HIV-associated neuropathy (see Dr. Ellis, above).

The results of this study suggest that cannabis administration during the day does not affect objective or subjective measures of sleep approximately 7-8 hours after the last use of cannabis.

## **"Impact of Repeated Cannabis Treatments on Driving Abilities"**

*Thomas Marcotte, Ph.D., University of California, San Diego*

The principal aim of this study was to examine whether routine administration of cannabis in the medical treatment of HIV-related neuropathy and spasticity associated with multiple sclerosis results in significant impairment in driving abilities. Participants in this study were individuals enrolled in the randomized clinical trials of cannabis for painful HIV neuropathy and for spasticity in multiple sclerosis conducted at UCSD (see Dr. Ellis and Dr. Corey-Bloom, above).

The results of this study are in preparation. Subjects were tested using a computerized driving simulator commonly used to demonstrate the effects of alcohol on driving ability. The driving simulator presents different driving conditions and circumstances and was done at four points: before cannabis, and at one, three, and 18 hours after the final dose in the therapeutic trials. These data will provide insights regarding the real life impact of using cannabis as medicine.

## **"Efficacy of Inhaled Cannabis in Diabetic Painful Peripheral Neuropathy"**

*Mark Wallace, M.D., University of California, San Diego*

The primary objective of this ongoing study is to evaluate the efficacy of smoked cannabis when used as an analgesic in painful neuropathy due to diabetes. In a double-blind, randomized, placebo-controlled trial, participants will inhale low, medium, or high dose vaporized cannabis or placebo. Concurrent testing with experimentally-induced pain will help identify the potential mechanisms of therapeutic effects.

This study is actively recruiting its intended sample of 20 participants. No preliminary results are available at this time.

## **"The Analgesic Effect of Vaporized Cannabis on Neuropathic Pain"**

*Barth Wilsey, M.D., University of California, Davis*

The primary aim of this study is to evaluate the analgesic effects of vaporized cannabis in patients with neuropathic pain of different origins. In a randomized clinical trial the effects of placebo and of low and medium (1.7 % and 3.5%) dose cannabis on clinical pain and on experimentally induced pain will be assessed. As noted above, use of experimentally-induced pain may help identify mechanism of actions.

This study is beginning to recruit participants. No preliminary results are available at this time.



## Completed Pre-Clinical Studies

---

In addition to testing the possible benefits of medicinal cannabis, the CMCR supported a small number of laboratory and animal studies which might lead to either developing new treatments in humans, or better understanding the mechanisms of therapeutic actions.

### **“Mechanisms of Cannabinoid Analgesia”**

*Howard Fields, M.D., Ph.D., University of California, San Francisco*

The aim of this study was to determine whether cannabinoids might be a useful class of medication for migraine and other headaches or facial pain conditions.

The full results of this study were published in the journal *Pain* (Papanastassiou et al., 2003 – see reference list). A cannabis-like drug (WIN 55,212-2) given to rats under anesthesia showed reduced activity of individual nerve cells transmitting pain, whereas giving another drug which blocked cannabis receptors on these nerve endings reversed this effect. Moreover, the analgesic effect of the cannabis-like drug was evident in tests of facial pain (heat) in awake rats. This study therefore provided direct scientific evidence, at the level of both individual nerve cells and in awake animals, of analgesic effects of cannabis-like compounds on head and facial pain. Randomized clinical trials in humans might be conducted to determine if cannabis could treat facial pain or headache.

### **“Cannabinoids in Fear Extinction”**

*Mark Barad, M.D., Ph.D., University of California, Los Angeles*

The aim of this study was to determine if a cannabis-like agent could suppress fear-inducing memories or images that might be the basis for some psychiatric conditions such as Post-Traumatic Stress Disorder (PTSD) and other anxiety disorders. Therapeutic effects were thought possible because earlier research suggested that specialized in-built cannabinoid receptors in the brain are necessary for suppression of normal fears.

Tests using three different synthetic cannabis-like compounds showed no significant differences in behavior between mice treated with study drugs and untreated mice trained to fear specific locations. This study suggests that acutely enhancing the brain's internal cannabinoid system does not extinguish specific fears (of place memory) in animals.

### **“Effects of Cannabis Therapy on Endogenous Cannabinoids”**

*Daniele Piomelli, Pharm.D., Ph.D., University of California, Irvine*

The aim of this study was to determine the short- and longer-term effects of THC on the natural in-built system of nervous system chemical transmitters called endocannabinoids, which help regulate movement, cognition, pain and other physiological processes. Amplification or interference with activity of this system could influence outcomes of cannabinoid treatment.

These experiments contributed preliminary data to work that was later published in the journal *Neuropsychopharmacology* (Giuffrida et al., 2004 – see reference list). A synthetic cannabis-like compound had no effects on the levels of anandamide, an endocannabinoid, in blood or in brain tissue from regions involved in memory, motivation, movement, and wakefulness. Chronic, but not acute, treatment caused a marked increase in anandamide levels in the brain hippocampus, a region crucially involved in learning and memory. This study provides evidence indicating that exposure to cannabis-like drugs can alter endocannabinoid signaling in the brain. Alterations in this important signaling system might be involved in mediating the actions of cannabis in humans.

---

## **“Effects of Medicinal Cannabis on CD4 Immunity in AIDS”**

*Rachel Schrier, Ph.D., University of California, San Diego*

The aim of this study was to determine if cannabis might suppress the immune system in individuals with HIV. This is an important question since already fragile immunity is characteristic of AIDS and other serious illness where cannabis might be used.

Results of the study are being prepared for publication. Briefly, immune system cells (CD4+ white blood cells) obtained from 15 individuals with AIDS participating in another study were exposed to three concentrations of THC in tests of their functional “competence.” There was no evidence of acute impairment of immune function at concentrations achievable in living humans. These results parallel other research showing that short-term cannabis administration does not diminish the circulating number of this white blood cell essential for immunity.

---

## **Discontinued Studies**

Five clinical studies were discontinued before completion, because they could not accrue a sufficient number of participants. The scientific and safety design of two studies, one studying the combination of cannabis and opioids (e.g., morphine) for cancer pain relief, and one on relief of muscle spasticity in multiple sclerosis, required either a nine day hospitalization or 16 weeks without driving an automobile. Understandably, chronically ill patients were reluctant to be re-hospitalized for research, or to surrender driving privileges for an extended period.

Two other cancer studies faced different “real life” obstacles to recruitment. One study on cannabis for severe nausea and vomiting due to chemotherapy could not identify a sufficient number of patients with sufficiently severe nausea. It appeared that current anti-nausea treatments are often highly effective. Alternative or adjunctive therapy may be required only by a minority of patients. Another project on cannabis for advanced cancer pain unresponsive to all other analgesics found that local hospice agencies were willing to refer potential participants. These patients, however, were often already smoking cannabis for pain control. One study of cannabis for use at home for neuropathic pain did not elicit sufficient interest, despite outreach to the community through advertisements and focus groups. Although the outcomes of these studies is disappointing, valuable lessons were learned in terms of design of future studies and selection of appropriate populations for study.

## Summary And Future Directions

---

Results of CMCR studies support the likelihood that cannabis may represent a possible adjunctive avenue of treatment for certain difficult-to-treat conditions like neuropathic pain and spasticity. In establishing the University of California CMCR, the California Legislature enabled the creation of what is now arguably a world-class resource both for state-of-the-art clinical trials on medicinal cannabis and its derivatives, and for developing knowledge on the potential and limitations of cannabinoid therapeutics for selected indications. By facilitating high caliber clinical trials, whose results are published in leading peer-reviewed scientific journals, the CMCR is providing physicians and policy makers with solid scientific data to inform both medical research and policy decisions. As a seasoned and unique resource, the CMCR is well-positioned to inform public health and policy decision-makers.

Worldwide, the merit of new therapies is rigorously evaluated by a series of clinical trials, termed Phase I, Phase II, Phase III, and Phase IV. In Phase I, usually involving 20-50 participants, several possible doses of a drug are tested, safety is assessed, and hints of therapeutic value are revealed. Drug development then proceeds to Phase II trials (which may recruit up to several hundred individuals) to more accurately gauge the efficacy of treatment along with determining short term side effects and risks. Results from Phase II trials with smoked cannabis in neuropathic pain form the basis of the CMCR's efforts to date. In the next step, Phase III trials, involving hundreds to several thousand patients, are designed to provide definitive assessment of the efficacy of new treatment for specific conditions (usually by comparing the newer therapy to the best "standard" treatment available), while also adding to a better understanding of benefit-risk relationships. Finally Phase IV trials, conducted after a treatment is licensed or approved for general medical use, gather additional information on benefits, risks, and optimal use of the therapy. The expertise developed at CMCR is well-suited to contribute to each of these phases of cannabinoid research.

Were support for the CMCR to continue, research might focus on 1) larger placebo-controlled studies to generate definitive data on therapeutic merit (i.e., Phase III trials), 2) head-to-head comparisons with other current therapies (in Phase II or III studies), or 3) expanded studies evaluating cannabis as an adjunct to existing treatment with opioids and non-steroidal anti-inflammatory drugs (i.e. Phase II and III research determining if cannabinoids have an "opioid-sparing" effect, that is, if they might allow use of lower doses of opioids without sacrificing pain relief). Other Phase II and III studies might move from the question of efficacy to overall effectiveness, that is, evaluating 1) alternative delivery systems (e.g., vaporization) that reduce the harmful effects of smoking, 2) models of take-home treatment that more accurately mimic the way drugs are prescribed, and 3) long-term studies to assess emergent toxicities, stability of treatment effects, and possible development of tolerance to treatment over time. This research might extend into formal Phase IV trials.

Studies also might be conducted on newly-developed synthetic agents which enhance, antagonize, or otherwise modulate the cannabinoid system, comparing their efficacy to cannabis as a botanical product. In any event the "fundamental" nature of the endocannabinoid system—evident by its participation in essential functions like movement, pain, moods and other behaviors—suggests continuing clinical research on cannabis might yield important contributions to health care.

# CMCR Roster

## Scientific Review Board

James Anthony, Ph.D., M.Sc.  
 William Breitbart, M.D.  
 Alan Budney, Ph.D.  
 Don Cherek, Ph.D.  
 Steven Childers, Ph.D.  
 Reena Deutsch, Ph.D.  
 William L. Degey, Ph.D.  
 Judith Feinberg, M.D.  
 Richard Foltin, Ph.D.  
 Richard Gracely, Ph.D.  
 Margaret Haney, Ph.D.  
 Miles Herkenham, Ph.D.  
 Karl Kieburz, M.D., M.P.H.  
 Robert A. Parker, Sc.D.  
 Frank Porreca, Ph.D.  
 Judith Rabkin, Ph.D., M.P.H.  
 Srinivasa Raja, M.D.  
 Richard Rauck, M.D.  
 Wilfred Van Gorp, Ph.D.  
 Leslie Weiner, M.D.  
 Sandra P. Welch, Ph.D.  
 Tanya Wolfson, M.A.

Johns Hopkins University  
 Memorial Sloan Kettering Cancer Center  
 University of Vermont  
 University of Texas Health Sciences Center  
 Wake Forest University  
 University of California, San Diego  
 Virginia Commonwealth University  
 University of Cincinnati Holmes Hospital  
 Columbia University  
 NIDCR - National Institutes of Health  
 Columbia University  
 National Institute of Mental Health  
 University of Rochester  
 Harvard University  
 University of Arizona  
 Columbia University  
 Johns Hopkins University  
 Wake Forest University  
 Columbia University  
 University of Southern California  
 Virginia Commonwealth University  
 University of California, San Diego

## National Advisory Council

J. Richard Crout, M.D.  
 Samuel A. Deadwyler, Ph.D.  
 Dale Gieringer, Ph.D.  
 Lester Grinspoon, M.D.  
 Janet Joy, Ph.D.  
 Legis Judd, M.D.  
 Alexandros Makriyannis, Ph.D.  
 T. Philip Malan, M.D., Ph.D.  
 Billy Martin, Ph.D.\*  
 Charles O'Brien, M.D., Ph.D.  
 John Phair, M.D.  
 June Machover Reinisch, Ph.D.  
 Roger A. Roffman, D.S.W.  
 Donald P. Tashkin, M.D.  
 Robert Temple, M.D.  
 Scott Thorpe, J.D.  
 John Vasconcellos  
 Tom Vischi

Crout Consulting  
 Wake Forest University  
 California NORML  
 Professor Emeritus, Harvard Medical School  
 Institute of Medicine  
 University of California, San Diego  
 University of Connecticut  
 University of Arizona  
 Virginia Commonwealth University  
 University of Pennsylvania  
 Northwestern University Medical School  
 R2 Science Communications, Inc.  
 University of Washington  
 University of California, Los Angeles  
 Food and Drug Administration  
 Special Assistant Attorney General, State of California  
 Retired, California State Senate  
 Retired, Department Health and Human Services

\*Deceased

## Acknowledgement

CMCR particularly wishes to acknowledge the contributions of Tom Marcotte, Ph.D. as Center Manager, Shondra Neumayer, R.N. and Heather Bentley, CCRA as Project Managers, and Ben Gouaux as a Research Associate.

# CMCR Supported Publications

## Results of CMCR Studies

Abrams DI, Jay CA, Shade SB, Vizoso H, Reda H, Press S, Kelly ME, Rog botham MC, Petersen KL. Cannabis in painful HIV-associated sensory neuropathy: A randomized placebo-controlled trial. *Neurology* 2007 68: 515-521.

Abrams DI, Vizoso HP, Shade SB, Jay C, Kelly ME, Benog itz NL. Vaporization as a Smokeless Cannabis Delivery System: A Pilot Study. *Clin Pharmacol Ther.* 2007 82(5): 572-578.

Ellis R, Toperoff W, Vaida F, van den Brande G, Gonzales J, Gouaux B, Bentley H, Atkinson JH. Smoked Medicinal Cannabis for Neuropathic Pain in HIV: A Randomized, Crossover Clinical Trial. *Neuropsychopharmacology*, 2008. 34(3): 672-680.

Giuffrida A, Leg eke FM, Gerth CW, Schreiber D, Koethe D, Faulhaber J, Klosterkötter J, Piomelli D. 2004. Cerebrospinal anandamide levels are elevated in acute schizophrenia and are inversely correlated with psychotic symptoms. *Neuropsychopharmacology*, 29, 2108-2114.

Papanastassiou AM, Fields HL, Meng ID. (2004). Local application of the cannabinoid receptor agonist, WIN 55, 212-2, to spinal trigeminal nucleus caudalis differentially affects nociceptive and non-nociceptive neurons. *Pain*, 107 (3); 267-75.

Wallace M, Schulteis G, Atkinson JH, Wolfson T, Lazzaretto D, Bentley H, Gouaux B, Abramson I. Dose-dependent Effects of Smoked Cannabis on Capsaicin-induced Pain and Hyperalgesia in Healthy Volunteers. *Anesthesiology*. 107(5):785-796, November 2007.

Wilsey B, Marcotte T, Tsodikov A, Millman J, Bentley H, Gouaux B, Fishman S. April 2008 A Randomized, Placebo-Controlled, Crossover Trial of Cannabis Cigarettes in Neuropathic Pain. *Journal of Pain*, 9 (6); 506-521.

## Published Abstracts

Abrams, D., Jay, C., Vizoso, H., Shade, S., Reda, H., Press, S., Kelley, M.E., Rog botham, M., Petersen, K. Smoked Cannabis Therapy for HIV-Related Painful Peripheral Neuropathy: Results of a Randomized, Placebo-Controlled Clinical Trial. 2nd Annual Meeting of the International Association for Cannabis as Medicine. 2005.

Abrams DI, Jay C, Petersen K, Shade S, Vizoso H, Reda H, Benog itz N, Rog botham M. The Effects of Smoked Cannabis in Painful Peripheral Neuropathy and Cancer Pain Refractory to Opioids. Proceedings of the International Association of Cannabis as Medicine, Cologne, 2003, p.28.

Abrams D, Vizoso H, Shade S, Jay C, Kelley ME, Benog itz N. Vaporization as a Smokeless Cannabis Delivery System: A Pilot Study. 2nd Annual Meeting of the International Association for Cannabis as Medicine. 2005.

Corey-Bloom J, Wolfson T, Gamst A, Jin S, Marcotte T, Bentley H, Gouaux B. Short-Term Effects of Medicinal Cannabis on Spasticity in Multiple Sclerosis. Poster presented at the 60th Annual Meeting of the American Academy of Neurology (Chicago, IL). 2008.

Jay C, Shade S, Vizoso H, Reda H, Petersen K, Rog botham M, Abrams D. The Effect of Smoked Marijuana on Chronic Neuropathic and Experimentally-Induced Pain in HIV Neuropathy: Results of an Open-Label Pilot Study. Proceedings 11th Conference on Retroviruses and Opportunistic Infections, abstract 496, p.243, 2004.

Lopez C, Toperoff W, van den Brande G, Tapert S, Atkinson JH, Drummond SPA. Increased Sleep Disturbances in Patients with HIV-Related Neuropathy. 2005 Annual Meeting of the Associated Professional Sleep Societies.

Marcotte T, Rosenthal T, Corey-Bloom J, Roberts E, Lampinen S, Allen W. The Impact of Cognitive Deficits and Spasticity on Driving Simulator Performance in Multiple Sclerosis. Proceedings of the Third International Driving Symposium on Human Factors in Driver Assessment, Training, and Vehicle Design. 2005.

Schrier R, Soto P, Hamlat C, Durand D, Ceci K, Ellis R. (2004, 3). Effects of in Vitro Cannabinoids on T-cell Responses of HIV Infected Patients. Poster presented at the 10th Society on Neuroimmune Pharmacology Conference (Santa Fe, NM).

## Other CMCR-Supported Publications

- † Darmani NA, Izzo AA, Degenhardt B, Valenti M, Scaglione G, Capasso R, Sorrentini I, Di Marzo V. 2005. Involvement of the cannabimimetic compound, N-palmitoyl-ethanolamine, in inflammatory and neuropathic conditions: Review of the available pre-clinical data, and first human studies, *Neuropharmacology*, 48:8, 1154-1163.
- † Fattore L, Spano S, Cossu G, Deiana S, Fadda P, Fratta W. 2005. Cannabinoid CB1 antagonist SR 141716A attenuates reinstatement of heroin self-administration in heroin-abstinent rats, *Neuropharmacology*, 48:8, 1097-1104.
- † Fride E, Ponde D, Breuer A, Hanus L. 2005. Peripheral, but not central effects of cannabidiol derivatives: Mediation by CB1 and unidentified receptors, *Neuropharmacology*, 48:8, 1117-1129.
- † Fu J, Oveisi F, Gaetani S, Lin E, Piomelli D. 2005. Oleoylethanolamide, an endogenous PPAR-[alpha] agonist, lowers body weight and hyperlipidemia in obese rats, *Neuropharmacology*, 48:8, 1147-1153.
- † Grant I. 2005. Foreword by Igor Grant, M.D., Director, Center for Medicinal Cannabis Research (CMCR), *Neuropharmacology*, 48:8, 1067.  
     Grant I, Cahn BR. (2005). Cannabis and Endocannabinoid modulators: Therapeutic Promises and Challenges. *Clinical Neuroscience Research*. 5(2-4):185-199.  
     Grant I, Gonzalez R, Carey C, Natarajan L, Wolfson T. 2003. Non-acute (residual) neurocognitive effects of cannabis use: A meta-analysis study. *Journal of the International Neuropsychological Society*, 9, 679-689.  
     Gonzalez R, Carey C, Grant I. Nonacute (Residual) Neuropsychological Effects of Cannabis Use: A Qualitative Analysis and Systemic Review. *J Clin Pharmacol* 2002; 42: 485-575.
- † Hillard CJ, Jarrahian A. 2005. Accumulation of anandamide: Evidence for cellular diversity, *Neuropharmacology*, 48:8, 1072-1078.  
     Ilan A, Gevins A, Role K, Vizoso H, Abrams D. The Cognitive Neuropsychological Effects of Medicinal Marijuana in HIV+ Patients with Peripheral Neuropathy. 2nd Annual Meeting of the International Association for Cannabis as Medicine. 2005.
- † Lupica CR, Riegel AC. 2005. Endocannabinoid release from midbrain dopamine neurons: a potential substrate for cannabinoid receptor antagonist treatment of addiction, *Neuropharmacology*, 48:8, 1105-1116.
- † Makriyannis A, Mechoulam R, Piomelli D. 2005. Therapeutic opportunities through modulation of the endocannabinoid system, *Neuropharmacology*, 48:8, 1068-1071.
- † Pacher P, Bátkai S, Kunos G. 2005. Blood pressure regulation by endocannabinoids and their receptors, *Neuropharmacology*, 48:8, 1130-1138.
- † Pertwee RG, Thomas A, Stevenson LA, Maor Y, Mechoulam R. 2005. Evidence that (-)-7-hydroxy-4'-dimethylheptyl-cannabidiol activates a non-CB1, non-CB2, non-TRPV1 target in the mouse vas deferens, *Neuropharmacology*, 48:8, 1139-1146.
- † Salim K, Schneider U, Burstein S, Hoy L, Karst M. 2005. Pain measurements and side effect profile of the novel cannabinoid ajulemic acid, *Neuropharmacology*, 48:8, 1164-1171.
- † Ueda N, Tsuboi K, Lambert DM. 2005. A second N-acyl ethanolamine hydrolase in mammalian tissues, *Neuropharmacology*, 48:8, 1079-1085.
- † Zhuang SY, Bridges D, Grigorenko E, McCloud S, Boon A, Hampson R, Deadwyler SA. 2005. Cannabinoids produce neuroprotection by reducing intracellular calcium release from ryanodine-sensitive stores, *Neuropharmacology*, 48:8, 1086-1096.

†Contents of CMCR special issue of the journal *Neuropharmacology*



THE SACRAMENTO BEE

## Opioids drive continued increase in drug overdose deaths

Published Wednesday, Feb. 20, 2013

ATLANTA, Feb. 20, 2013 -- **Drug overdose deaths increase for 11<sup>th</sup> consecutive year**

ATLANTA, Feb. 20, 2013 /PRNewswire-USNewswire/ -- Drug overdose deaths increased for the 11th consecutive year in 2010, according to an analysis from the Centers for Disease Control and Prevention. The findings are published today in a research letter, "Pharmaceutical Overdose Deaths, United States, 2010," in the Journal of the American Medical Association (JAMA).

CDC's analysis shows that 38,329 people died from a drug overdose in the United States in 2010, up from 37,004 deaths in 2009. This continues the steady rise in overdose deaths seen over the past 11 years, starting with 16,849 deaths in 1999. Overdose deaths involving opioid analgesics have shown a similar increase. Starting with 4,030 deaths in 1999, the number of deaths increased to 15,597 in 2009 and 16,651 in 2010.

In 2010, nearly 60 percent of the drug overdose deaths (22,134) involved pharmaceutical drugs. Opioid analgesics, such as oxycodone, hydrocodone, and methadone, were involved in about 3 of every 4 pharmaceutical overdose deaths (16,651), confirming the predominant role opioid analgesics play in drug overdose deaths.

CDC researchers analyzed data from CDC's National Center for Health Statistics 2010 multiple cause-of-death file, which is based on death certificates.

The researchers also found that drugs often prescribed for mental health conditions were involved in a significant number of pharmaceutical overdose deaths. Benzodiazepines (anti-anxiety drugs) were involved in nearly 30 percent (6,497) of these deaths; antidepressants in 18 percent (3,889), and antipsychotic drugs in 6 percent (1,351). Deaths involving more than one drug or drug class are counted multiple times and therefore are not mutually exclusive.

"Patients with mental health or substance use disorders are at increased risk for nonmedical use and overdose from prescription painkillers as well as being prescribed high doses of these drugs," said CDC Director Tom Frieden, M.D., M.P.H. "Appropriate screening, identification, and clinical management by health care providers are essential parts of both behavioral health and chronic pain management."

Additional steps are being taken at the national, state and local levels, as well as by non-governmental organizations, to help prevent overdoses from prescription drugs.



In particular, the federal government is:

- Tracking prescription drug overdose trends to better understand the epidemic.
- Encouraging the development of abuse-deterrent opioid formulations and products that treat abuse and overdose.
- Educating health care providers and the public about prescription drug abuse and overdose.
- Requiring that manufacturers of extended-release and long-acting opioids make educational programs available to prescribers about the risks and benefits of opioid therapy, choosing patients appropriately, managing and monitoring patients, and counseling patients on the safe use of these drugs.
- Using opioid labeling as a tool to inform prescribers and patients about the approved uses of these medications.
- Developing, evaluating and promoting programs and policies shown to prevent prescription drug abuse and overdose, while making sure patients have access to safe, effective pain treatment.

Promising steps that many states are taking include:

- Starting or improving prescription drug monitoring programs, which are electronic databases that track all prescriptions for opioids in the state.
- Using prescription drug monitoring programs, public insurance programs, and workers' compensation data to identify improper prescribing of opioids.
- Setting up programs for public insurance programs, workers' compensation programs, and state-run health plans that identify and address improper patient use of opioids.
- Passing, enforcing and evaluating pill mill, doctor shopping and other state laws to reduce prescription opioid abuse.
- Encouraging state licensing boards to take action against inappropriate prescribing.
- Increasing access to substance abuse treatment.

For more information about prescription drug overdoses in the United States, please visit [www.cdc.gov/HomeandRecreationalSafety/Poisoning](http://www.cdc.gov/HomeandRecreationalSafety/Poisoning).

U.S. Department of Health and Human Services

*CDC works 24/7 saving lives, protecting people from health threats, and saving money through prevention. Whether these threats are global or domestic, chronic or acute, curable or preventable, natural disaster or deliberate attack, CDC is the nation's health protection agency.*

SOURCE Centers for Disease Control and Prevention (CDC)



Order Reprint

Share

Facebook

Twitter

Share

StumbleUpon

Email



**WALK IN MEDICAL CLINIC**  
**THE EVALUATION CENTER FOR**  
**MEDICAL MARIJUANA**

**Do you suffer from...**

• Loss of Appetite (Anorexia)	• Arthritis
• Chronic Pain	• Cancer, AIDS
• Glaucoma	• Migraine Headaches
• Persistent Muscle Spasms	• Severe nausea, vomiting
• Sickle Cell Anemia	• Depression or Anxiety
• <b>Neurological &amp; Psychiatric Disorders:</b> (Seizures, Multiple Sclerosis, Alzheimer's, ADHD, PTSD, Bipolar)	
• Gastrointestinal Disorders (IBS, GERD)	• Menstrual Cramps & Pain
• Auto-immune (Lupus, Scleroderma)	• Hepatitis C
• Sleep Disorders, Insomnia	• Chronic Fatigue
• Diabetic Neuropathy	• Asthma (Severe)

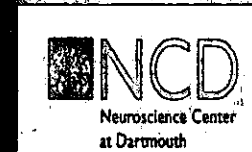
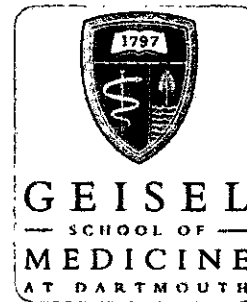
**OR ANY CHRONIC OR PERSISTENT MEDICAL SYMPTOM**

As specified under Florida's Medical Marijuana Use Act, Chapter 381, F.S. 381.001(2)(b).  
 Patients who qualify legally need not be in the state of Florida to receive medical marijuana.  
 For which patients are exempt from the 30-day waiting period.

**Eighth Annual Dartmouth  
Symposium on Substance Use**

**Medical Marijuana:  
Compassionate Care or  
Oxymoron?**

**E. Alfonso Romero-Sandoval MD, PhD**  
Assistant Professor of Anesthesiology and  
Pharmacology and Toxicology



Cannabinoid  
Pharmacology and  
Clinical Promise

 **Dartmouth-Hitchcock**

# + Endocannabinoid system

## ■ Receptors

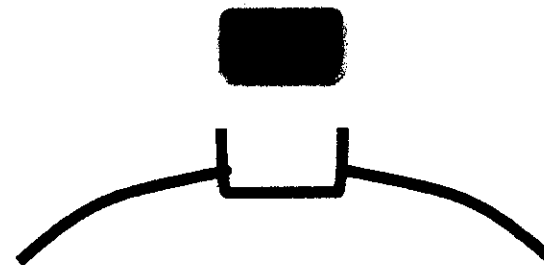
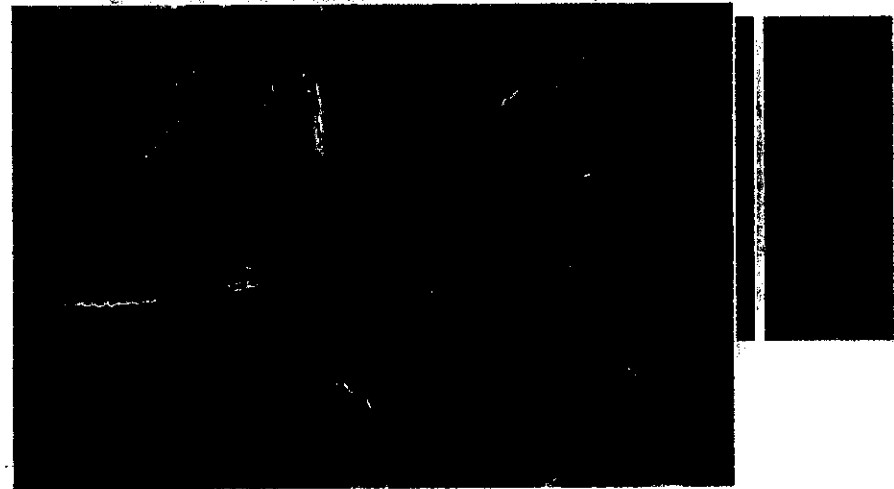
- CB1 – Mostly in the brain
- CB2 – Mostly out of the brain

## ■ Molecules that activate the receptors (endocannabinoids)

- Anandamide
- 2-Arachidonoylglycerol

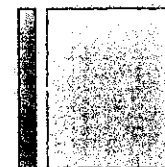
## ■ Molecules that degradate endocannabinoids

- Fatty acid amide hydrolase (FAAH)
- Monoacylglycerol lipase (MAGL)

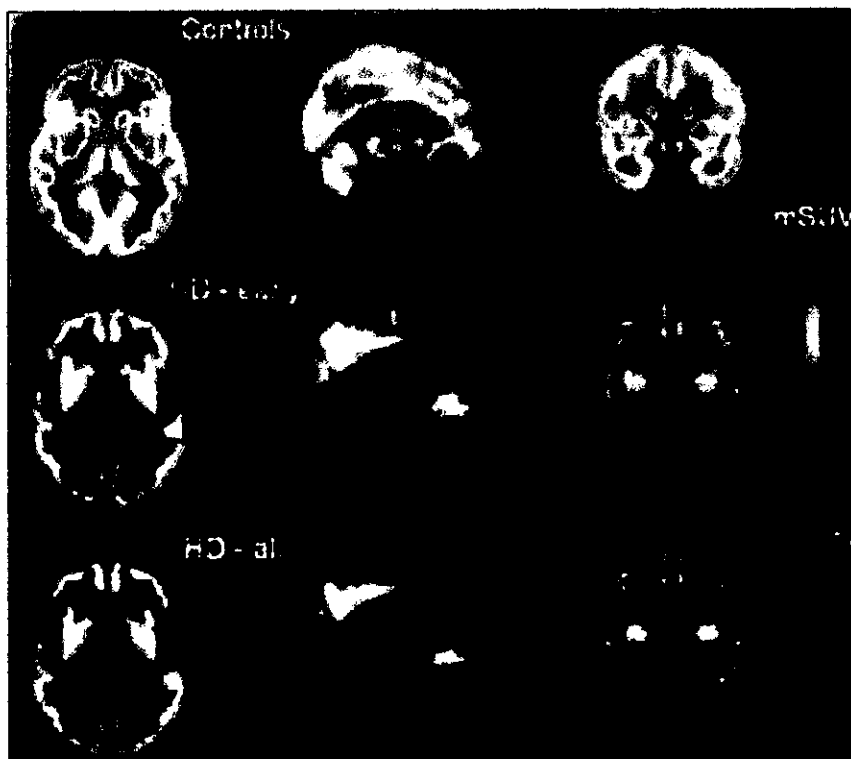




# Cannabinoid Receptors



- Tetrahydrocannabinol (THC) is the major active ingredient of marijuana.
  - Binds mostly to CB1 receptors
- In the brain, CB1 receptors are found in high concentrations in areas that influence pleasure, memory, thought, concentration, sensory and time perception, appetite, pain, and movement coordination.
- CB1 receptors are not present in cardiopulmonary centers in the brain.
- Patients with Huntington Disease show a reduction of brain CB1.
- CB1 receptors are expressed in brain areas that control pain.

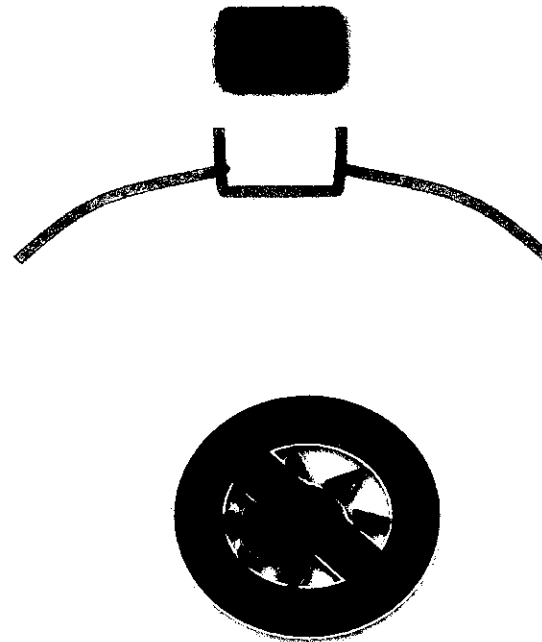


**FIGURE 1.** Cross-sectional, partial-volume corrected, modified standardized uptake value (mSUV) parametric images, averaged for all controls ( $n = 14$ ), early-HD patients ( $n = 7$ ), and total group of HD patients ( $n = 19$ ).

Van Laere et al (2010) Journal of Nuclear Medicine

# + Endocannabinoids and Pain

- Analgesic effects by act in in the brain and out of the brain
- Endocannabinoids are elevated in areas that process pain signals
- Mediate stress-induced analgesia
- The elevation of endocannabinoids reduces pain
  - By the blockade of the molecules that degradate endocannabinoids





# Postoperative and Chronic Pain

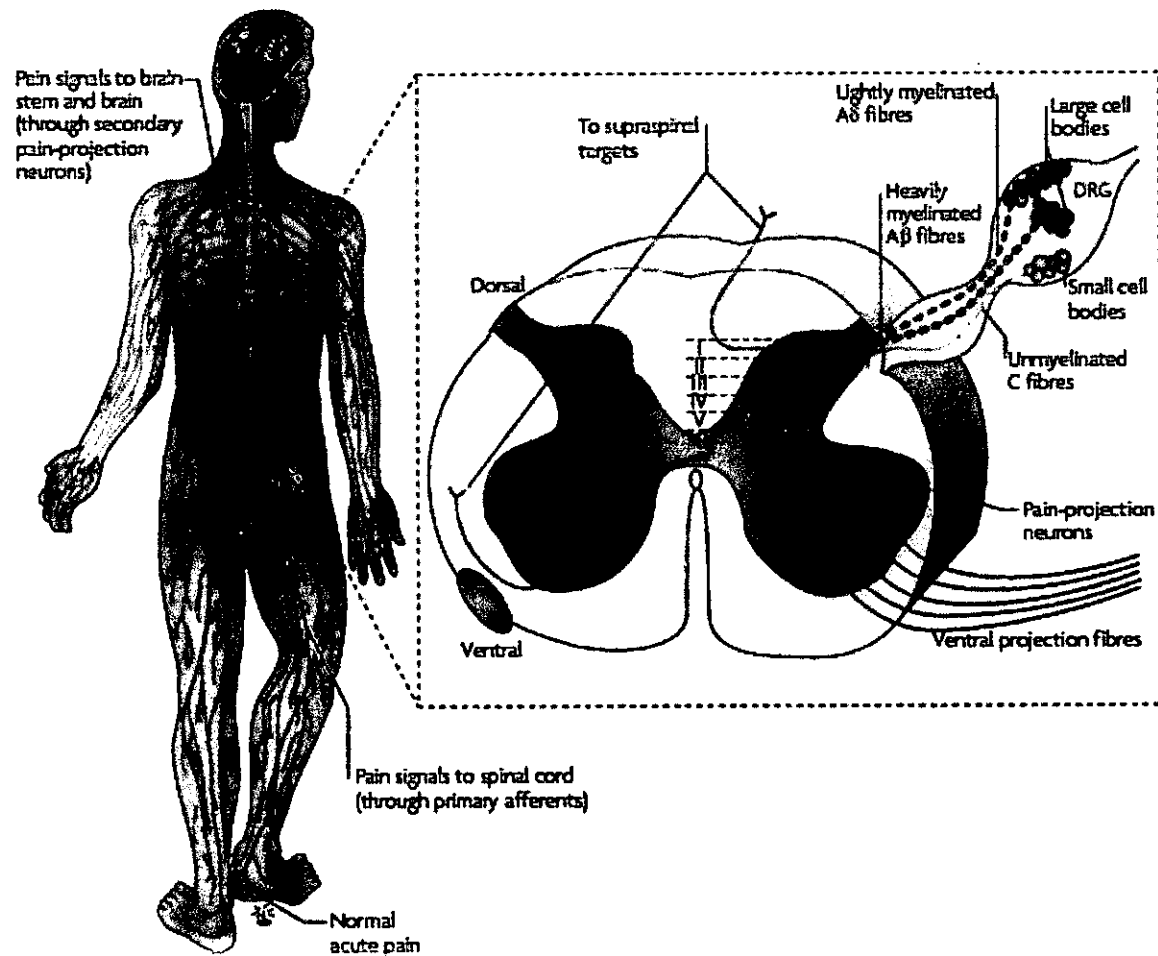


- Chronic pain affects 100 million
- Costs \$635 billion annually
- Following common surgeries:
  - Persistent pain in 10-50%
  - Disability in 2-10%
- Mechanisms responsible for the transition from acute to chronic pain are unknown



+

# Pain processing

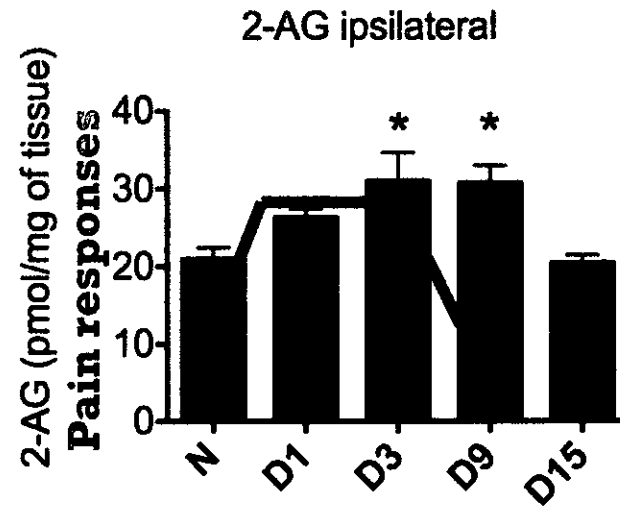
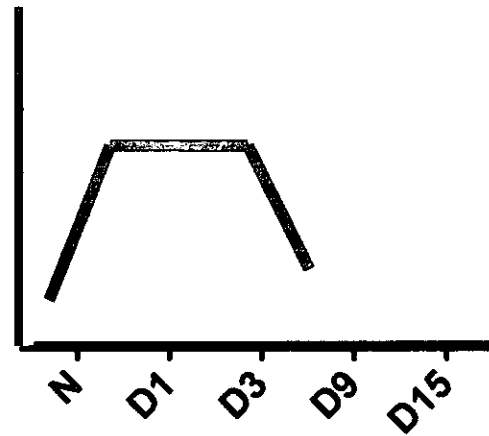




+

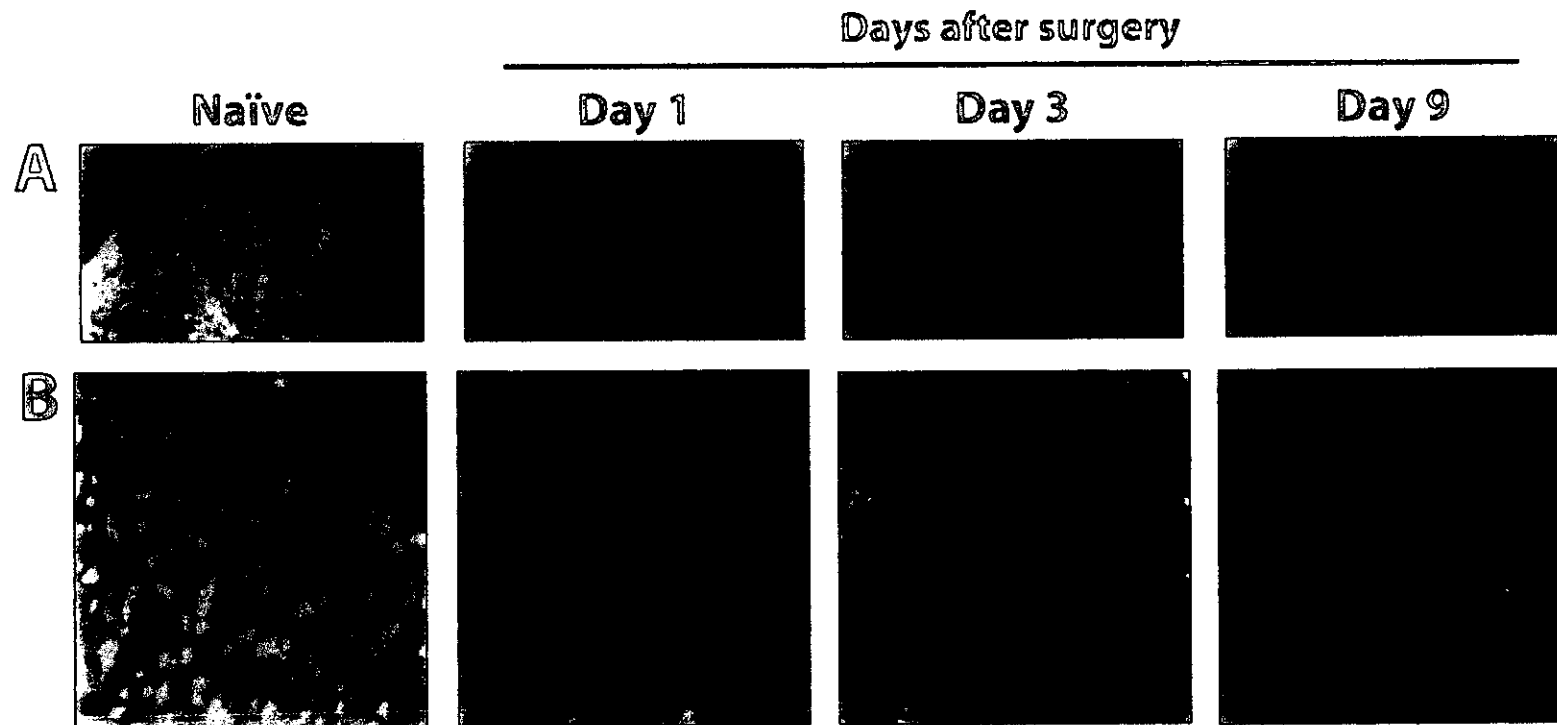
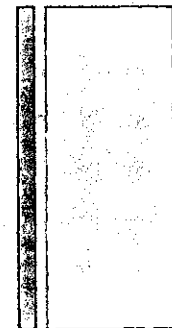
## Postoperative pain and ECBs in spinal cord

Pain responses



+

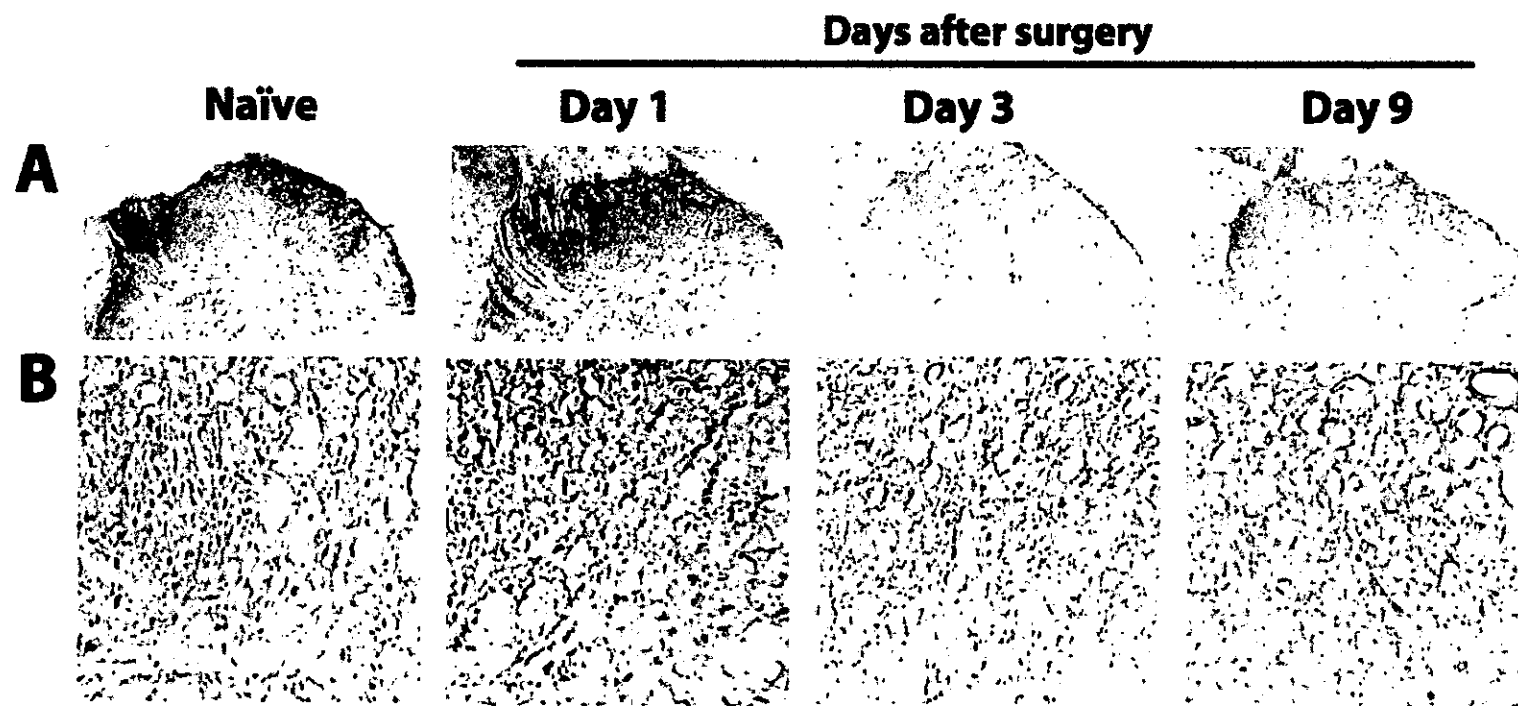
# Paw Incision: CB1 expression



\* $p < .05$  vs. Naïve Control

+

## Paw Incision: CB2 expression



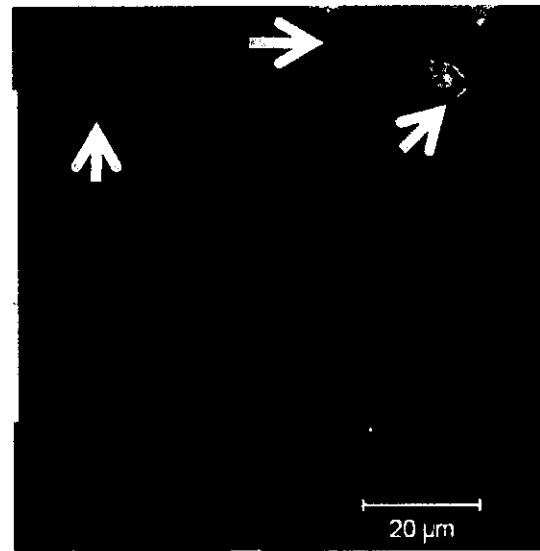
\* $p < .05$  vs. Naive Control

Alkaitis et al., PLoS One 2010

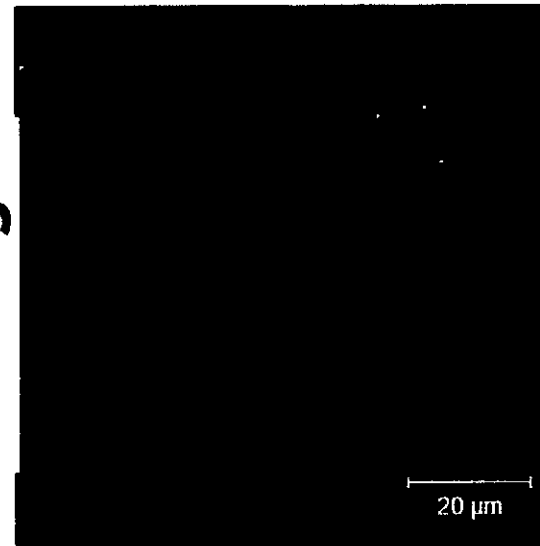
# CB1 cellular expression

## CB1 receptor

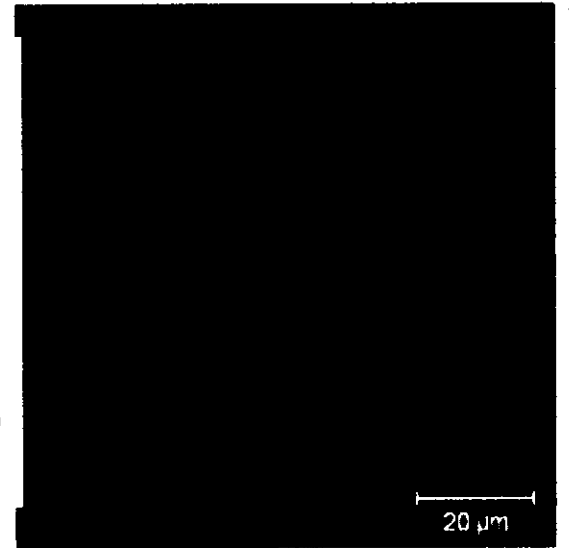
### Neurons



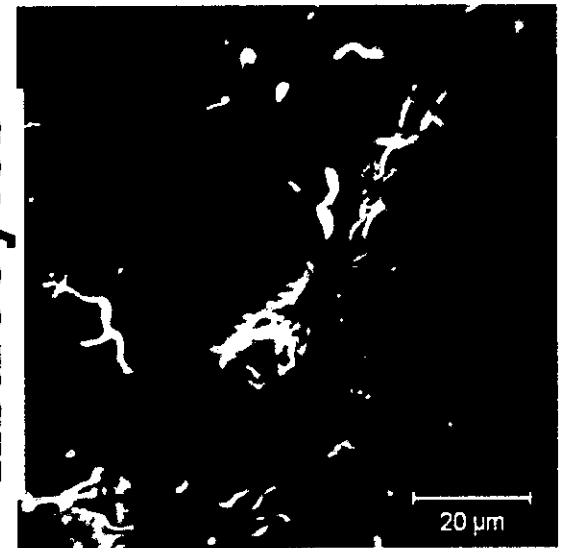
### Microglia



### Perivascular



### Astrocytes



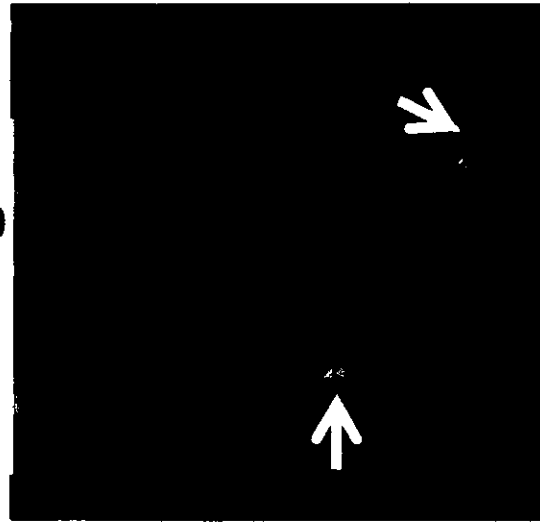
# CB2 cellular expression

## CB2 receptor

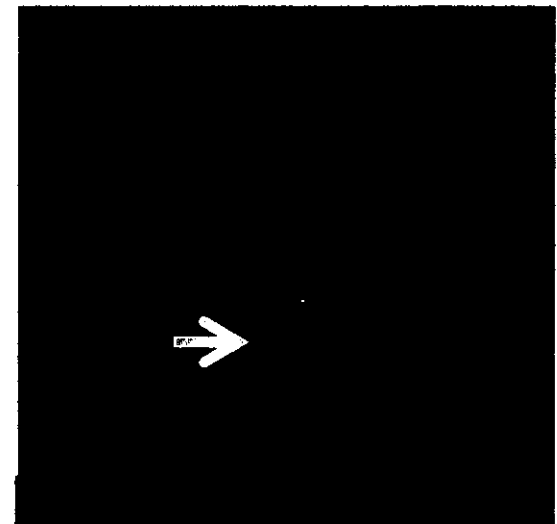
Neurons



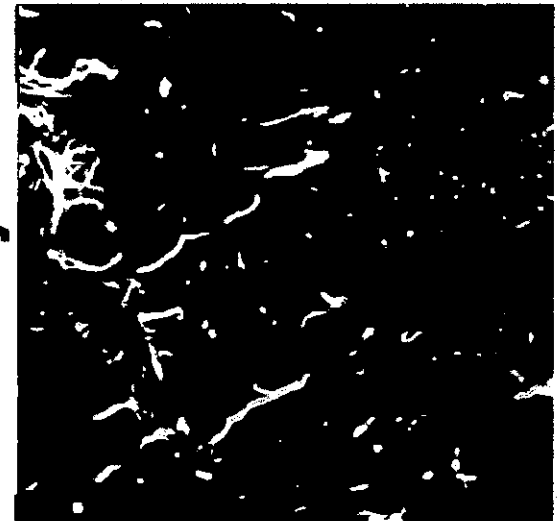
Microglia



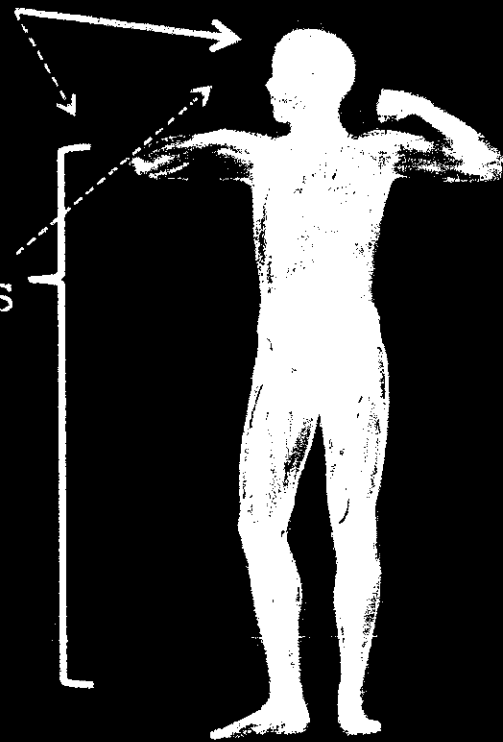
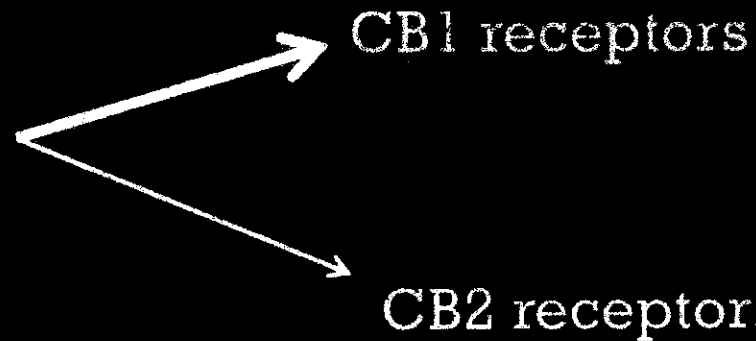
Perivascular



Astrocytes



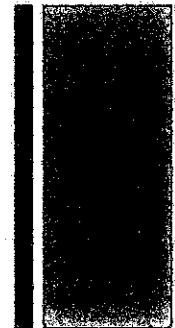
# + Cannabinoid Pharmacology



- Smoked Marijuana
- Specific chemicals found in marijuana
- Chemicals that mimic marijuana's chemicals
- Chemicals that modulate the ECB system



# Cannabinoid Pharmacology



- The cannabis plant contains active ingredients with therapeutic potential for relieving

- **Pain**

- Spasticity
- Controlling nausea
- Stimulating appetite
- Decreasing ocular pressure.

# + Cannabinoid Pharmacology



- Alternatives for smoking marijuana
  - Sativex
  - Dronabinol (Marinol, synthetic THC)
  - Nabilone (Cesamet, synthetic cannabinoid, mimics THC)
- 
- Rimonabant (Acomplia, CB1 ANTAGONIST)



# Cannabinoids - Drugs

## ■ **Smoked marijuana (*Cannabis Sativa*)**

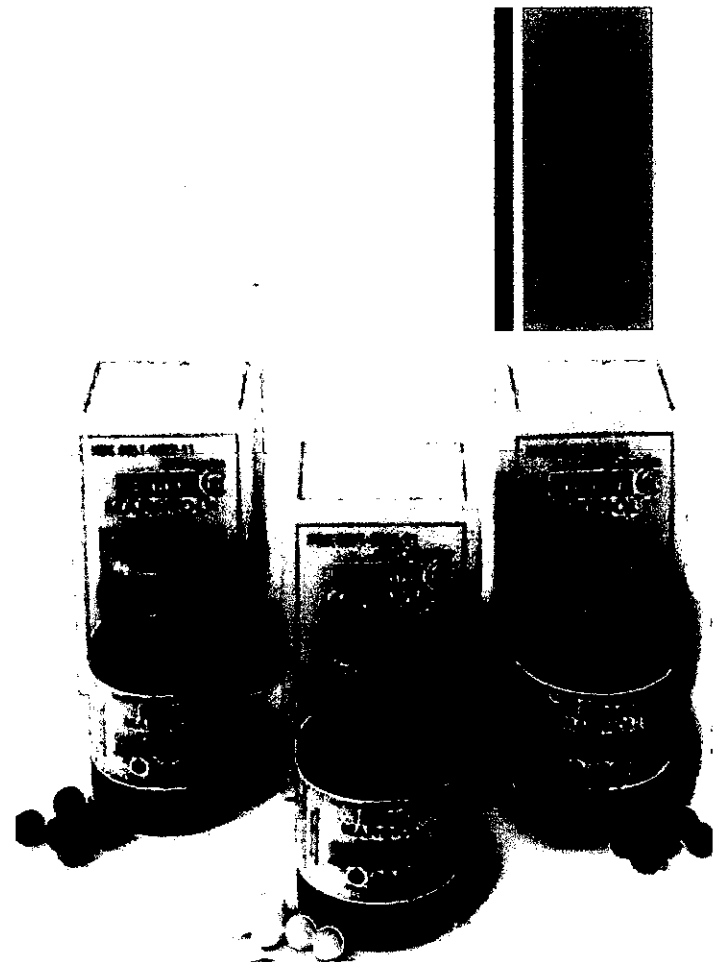
- According to DEA, it is an illegal Schedule I drug with no accepted medical use.
    - Potential of abuse, no medical use, lack of safety to be prescribed by doctors
  - It has 460 known compounds
  - 60 of these compounds are cannabinoid (unique to cannabis)
  - The main psychoactive compound is delta-9-tetrahydrocannabinol (THC)
  - Other major component is cannabidiol
- 
- The use of medical marijuana is currently legal in 16 states and the D.C..





# Cannabinoids - Drugs

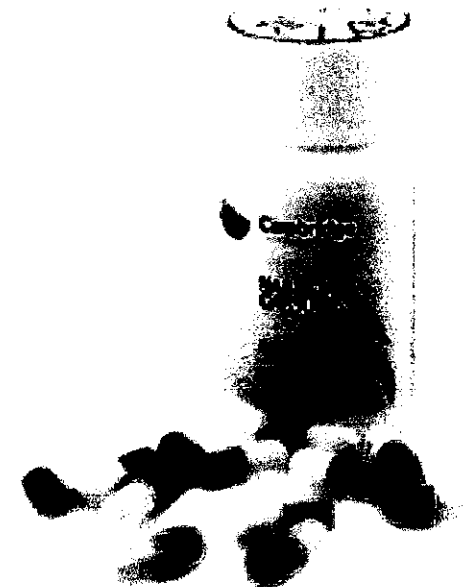
- ❑ **Dronabinol (Marinol, synthetic THC)**
  - ❑ Schedule III (medical use and less risk of abuse)
  - ❑ Approved by FDA in 1985
    - ❑ Nausea and vomiting caused by chemotherapy
  - ❑ Approved by FDA in 1992
    - ❑ Loss of appetite and weight loss in AIDS patients
  - ❑ Major concerns
    - ❑ Some patients describe a strong effect at first, and then wore off quickly.
    - ❑ It is very expensive (\$200-800 monthly)
    - ❑ Difficult for nauseous patients to consume the pill.



# Cannabinoids - Drugs

## ■ **Nabilone (Cesamet, synthetic cannabinoid, mimics THC)**

- Schedule II (risk of abuse, with medical use)
- Approved by FDA in 1985 but it was first marketed in 2006.
  - Nausea and vomiting caused by cancer chemotherapy
  - It is also used for loss of appetite and weight loss in AIDS patients
- Adjunct analgesic for neuropathic pain in Mexico.





# Cannabinoids - Drugs

## ■ **Sativex (THC-cannabidiol, 1:1. Nabiximols in US)**

- Oromucosal mouth spray

- FDA issued an investigational new drug (IND) application for Sativex in 2006

- IND allows Sativex to be studied for potential approval for marketing if it is deemed safe and effective.

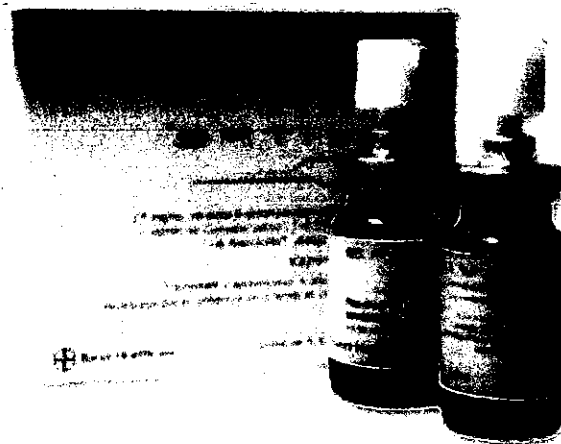
- Multiple Sclerosis (UK, Spain, Canada and New Zealand)

- Cancer pain (Canada)

- Neuropathic pain (Canada)

- Problems

- Cost (1 vial for 10 days costs \$125 in Canada; 125 pounds in UK)





# Cannabinoid Pharmacology

## ■ Rimonabant (Acomplia, CB1 ANTAGONIST)

- Anti-obesity drug, reduces appetite (Europe).
- Withdrawn from market due to side-effects (depression and suicidal thoughts)
- Potential efficacy for smoke cessation (under study)





# Cannabinoid Clinical Promise

## Potential safer alternatives for marijuana

### □ Tetracan

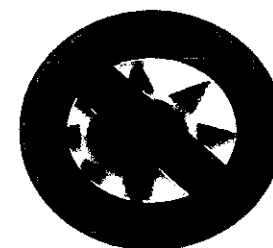
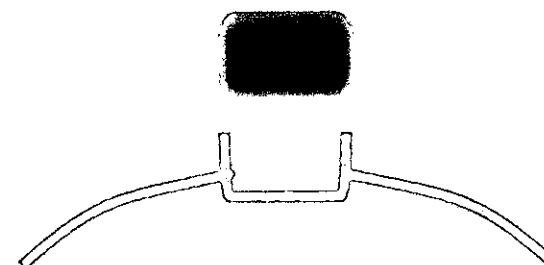
- Medical marijuana patch (Medical Marijuana Delivery Systems, MMDS) LLC.
- May be marketed for dispensaries soon.

### □ Synthetic activators of CB receptors (agonists)

- CB1 or non-selective agonists
- CB2 agonists

### □ Compounds that enhance endocannabinoids (natural/biological agonists).

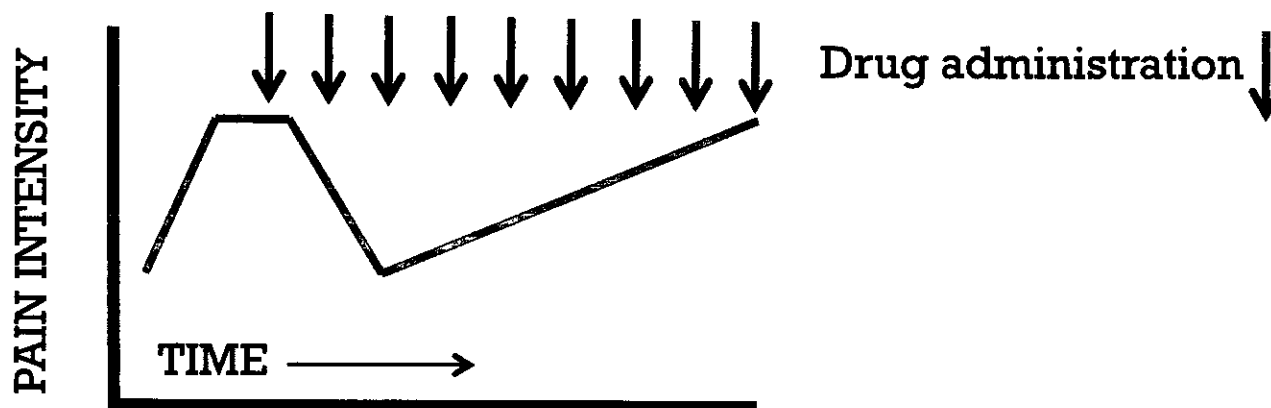
- Blockers of endocannabinoids degradative molecules



# Cannabinoid Clinical Promise

## CB1 or non-selective activators

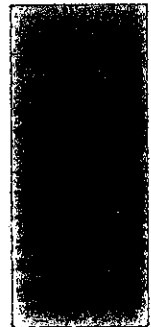
- Effectively block pain responses in virtually every pain model
  - Acute inflammatory, cancer, chronic neuropathic, surgical, etc.
  - Effects were independent of route of administration
- Limitations: Consistently produced psychotropic effects (brain actions)
  - Catalepsy and reduced motor activity.
  - The long term administration produces tolerance.





# Cannabinoid Clinical Promise

## CB1 or non-selective activators



- ❑ **Alternative: Avoid brain actions by targeting sites out of the brain (periphery).**
  - ❑ It has been shown that CB1 activators that do not act in the brain are effective in several types of pain experimentally (inflammation, nerve injury or cancer).
  - ❑ Thus, drugs that do not enter the brain could be ideal for certain types of pain in which brain circuits are not essential
    - ❑ Prevention to transition from acute to chronic pain
    - ❑ Postoperative pain at the time of surgery
    - ❑ Inflammatory pain of short duration
- ❑ **Precautions:**
  - ❑ CB1 activators may regulate immune responses: potential risk of infection or wound healing.



# Cannabinoid Clinical Promise

CB1 or non-selective activators

## Clinical studies – Acute pain

- ❑ THC or nabilone (THC analogue) has not proven to reduce acute pain in humans (postoperative).
- ❑ In some cases analgesic effects were achieved with doses that enhanced frequency and intensity of side effects.
- ❑ In other cases CB1 agonists induced higher pain intensities.
- ❑ There is a clear disconnection between experimental studies and human trial results.
- ❑ Conclusion
  - ❑ CB1 agonists cannot be recommended for this condition.

# Cannabinoid Clinical Promise

**CB1 or non-selective activators**

**Clinical studies – Chronic pain**

## ☐ Pain in Multiple Sclerosis

- ☐ Dronabinol and Cannabidiol have shown efficacy in reducing MS pain.
- ☐ Dronabinol improved functional tests in MS patients.
- ☐ CB1 or non-selective activators are recommended as second line therapy for pain and spasticity in MS patients.
  - ☐ Potential risk of abuse and psychiatric adverse events due to long term treatment.

## ☐ Neuropathic Pain (NP, due to nerve damage)

- ☐ THC or sativex have shown about 30% improvement in these patients: peripheral nerve lesions or HIV-associated NP.
- ☐ These types of pain are resistant to common treatments for NP.



# Cannabinoid Clinical Promise

**CB1 or non-selective activators**

**Clinical studies – Chronic pain**

- ❑ **Cancer Pain, Rheumatoid Arthritis or Fibromyalgia syndrome**
  - ❑ THC, cannabidiol, dronabinol and nabilone have shown about 30% relief.
  - ❑ These drugs also improved mood, sleep and coping.
  - ❑ In Fibromyalgia patients cannabinoids were more effective in patients with depression than in patients without depression. Suggesting that an action into the brain is important (high potential of side effects!)
- ❑ **Combination with opioids**
  - ❑ Dronabinol as adjuvant therapy seems to synergistically reduce pain with opioids. Additionally, dronabinol seems to reduce opioid tolerance (open-label clinical trial).
- ❑ **Conclusions**
  - ❑ Cannabinoids induce mild-moderate pain relief (about 30%), they are not more effective than current treatments. They improve mood and sleep quality. Recommended as second-line or for some individuals.



# Cannabinoid Clinical Promise

## CB2 selective activators



- ❑ They have shown to reduce pain responses in neuropathic, cancer and postoperative pain and in some types of inflammatory pain experimentally.
- ❑ In some cases CB2 activators can also interact with opioid receptors.
- ❑ They do not produce classic psychotropic cannabinoid effects (dependent on CB1 activation).
  - ❑ No catalepsy, reduction in motor activity or tolerance.
- ❑ The efficacy of CB2 agonist is not as high as CB1 agonists experimentally.
- ❑ Precautions:
  - ❑ CB2 activators strongly regulate immune responses: potential risk of infection or wound healing delay.



# Cannabinoid Clinical Promise

## CB2 selective agonists

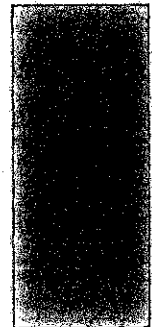
### Clinical studies

#### ☐ Acute Pain

- ☐ Cannabinor (Pharmos Corporation) did not show efficacy in acute pain (capsaicin) or postoperative pain (molar extraction).
- ☐ GW842166 (GSK) has failed to reduce tooth extraction-induced postoperative pain in patients.

#### ☐ Conclusion

- ☐ CB2 selective agonist cannot be recommended for acute pain conditions.





# Cannabinoid Clinical Promise

## ECB enhancers – blockers of ECB degradative molecules

- ❑ URB597 or PF-04457845 inhibits the enzyme that degrades anandamide.
- ❑ JZL184 inhibits the enzyme that degrades 2-AG.
- ❑ Effective experimentally in osteoarthritis, inflammatory pain, visceral pain, diabetic neuropathy, neuropathic pain, bone cancer pain
- ❑ They do not induce cannabinoid-like psychotropic effects.
- ❑ Theoretical Advantages:
  - ❑ ECBs are produced on-demand, therefore the inhibition of their degradative molecules would enhance ECBs only at sites where they are needed and important. This may explain the lack of cannabinoid-side effects in pain conditions experimentally.





# Cannabinoid Clinical Promise

ECB enhancers – enzyme inhibitors

## Clinical studies

- PF-04457845 effectively induced an increase in anandamide in humans.
- PF-04457845 failed to relieve pain in patients with osteoarthritis.

## ■ Conclusion

- ECB enhancers are not recommended for OA pain. Some weaknesses of this clinical trial is the type of pain chosen: OA has a minimal inflammatory component.



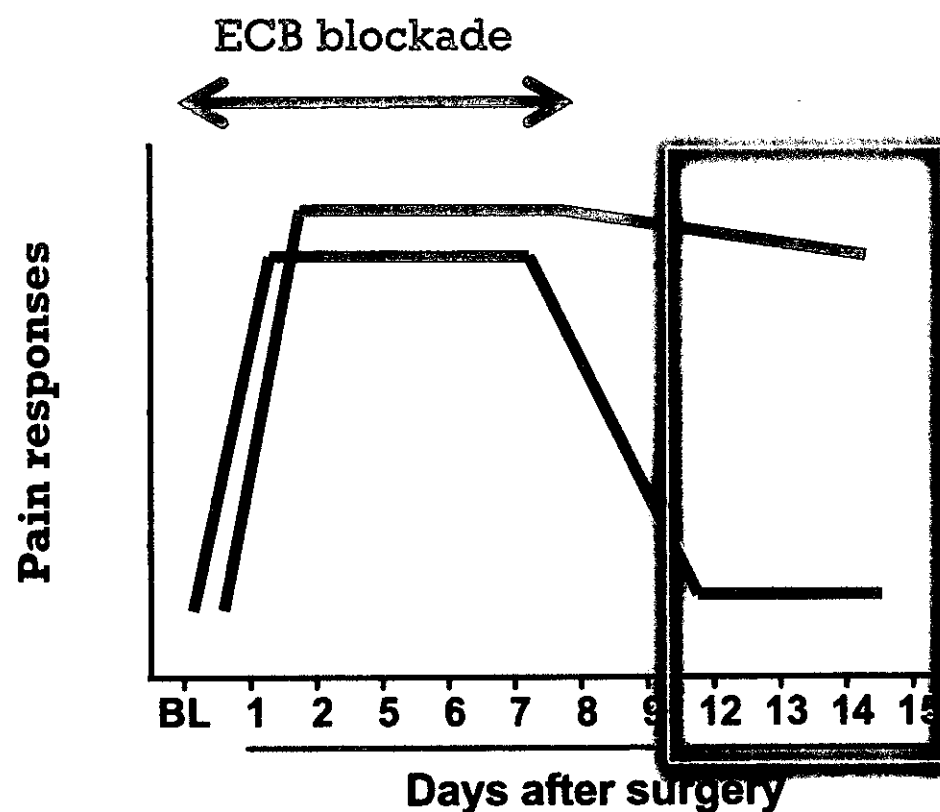
+

# Cannabinoid Clinical Promise

ECB enhancers – enzyme inhibitors

## Clinical Promise?

- ECBs drive the resolution of postoperative acute pain experimentally.







# Cannabinoid Clinical Promise

## Other conditions



- Obesity

- Drugs that modulate ECBs outside the brain seem a safer strategy (URB 447 peripherally restricted CB1 antagonist).

- Anxiety

- Cardiovascular conditions (atherosclerosis, blood pressure, heart function).

- Memory

- Gut microbiota

- Nicotine withdrawal



# Cannabinoid Clinical Promise

## Conclusions



- ❑ CB1 or non-selective activators cannot be recommended for acute pain.
- ❑ CB1 or non-selective activators induce mild-moderate pain relief (about 30%), but they are not more effective than current treatments. They improve mood and sleep quality. Recommended as second-line therapy specially for MS pain. For other chronic pain they could be useful for some individuals.
- ❑ CB analgesic effects are not sufficient for severe pain conditions. But their other neurologic effects may be beneficial as co-analgesics or as an adjuvant for multimodal therapeutic approaches for individual patients or certain type of patient groups.
- ❑ Precautions should be taken for CB1 activators when given for long term: Potential risk of abuse, psychiatric adverse events or tolerance formation.

# Cannabinoid Clinical Promise

## Conclusions

- CB2 activators cannot be recommended for acute pain conditions.
- ECB enhancers are not recommended for OA pain.
- Since CB1 activators compounds are more potent than CB2 activators or ECBs, the clinical promise of these compounds is not clear, and it remains to be determined for other conditions (chronic pain or inflammatory conditions).
- The enhancement of ECBs may be beneficial in patients with risk to develop chronic pain following injuries or surgeries. The identification of patients with that risk remains elusive.
- More research on cannabinoids is necessary.

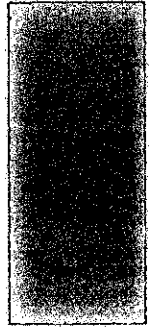
# Cannabinoid Clinical Promise

## Conclusions

- Cannabis is claimed to produce a stronger analgesic effect than synthetic cannabinoids. This may be due to a complex combination of several components in the plant.
- More studies are needed to compare cannabis effect vs. synthetic compounds.
- The regulation of marijuana plant as a medicine seems difficult. This is due to the complexity in regulating exact chemical contents and in the logistic of production. Not to mention the federal government policy of zero-tolerance toward illicit drugs.



# Cannabinoid Clinical Promise



**Thanks**

Professional Organization Positions on  
Medical Marijuana: IOM Report to Today

Medical Marijuana:  
Compassionate Care or Oxymoron?

Dartmouth College  
May 11, 2012

Herbert D. Kleber, M.D.  
Professor of Psychiatry  
Director, Division on Substance Abuse  
Columbia University/NYSPI

# Introduction

- Many pro-medical marijuana (MJ) groups have endorsed the Institute of Medicine (IOM) report of 1999 as supporting their position
- Reality is more nuanced
- What did the report say?

# Institute of Medicine (IOM) Report

- In 1999, IOM issued a report, “Marijuana and Medicine: Assessing the Science Base”
- It concluded: “Scientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation; smoked marijuana, however, is a crude THC delivery system that also delivers harmful substances”
- The report made six recommendations including:
  1. Clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems



## Institute of Medicine (IOM) Report (cont)

2. Clinical trials of marijuana use for medical purposes should be conducted under the following limited circumstances:
3. Trial should involve only short-term marijuana use (less than six months)
4. Should be conducted in patients with conditions for which there is reasonable expectation of efficacy
5. Should be approved by institutional review boards
6. Should collect data about efficacy

# Institute of Medicine (IOM) Report (cont)

- Short-term use of smoked MJ (less than six months) for patients with debilitating symptoms (e.g., intractable pain or vomiting) must meet the following conditions:
  - Failure of all approved medications to provide relief has been documented
  - The symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs
  - Such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness
  - Involves an oversight strategy comparable to an institutional review board that could provide guidance within 24 hours of submission by a physician to provide MJ to a patient for specified use

## Institute of Medicine (IOM) Report<sub>(cont)</sub>

- The report acknowledged that there is no clear alternative for some people suffering from chronic conditions that might be relieved by smoking marijuana, such as pain or AIDS wasting

## Institute of Medicine (IOM) Report (cont)

- One possible approach is to treat patients as n-of-1 clinical trials, in which patients are fully informed of their status as experimental subjects using a harmful drug delivery system and...their condition is closely monitored and documented under medical supervision....We recommend these n-of-1 clinical trials using the same oversight mechanism as that proposed in the above recommendations.

## AMA Report A01: Medical Marijuana - 2001

- To update its 1997 policy, and in response to the intensifying public debate, in 2001 the American Medical Association's Council on Scientific Affairs reviewed the literature and produced a report: *Medical Marijuana* (A-01)
- Its recommendations were adopted as AMA policy
- The report reviews State initiatives concerning medical marijuana including among others: current regulations and efforts to support research; major proposed medical uses of marijuana, analgesic effects of THC and smoked marijuana; adverse effects of marijuana
- The report enumerated five recommendations

## Policy of the American Medical Association on Medical Marijuana

1. The AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy
2. The AMA recommends that marijuana be retained in Schedule I of the Controlled Substances Act pending the outcome of such studies
3. The AMA urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into MJ medical utility

## Policy of the American Medical Association on Medical Marijuana (cont)

4. The AMA believes NIH should use its resources and influence to support development of a smoke-free inhaled delivery system for MJ or delta-9-tetrahydrocannabinol (THC) to reduce health hazards associated with the combustion and inhalation of MJ
5. The AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions

## American Psychiatric Association (APA) Position Statement on “Marijuana as Medicine,” 2009

- Compassion for the ill, along with research support for safety and efficacy, should be guiding principles in the assessment and approval process of cannabis-derived agents’ medical efficacy
- The American Psychiatric Association endorses the position adopted by the AMA-2001 (*Medical Marijuana*, Report A01), except their position paper applies only to adults
- The APA urges the AMA to amend its position to indicate that since the therapeutic value of cannabinoid research is less likely to be in the area of drug abuse or other psychiatric disorders, the appropriate NIH institutes, other than NIDA or NIMH, should sponsor such research



## APA Position Statement (cont)

- The APA endorses the recommendations made by the Institute of Medicine (IOM) in its 1999 report, *Marijuana and Medicine: Assessing the Science Base*
- For those chronic conditions that show efficacy at six months, longer studies may be indicated. If so, APA urges simultaneous study of adverse effects, including, but not limited to, the likelihood of addiction. Adverse effects should be studied for shorter trials as well.
- Given the problems inherent in using the smoked form, every effort should be made to use non-smoked routes in treatment. Pharmaceutical companies should be encouraged to develop oral, transdermal, or aerosol routes, including generics, which are not cost prohibitive to the patient

American Psychiatric Association Report:2009  
Changes since release of the 1999 IOM Report and the 2001  
AMA report on Medical M.J. (A-01)

- From 2001 to 2007, approximately 115 articles on the subject of medical marijuana were published; they reveal little change since the publication of the Institute of Medicine Report in 1999
- 1. The primary proposed medical uses of marijuana remain as an antiemetic for severe nausea/vomiting associated with cancer chemotherapy or other causes; treatment for intractable hiccups; for cachexia associated with AIDS or cancer; spasticity secondary to neurologic diseases such as multiple sclerosis; pain management, especially neuropathic pain; and rheumatoid arthritis

## APA Report (cont)

2. Results of the various studies were mixed. In some, there was not objective improvement but patients described subjective relief. In others, there was objective improvement, and in others improvement was less than with existing medications. Emerging possibilities for cannabinoids could include neuroprotection, anti-inflammation, immunomodulation, and modulation of glial cells.
3. Possible new agonist agents acting at cannabinoid receptors may be able to dissociate therapeutic effects from psychoactive effects

## APA Report (cont)

- Risk factors for marijuana include adverse psychiatric, cardiovascular, respiratory, and immunologic events. Recent studies suggest both an increased risk of schizophrenia (4-6) and doubling of grey matter loss in schizophrenia associated with marijuana use (7).

## APA Report (cont)

- Future delivery forms are a transdermal patch, nasal patch, and a metered dose inhaler. THC without other cannabinoids or carcinogens is currently available in the United States as an oral tablet in the form of dronabinol (Marinol, a Schedule 3 agent).

## APA Report (cont)

- Many studies report oral MJ should not be first line in medications but should be part of the available arsenal. Most recommend further clinical trials of effectiveness (8).
- A metered dose inhaler containing THC and cannabidiol, a non-psychoactive cannabinoid (Sativex), has been approved in Canada for treatment of some symptoms of multiple sclerosis and is being studied in the United States for chronic pain secondary to cancer.
- *Authors of the APA Position Statement reviewed 115 articles that were published from 2001-2007.*
- *Majority of articles used cannabis preparations via the oral route. Some used just THC, others a plant extract.*

## APA Report (cont)

- Since the discovery and cloning of cannabinoid receptors (CB1 and CB2) in the 1990's and a number of endogenous ligands, interest in the endocannabinoid system has markedly expanded
- Cannabinoids interact with a number of other receptor systems, appear to affect a number of bodily functions and may have efficacy in various medical conditions for which current treatments may be inadequate

## APA Report (cont)

- There are more than 460 active chemicals and over 60 unique cannabinoids in the cannabis sativa plant
- However, CB<sub>1</sub> receptor agonists may have undesirable CNS impact, and requisite doses may not be attainable before excessive side effects develop



## APA Position Statement – 2009 (cont)

### REFERENCES

1. Marijuana and Medicine: Assessing the Science Base by Institute of Medicine, Janet E. Joy, Jr. Stanley J. Watson, and Jr. John A. Benson (Hardcover - Jul 15, 1999), p. 177-179.
2. Abrams, D.I., Jay, C., Petersen, K., Shade, S., Vizoso, H., Reda, H., Benowitz, N., Rowbotham, M. The Effects of Smoked Cannabis in Painful Peripheral Neuropathy and Cancer Pain Refractory to Opioids. Proceedings of the International Association of Cannabis as Medicine, Cologne, 2003, p. 28.
3. Drysdale AJ, Platt B. Cannabinoids: mechanisms and therapeutic applications in the CNS. Curr Med Chem. 2003 Dec;10(24):2719-32.
4. Moore, T.H.M., Zammit, S., Lingford-Hughes, et al Cannabis Use and Risk of Psychotic or Affective Mental Health Outcomes: A Systematic Review. Lancet 2007, 370: 319-28.
5. Nordentoft, M., Hjorthoj, C. Cannabis Use and Risk of Psychosis in Later Life. Lancet 2007; 370:293-94.

## APA Position Statement – 2009 (cont)

### REFERENCES

6. Gonzalez-Pento, A., Vega, P., Ibanez, B. et al Impact of Cannabis and Other Drugs on Age at Onset of Psychosis. *J. Clin Psychiatry* 2008; 69: 1210-16.
7. Rais, M., Calin, W., Van Haren, N. Excessive Brain Volume Loss Over Time in Cannabis- Using First Episode Schizophrenic Patients *Am J. Psychiatry* 2008; 165: 490-496.
8. Medical marijuana: emerging applications for the management of neurologic disorders. *Phys Med Rehabil Clin N Am.* 2004 Nov; 15(4):943- 54, ex.

## Center for Medicinal Cannabis Research

### Completed Studies

1. Cannabis for treatment of HIV - Related Peripheral Neuropathy. Donald Abrams, M.D.
2. Vaporization as a "Smokeless" Cannabis Delivery System. Donald Abrams, M.D.
3. Short-Term Effects of Cannabis Therapy on Spasticity in MS, Jody Corey-Bloom, M.D., Ph.D.
4. Sleep and Medicinal Cannabis, Sean Drummond, Ph.D.
5. Placebo-controlled, Double-Blind Trial of Medicinal Cannabis in Painful HIV Neuropathy, Ronald Ellis, M.D., Ph.D.
6. Impact of Repeated Cannabis Treatments on Driving Abilities, Thomas Marcotte, Ph.D.
7. Mechanisms of Cannabinoid Analgesia, Ian Meng, Ph.D.
8. Effects of Cannabis Therapy on Endogenous Cannabinoids, Daniele Piomelli, Pharm.D., Ph.D.

# Center for Medicinal Cannabis Research

## Completed Studies (cont)

9. Effects of Medicinal Cannabis on CD4 Immunity in AIDS, Rachel Schrier, Ph.D.
10. Analgesic Efficacy of Smoked Cannabis, Mark Wallace, M.D.
11. Efficacy of inhaled Cannabis in Diabetic Peripheral Neuropathy, Mark Wallace, M.D.
12. A Double-Blind, Active Placebo-Controlled Crossover Trial of the Antinociceptive Effects of Smoked Marijuana on Subjects with Neuropathic Pain; Correlation with Changes in Mood, Cognition, and Psychomotor Performance, Barth Wilsey, M.D.
13. The Analgesic Effect of Vaporized Cannabis on Neuropathic Pain in Spinal Cord injury, Barth Wilsey, M.D.
  - Total of 7 controlled clinical trials of which 5 have been published in peer-reviewed journals (2010), 3 involved neuropathic pain, 1 involved experimental pain and 1 pilot study for a cannabis delivery device.

## Clinical Studies with Cannabis and Cannabinoids 2005-2009

Hazekamp, A., Grotenhermen, F.

- Included clinical studies that were randomized, (double) blinded, and placebo-controlled between 7/1/05-8/1/09
- Open label studies were excluded
- Thirty-seven controlled studies evaluating the effects of cannabinoid were identified
- Based on clinical results, cannabinoids present an interesting therapeutic potential mainly as analgesics in chronic neuropathic pain, appetite stimulants in debilitating diseases (cancer and AIDS), and treatment of multiple sclerosis

# Conclusions

- Since the release of the IOM report in 1999, there has been a number of other reports.
- There is general agreement on some points:
  - The smoking route as a way of delivery of the active MJ ingredients is problematic, both because of potential carcinogenic toxins and the difficulty of assuring delivery of the same dose
  - The smoking route, because of the rapidity with which the ingredients hit the brain increases MJ's euphorigenic and its dependence-inducing potential

## Conclusions (cont)

- Although the FDA is far from perfect, it is all we currently have to try and insure standardized composition, purity, potency, and effectiveness
- Although there is medicinal value in various ingredients in the cannabis plant, they should be brought to the public via FDA approval and testing process, not by referenda

# Conclusions (cont)

- A number of indications have been shown to benefit from cannabinoids
  - In general they can be helped by oral cannabinoids (e.g., dronabinol or nabilone)
  - Or there are existing medications which can fill the need
- When these are not the case, the IOM recommendation of “n-of-1” studies with careful record keeping, oversight strategy approval and follow-up should be considered
- The indications with the most empirical support are:
  - Analgesics in chronic neuropathic pain
  - Appetite stimulants in debilitating diseases (cancer and AIDS)
  - Treatment of certain aspects of multiple sclerosis



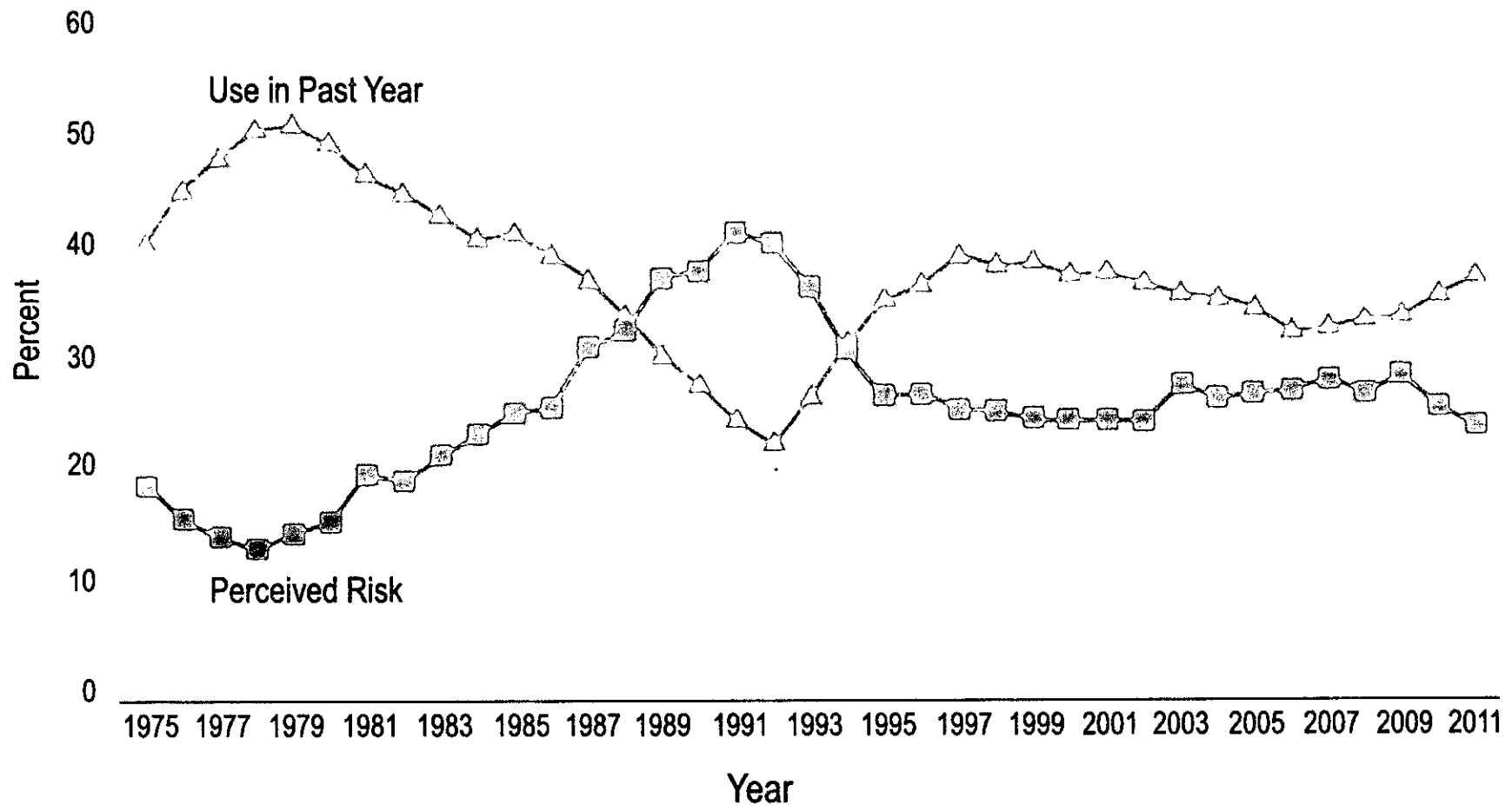
# Conclusions<sub>(cont)</sub>

- IOM report – “N-of-1” recommendation not followed; instead free-for-all especially with California and Colorado dispensary system
  - Nothing really learned from these systems from medical point of view
  - Minimal to none medical oversight or follow-up of users
  - Basically legalized recreational MJ
  - Composition of dispensary MJ varies in both % of THC and presence of other cannabinoids
- AMA 2001 report
  - NIH did not facilitate grant applications and well-designed clinical research into MJ medical utility

## Conclusions (cont)

- NIH did not support development of smoke-free inhaled delivery system to decrease health hazards
- APA 2009 Position Statement and Report
  - Main proposed medical uses of MJ have not changed much from APA summary or Hazekamp review
- Role of other cannabinoids, especially cannabidiol (CBD), which could have a number of potential useful effects, has been inadequately studied
- “Medical MJ” state referenda may be playing a deleterious role in “perceived risk” and leading to increased adolescent use

### Trends in Annual Use of Marijuana vs. Perceived Risk Among 12<sup>th</sup> Graders



Source: University of Michigan, 2010 Monitoring the future study; figure excerpted from Kleber H & DuPont R, *AJP*, in press



Marijuana Policy Project  
236 Massachusetts Ave. NE, Suite 400  
Washington, DC 20002  
p: (202) 462-5747 • f: (202) 232-0442  
info@mpp.org • www.mpp.org

*"We change laws."*

### **Why is it necessary for HB 573 to include home cultivation in addition to ATCs?**

HB 573 (amendment 2013-0478h) would allow each qualifying patient to cultivate up to four mature plants in an enclosed, locked facility or to designate a caregiver who would do so. Each cultivation location would have to be registered with DHHS.

Additionally, the bill calls for the creation of five non-profit, state-regulated Alternative Treatment Centers (ATCs). There are many advantages associated with ATCs, as follows:

- ATCs are critical for patients who urgently need medical marijuana and can't wait the four months it would take to grow their own plants. An example would be cancer survivor Dennis Acton, a Fremont resident who began radiation treatments just days after being diagnosed with testicular cancer. A patient in these circumstances certainly can't afford to plant seeds and wait four months for them to grow.
- ATCs are a secure and convenient alternative to the black market. Many patients do not have the time, ability, or desire to cultivate their own plants, and having access to a secure and professionally-operated ATC would benefit these patients by ensuring they never have any reason to interact with a black market dealer. Additionally, marijuana plants need to be watered and cared for daily, which is not feasible for patients who are frequently hospitalized.
- ATCs serve an important educational function. Many patients have never used marijuana before, and those who do have experience with marijuana may not know about vaporizers and other, more healthful alternatives to smoking. A well-trained ATC employee can answer patients' questions and help them understand how to derive the most benefit from their medical use of marijuana, while minimizing risks.

On the other hand, patients with long-term needs see many advantages to cultivating their own plants. The primary advantages of home cultivation for patients are cost, access, and, in the short term, availability.

- Home cultivation can be much cheaper for patients than relying on an ATC, which is critical because many patients can't afford their medical bills as it is. Currently, prices at the ATCs in Maine are very similar to those found on the black market (approx. \$400/ounce). Cost becomes a much bigger issue for patients who choose to ingest marijuana orally via foods or tinctures because the bioavailability is much lower. Patients who consume marijuana orally may need three to five times as much marijuana to achieve the same number of effective doses as could be obtained via smoking.

- Assuming all five certified ATCs are able to get up and running, it's inevitable that some patients will not live near a dispensary. Patients who live in rural areas, such as Coos County, may have trouble accessing an ATC, and some patients do not own cars or are unable to travel because of their conditions.
- For at least the first two years of the program, availability will be a major concern for patients who need medical marijuana and can't wait for ATCs. DHHS could take up to a year after the bill passes to make rules governing ATCs, and up to 18 months before issuing five ATC certificates. Since it will take ATCs about four months just to grow the plants, it's unlikely that any ATC would be able to open in less than two full years following passage of the law. Some of the patients involved in the effort have been recommended marijuana by their physicians for several years now, and they can't afford to wait two years or more for a legal source. In one sad example, muscular dystrophy patient Clayton Holton, a Rochester resident who has been advocating for this law since 2007, testified this year that his weight is down to 66 pounds and his health is failing. (Oxycontin helps with Clayton's pain, but he says "it turns me into a zombie," and it certainly doesn't help him eat.)

The above analysis assumes the federal government will not interfere with New Hampshire's process of implementing and regulating ATCs. Unfortunately, despite the clear benefits of well-regulated ATCs, the federal government has continually refused to promise such entities immunity from federal prosecution. Although the federal government has not interfered with dispensaries in Maine and other states with clear regulations, such interference remains possible under current policy. It's also possible federal policy could change for the worse, creating a hostile environment for ATCs and preventing them from serving patients. If home cultivation is not legal for patients, their only option in the absence of ATCs would be the black market.

- The federal government has said it would not target individual patients and their caregivers for prosecution, meaning patients cultivating a limited supply of medical marijuana should not be at risk. However, the Department of Justice has repeatedly indicated that it may prosecute businesses that grow and sell medical marijuana. While it has not targeted dispensaries in states with strict regulations, that could change.
- A new president will take office in less than four years, and although it's possible the next administration will be hostile to dispensaries, it's very unlikely patients or caregivers would be targeted by federal authorities. Even under the administration of President George W. Bush, which featured two attorneys general who strongly opposed medical marijuana, individual patients and caregivers were not targets for federal prosecution.
- Fourteen states, including Maine and Vermont, allow any qualifying patient to cultivate a safe supply or to designate a caregiver to do so. Although the home

cultivation provisions in HB 573 are more restrictive than most, these laws are generally working well, enjoy strong popular support, and have not led to increased rates of teen marijuana use.

- In February 2012, Delaware Governor Jack Markell suspended implementation of state-regulated dispensaries in that state after receiving a letter from the state's U.S. attorney stating that dispensaries would not be immune from federal prosecution. Delaware's law, which did not allow home cultivation, passed in 2011, but it's not clear when, or how, patients will be able to legally access medical marijuana in Delaware.
- In New Jersey, the medical marijuana bill was signed into law in January 2010. Six ATCs were approved, but the first one did not open until December 2012. The law does not allow home cultivation. Today, more than three years after the law was signed, only one ATC is open in the state, and it reports being overwhelmed with patients. Patients report having to wait over a month for an appointment, and they say the ATC is selling marijuana for higher than black market prices. The other five approved ATCs are not yet close to opening in New Jersey because of various difficulties, including obtaining state and local approval.
- HB 573 contains ample safeguards. All patients approved under HB 573 would have to register with the state and would be required to disclose their cultivation locations, which would have to be enclosed and locked. The bill also contains enhanced penalties for registered patients or caregivers who sell marijuana to non-cardholders, including felony penalties and ID card revocation.
- Maine and Vermont have allowed home cultivation since 1999 and 2004, respectively. These laws continue to enjoy strong and broad public support. A February 2012 Public Policy Polling poll in Vermont found 75% support for the state's law.

In summary, although we believe New Hampshire should move forward with ATCs, we believe it is also necessary for the bill to allow limited home cultivation.

**HB 573, Amendment 2013-0478h**  
**A Section-by-Section Overview**

**126-W:1 Definitions**

**"Alternative treatment centers"** must be not-for-profit. ATC agents must be 21 or older and must not have been convicted of a drug-related offense (Page 1: lines 8-13).

**"Cultivation location"** must be locked, enclosed, and reported to DHHS. It "may be a closet, a room, a greenhouse, a building, or another enclosed area that is secured with one or more locks or other security devices" (Page 1, lines 14-18).

A **"designated caregiver"** is optional for a patient who needs help with cultivation. The caregiver must be 21 and never convicted of a drug-related offense (Page 1, lines 20-24).

**"Marijuana"** and **"medical use"** are defined, clarifying that visiting qualifying patients cannot cultivate and that caregivers may not ingest marijuana, although they may engage in "medical use" as defined (Page 1, line 25 to Page 2, line 8).

**"Provider"** is a physician, APRN, or CRNA licensed to prescribe drugs to humans. If the patient's qualifying condition is post-traumatic stress disorder, the provider must be a licensed psychiatrist (Page 2, lines 11-15).

**"Provider-patient relationship"** is defined, requiring physicians to take a medical history, perform a physical examination, review prior treatment, create records, and offer follow-up care. This provision can be expected to stop one area of abuse that has been observed in a few other states, where a small number of unscrupulous doctors have engaged in the practice of writing large numbers of recommendations without actually examining the patients (Page 2, lines 19-28).

**"Qualifying medical condition"** – this definition, which was revised several times last year alone, includes two important parts. (a) is a list of conditions, including multiple sclerosis, Crohn's disease, and HIV/AIDS. (b) is a list of symptoms caused by "a severely debilitating or terminal medical condition or its treatment," including "wasting syndrome, severe 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, severe nausea, severe vomiting, seizures, or severe, persistent muscle spasms" (Page 2, line 29 to Page 3, line 1).

Note: (a) and (b) are tied together by the words "either" in line 29 and "or" in line 33. This is very important because some patients have rare conditions not listed in (a), and in some cases, doctors may not be certain of a diagnosis but believe marijuana may help alleviate a patient's symptoms.

A **"qualifying patient"** possesses a valid **"registry identification card"** issued by DHHS (Page 3, lines 2-6).

**"Seedling," "unusable marijuana," "usable marijuana,"** and **"visiting qualifying patient"** are defined on page 3 (lines 7-17).

A **"written certification"** is provided if, after a full medical assessment "made in the course of a provider-patient relationship of at least 3 months in duration," the provider's professional opinion is that "the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient," and the patient has a qualifying medical condition (Page 3, lines 18-27).

## **126-W:2 Medical Marijuana Protections**

**I. and II.** A qualifying patient is protected from arrest when cultivating or possessing marijuana in compliance with this section. The patient or caregiver may possess up to four mature plants and up to 12 seedlings at the cultivation location reported to DHHS. The patient or caregiver may possess up to six ounces of usable marijuana at the cultivation location, but only two ounces of usable marijuana when not at the cultivation location (Page 3, line 29 to Page 4, line 20).

**III.** A qualifying patient or designated caregiver may give marijuana to a qualifying patient but may not sell the marijuana (Page 4, lines 21-25).

**IV.** A designated caregiver may receive compensation for costs, but not labor (Page 4, lines 26-29).

**V.** Qualifying patients and designated caregivers are "presumed to be lawfully engaged in the medical use of marijuana" if they possess valid ID cards and an amount of marijuana that does not exceed the established limits. This presumption is rebuttable by evidence to the contrary (Page 4, line 30 to Page 5, line 4).

**VI.** Visiting qualifying patients are protected if they produce a valid ID card or its equivalent from another state, along with a statement from their provider indicating that the patient has a qualifying condition under NH law. Visiting qualifying patients may not cultivate marijuana in NH (Page 5, lines 5-12).

**VII.** "A person otherwise entitled to custody of, or visitation or parenting time with, a minor, shall not be denied such a right for conduct allowed under this chapter, and there shall be no presumption of neglect or child endangerment" (Page 5, lines 14-16).

**VIII.** A qualifying patient's use of medical marijuana is considered equivalent to



use of any other medication "for the purposes of medical care, including organ transplants" (Page 5, lines 17-20).

**IX.** "A provider shall not be subject to arrest... prosecution... or denied any right or privilege... solely for providing written certifications" or otherwise suggesting that a patient is likely to benefit from medical marijuana. However, providers may be sanctioned by licensing entities if they fail "to properly evaluate a patient's medical condition" (Page 5, lines 21-28).

**X. and XI.** Alternative treatment centers and alternative treatment center agents are protected from arrest while acting pursuant to this chapter and rules created by DHHS (Page 5, line 29 to Page 6, line 12).

**XII.** Seeds may be donated to ATCs (Page 6, lines 13-17).

**XIII.** Marijuana or related property shall not be seized or forfeited as long as activities remain within those protected by this chapter (Page 6, lines 18-22).

**XIV.** A non-cardholding individual shall not be arrested or prosecuted "simply for being in the presence or vicinity of the medical use of marijuana" (lines 23-27).

**XV.** State and local law enforcement "shall not provide any information from any marijuana-related investigation of the individual or entity to any law enforcement agency that does not recognize the protection of this chapter." This does not apply if the "agency has probable cause to believe the person is distributing marijuana to a person who is not allowed to possess it under this chapter" (Page 6, lines 28-37).

**XVI.** "A person who ceases to be a qualifying patient or designated caregiver shall have 10 days after notification by the department to dispose of marijuana" in one of four specified ways (Page 7, lines 1-11).

### **126-W:3 Prohibitions and Limitations on the Use of Medical Marijuana**

**I.** "A qualifying patient may use medical marijuana on privately owned real property only with the permission of the property owner" or tenant. If smoking violates a tenant's lease, a qualifying patient may consume by ingesting or vaporizing the marijuana. Vaporization means heating the marijuana to a temperature below the point of combustion and inhaling the vapors, and is a healthier alternative to smoking (Page 7, lines 13-21).

**II.** "Nothing in this chapter shall exempt any person from arrest or prosecution for" being under the influence while "operating a motor vehicle," being "in his or her place of employment, without the written permission of the employer," or "operating heavy machinery." Patients and caregivers are not protected if they exceed the limits or if the patient smokes "in any public place" (Page 7, line 22 to Page 8, line 1).

III. "Nothing in this chapter shall be construed to require" ... "any health insurance provider... to be liable for any claim for reimbursement," or to require that property owners allow marijuana use by "a guest, client, customer, or other visitor," or to require that employers accommodate medical use of marijuana at any place of employment, or any jail or penal institution (Page 8, lines 2-11).

IV. Fraudulent representation to a law enforcement official of any fact or circumstance relating to the medical use of marijuana to avoid arrest or prosecution shall be punishable by a fine of \$500," plus any other penalties that may apply (Page 8, lines 12-15).

V. A patient or caregiver who leaves home possessing marijuana without his or her ID card may be subject to a \$100 fine (Page 8, lines 16-18). (Note: This was requested by the Association of Police Chiefs and added to the bill last year.)

VI. "Any qualifying patient or designated caregiver who sells marijuana to another person who is not a qualifying patient or designated caregiver" is subject not only to the usual felony provided in RSA 318-B:26, but also the enhanced penalty specified in RSA 318-B:26, IX-a, along with having his or her ID card revoked (Page 8, lines 19-22).

VII. DHHS may revoke cards for violations of this chapter (Page 8, lines 23-25).

#### **126-W:4 Departmental Administration, Registry Identification Cards**

I. DHHS shall issue a registry identification card to qualifying patients who submit the correct information, including a written certification and a fee. The patient may designate a caregiver and/or designate no more than one ATC. The applicant must sign a statement pledging not to divert marijuana and acknowledging that he or she understands the enhanced felony for diversion, in addition to other penalties for illegal sale (Page 8, line 27 to Page 9, line 7).

II. DHHS shall issue a registry identification card to a designated caregiver if he or she provides the correct info, including a complete set of fingerprints and a signed statement pledging not to divert marijuana. Applicants to become designated caregivers "shall submit to a state and federal criminal records check" (Page 9, line 8 to Page 10, line 3).

III. DHHS shall approve or deny an application for a qualifying patient within 15 days and for a designated caregiver within 45 days (Page 10, lines 4-13).

IV. DHHS shall issue ID cards to applicants within 5 days of approval. Cards expire in one year, unless the provider specifies an earlier date in the written certification. Cards shall include name, mailing address, date of birth, dates of issuance and expiration, a random, unique 10 digit ID number, the registry

number for a designated ATC (if any), a photograph, and statements explaining what protections apply to the cardholder. The caregiver can only grow if the patient hasn't designated an ATC, and a patient can only grow if he or she does not have a designated caregiver (Page 10, line 14 to Page 11, line 6).

V. For patients under 18 years of age, the applicant's provider must explain the potential risks and benefits to the responsible parent or guardian. The responsible parent or guardian must consent in writing to allow and control the patient's use of medical marijuana (Page 11, lines 7-18).

VI. DHHS shall provide each approved applicant a statement explaining federal law, and that state law does not protect them from federal penalties (Page 11, lines 19-22).

VII. and VIII. DHHS shall track the number of patients who designate ATCs and send a monthly written statement to ATC with the registry numbers of each patient. DHHS shall also notify ATCs when patients who designate them revoke the designation or cease to be qualifying patients (Page 11, lines 23-37).

IX. Qualifying patients must notify DHHS before changing designated caregivers or ATCs, and before changing cultivation locations. If the patient's provider notifies DHHS in writing that the patient no longer suffers from the qualifying condition or that he or she no longer believes the patient would benefit from medical marijuana, the patient's card shall be voided by the department. DHHS shall issue new cards when patients' information changes. Patients who fail to notify the department of changes may be fined up to \$150. In the event of a lost card, the patient or caregiver shall notify the department within 10 days to receive a new card (Page 12, lines 1-25).

X. An ID card or application shall not constitute probable cause for a search (Page 12, lines 26-30).

XI. DHHS shall create and maintain a secure, confidential registry of qualifying patients and designated caregivers. If a local or state law enforcement officer affirms that he or she has probable cause to believe marijuana is being cultivated at a specific address or by a specific individual, the department may disclose whether the person or location is registered (Page 12, line 31 to Page 13, line 21).

XII. A surviving family member or other person must notify the department within 5 days of a qualifying patient's death, and marijuana must be disposed of or removed in accordance with rules (Page 13, lines 22-27).

There are three sections to the affirmative defense. The first affirmative defense (I.) is available to qualifying patients and caregivers who are arrested despite compliance with the law. In other words, this only applies to patients and caregivers who were not supposed to have been arrested in the first place and who were erroneously or wrongfully arrested (Page 13, line 29 to Page 14, line 4).

The second defense (II.) is available to patients who qualify for a registry identification card and have submitted their paperwork, but have not yet received their ID cards. These patients will only have a defense available, and thus would still face the trauma of an arrest, the stress of a trial, and the expense of obtaining a lawyer. However, some desperate patients who need marijuana to maintain their weight or to treat unbearable pain will not be able to wait the 15-20 days it will take to obtain an ID card. If they are unable to wait, this defense provides the patient with some relief without burdening police officers with determining who is and who is not qualified before the patient has an ID card. The patient must have submitted a valid application, must have no more marijuana than is otherwise allowed, and must comply with all the law's restrictions. This defense is only available to patients, not caregivers (Page 14, lines 5-22).

The final defense (III.) is also available only to patients, not caregivers. It applies to patients who qualify for ID cards while they wait for the health department to set up regulations and begin issuing ID cards. Like the defense in 126-W:5 (II), this would only prevent a conviction — not an arrest. Patients would have the burden of proving they have the required documentation, that they were complying with the restrictions in the law, and that they have a permissible amount of marijuana. In New Jersey, the health department took more than two years to implement the state's medical marijuana law. In the meantime, a multiple sclerosis patient named John Wilson was convicted of growing medical marijuana and was sentenced to five years in prison. This affirmative defense would prevent similar tragedies. The sole purpose of this last defense is to protect patients between when the law passes and when ID cards are available (Page 14, line 23 to Page 15, line 8).

#### **126-W:6 Departmental Rules**

I. and II. DHHS shall adopt rules within 90 days of passage regarding applications for registry identification cards. The department shall establish application and renewal fees. Fees from ID cards and ATCs "shall generate revenues sufficient to offset all state expenses of implementing and administering this chapter" (Page 15, lines 10-20).

III. DHHS shall adopt rules governing ATCs within one year of passage, as prescribed in this section (Page 15, line 21 to Page 16, line 15).

#### **126-W:7 Departmental Administration, Alternative Treatment Centers**

I. DHHS shall begin accepting applications for ATCs within 30 days of adoption of rules governing ATCs (Page 16, lines 17-18).

II., III., and IV. "Within 18 months of the effective date of this section, provided that at least 5 applications have been submitted that score sufficiently high to

receive a certificate," DHHS shall issue certificates to the five highest-scoring applicants. Any time a certificate is revoked or expires, or if at any time fewer than five ATCs hold certificates, DHHS shall accept applications for a new ATC, such that there will never be more than 5 ATCs (Page 16, lines 19-30).

**V.** ATC applicants must submit detailed plans and supporting materials, along with a fee, as described (Page 16, line 31 to Page 17, line 24).

Decisions will be made based on an "impartial and numerically scored competitive bidding process developed by the department" and based on the criteria described here: suitability of location (including input from cities and towns), the ATC's plan for operations and services, the applicant's experience, security plans, etc. (Page 17, line 25 to Page 18, line 23).

**VI., VII., and VIII.** After an ATC is approved, it must submit a registration and regulation fee. Info about ATC applicants is confidential except in cases described here. An ATC registration may be revoked if it commits a serious violation of the rules. (Page 18, lines 24 to Page 19, line 4).

**IX., X., and XI.** Each ATC shall pay an annual fee as determined by DHHS, and DHHS shall evaluate each ATC each year. ATCs shall be subject to reasonable inspection (Page 19, lines 5-18).

#### **126-W:8 Alternative Treatment Centers; Requirements**

**I., II., III., IV., and V.** ATCs must be non-profit, not within a residential district or within 1,000 feet of primary or secondary schools. ATCs shall conduct background checks on employees and not hire persons under 21 or who have any drug related convictions. Employees must wear ID badges (Page 19, line 20 to Page 20, line 8).

**VI., VII., and VIII.** ATCs must keep accurate records of each transaction and conduct monthly inventories, following each plant from seedling to the point of sale (Page 20, lines 9-25).

**IX.** ATCs shall submit an incident report form on the business day following any reportable incident, including theft, diversion, and other rules violations (Page 20, lines 26-36).

**X., XI., XII., and XIII.** ATCs may not use pesticides unless they become authorized for application on marijuana. No marijuana or paraphernalia may be visible from outside the property of an ATC. ATCs shall submit annual reports providing information required by the department to evaluate its operations. ATC agents must consult records with every sale to make sure the patient is not receiving more marijuana than permitted in a 10-day period (Page 20, line 37 to Page 21, line 20).

**XIV.** Marijuana transported from the grow facility to the ATC by ATC agents, or dispensed, must be labeled with a detailed trip ticket (Page 21, lines 21-36).

**XV.** ATCs shall not possess more than 80 plants, 160 seedlings, and 80 ounces of usable marijuana OR 4 mature plants, 12 seedlings, and 6 ounces for each patient who has designated the ATC, whichever amount is greater (Page 21 line 37 to Page 22, line 18).

**XVI.** All marijuana dispensed must be labeled by weight. Labels must also include information on the enhanced penalty for diverting medical marijuana. ATCs must provide educational materials to patients and caregivers, as described (Page 21, line 19 to Page 23, line 5).

**XVII.** ATCs must develop and maintain employee and agent policies as required, including training in adherence to confidentiality laws, security measures, and emergency response procedures (Page 23, lines 6-22).

**XVIII.** A provider shall not have an economic interest in an ATC, as specified (Page 23, lines 23-31).

#### **126-W:9 Annual Report**

**I.** DHHS shall report annually on the following: the ability of patients in all areas of the state to access medical marijuana, the effectiveness of ATCs individually and together, provider participation, the number of patients and caregivers by county, sufficiency of regulatory safeguards, any illegal diversion, and any other issues (Page 23, line 32 to Page 24, line 16).

#### **126-W:10 Registry Identification Card and Certificate Fund**

**I.** A fund is established for this program so fees will have a place to go. The money remains with DHHS, which is required to set fees sufficient to offset all state expenses associated with administering this chapter (Page 24, lines 17-28).

#### **Amendment to RSA 318-B:2 and B:26**

**I-b.** This is the enhanced diversion penalty. Any qualifying patient or caregiver who sells marijuana to a person who is not a qualifying patient or caregiver is guilty of a new felony, in addition to the usual felony for selling marijuana. RSA 318-B:26 is also amended to reflect this change. (Page 24, line 29 to Page 25, line 5).

**Effective Date.** The effective date of this bill is immediate upon passage (line 5).

*Chair*

**ATTORNEY GENERAL  
DEPARTMENT OF JUSTICE**

33 CAPITOL STREET  
CONCORD, NEW HAMPSHIRE 03301-6397

**MICHAEL A. DELANEY**  
ATTORNEY GENERAL



**ANN M. RICE**  
DEPUTY ATTORNEY GENERAL

February 27, 2013

Hon. James McKay, Chair  
House Committee on Health, Human Services,  
and Elderly Affairs  
Room 205  
Legislative Office Building  
Concord, New Hampshire

Re: House Bill 573, relative to the use of marijuana for medicinal purposes.

Dear Representative McKay:

I am writing on behalf of the Attorney General in opposition to House Bill 573, as amended, which would make marijuana legal under State law when it is prescribed for medical conditions. I expressed the Office's opposition to House Bill 573 at the hearing on February 21, but I did not have the amended version. At that time, Representative Laurie Harding asked me to review the amended bill and provide this Committee with my thoughts. Although the bill is different in many respects from the predecessor, it raises many of the same concerns.

I will not enumerate all of the issues that this proposed legislation raises. I have reviewed the bill, however, and in this letter I am offering some specific examples of those of problematic issues.

First, the Attorney General's Office opposes House Bill 573 in part because it would legalize marijuana for medical use, which would not promote public safety in our State. As I noted in my remarks, marijuana is a drug. It has been used by the driver in 20 percent of all fatal car crashes in New Hampshire. For a state that faces serious addiction issues, it is not in the interest of public safety to legalize this drug. Others at the hearing testified as to the adverse effects of marijuana, particularly on the development of the brain. I will not repeat their testimony here. Suffice it to say that the drug is not a benign substance. To the contrary, it poses many health risks and its use, cultivation, and distribution is rightly prohibited.

Passage of the bill would mislead the public by creating a false impression that the drug is, in fact, legal for medical use. Yet, marijuana would continue to be illegal under federal law, and would continue to subject users, cultivators, and distributors to severe criminal penalties in the federal courts, as well as civil forfeiture.

With respect to the particular provisions of the bill, there are a number of concerns. First, while this version does prohibit a person who has been convicted of a drug-related offense from becoming an alternative treatment center agent, Section 126-W: 1, II, it does not prevent persons who have been convicted of other crimes from becoming involved in a center. Convicted rapists, those who have committed crimes involving fraud or dishonesty, and other felons could become involved in these centers. It is not in the best interests of the citizens of New Hampshire to allow people who have committed these kinds of crimes to become involved in an endeavor of this nature.

The bill offers protection to patients and providers from prosecution by state and local law enforcement. *See* Section 126-W: 2, I. These sections, however, cannot provide protection from federal prosecution. It is also not clear what a law enforcement officer would be expected to do if served with a federal grand jury subpoena after he or she became aware of the use or distribution of marijuana under this bill. Under Section 126-W: 2, XV, the law enforcement officer "shall not provide any information... to any law enforcement agency that does not recognize the protection of this chapter." As I read the bill, it would require the officer to refuse to testify and thereby risk contempt of court in federal court or to face prosecution under State law. ("[A]ny prosecution of the individual or entity for a violation of this chapter shall be conducted pursuant to the laws of this state.").

The bill is inadequate to prevent the unauthorized distribution of the marijuana grown for medical use. For example, in Section 126-W: 2, XVI, a person who ceases to be a qualified patient or a designated caregiver may dispose of marijuana in one of four ways, only one of which involves law enforcement. Under this law, a person could turn the marijuana over to the new caregiver, mix it with other ingredients to render it unusable, or donate the marijuana to a qualifying patient. I can think of no other circumstance where a patient, who has been prescribed a controlled substance, can "donate" the balance of that substance to another patient after his or her use for the substance has concluded. To the contrary, "donating" a controlled substance to another person, without even the knowledge of the treating physician, is illegal under both State and federal law.

Please do not hesitate to contact me with any questions.

Sincerely yours,



Elizabeth C. Woodcock  
Assistant Attorney General  
Criminal Justice Bureau



## HB573 Suggestions

- Change the title to "Therapeutic Use of Cannabis" or "Therapeutic Use of Herbal Marijuana."
- Dispensing should be by the state (or contracted out by the state) or if privately owned, be non-profit.
- Preferably a mobile van to allow rural patients access without having to grow their own.
- Limit the amount a patient or caregiver may possess... like Vermont.
- Include an Advisory Committee to assist DHHS, much like the PMP Advisory Council under RSA 318-B:38.
- Limit the indications for use.
- The practitioner should qualify the patient for a certificate; not attest that the patient will likely benefit from cannabis use.
- Delete all references to "visiting qualifying patient."

## MM Advisory Committee

There shall be established a advisory committee for NH's medical marijuana program under the HHS oversight committee (RSA 126—).

Reports shall be submitted in June & December, & ~~also~~ posted on the general court web site & distributed to the Governor & the chair of the HHS oversight committee.

### Committee membership:

- 1) 2 members of the House
- 2) 1 member of the Senate
- 3) commissioner of HHS or designee
- 4) commissioner of DOS or designee
- 5) 2 ~~representatives~~ physicians designated by NHMS
- 6) 1 APRN designated by the NHNP Association.
- 7) 1 ~~representative~~ <sup>representative</sup> of the NH Chiefs of Police
- 8) 1 representative of New Futures
- 9) 1 representative appointed by the AG's office

### Duties

- 1.) oversees the development of guidelines for providers
- 2.) monitor & consult around the rulemaking process
- 3.) Track & analyze any indications that there is an increase in inappropriate use of medical marijuana.
- 4.) evaluate ongoing concerns related to law enforcement and the attorney general's office & department of safety.
- 5.) develop quality indicators for the effectiveness of NH's medical marijuana program



## New Hampshire Survey Results

**Q1** Do you support or oppose changing the law in New Hampshire to allow seriously and terminally ill patients to use medical marijuana if their doctors recommend it?

Support .....68% Not sure ..... 5%  
Oppose .....26%

**Q2** Which do you believe is a safer treatment for debilitating pain: the medical use of marijuana or Oxycontin?

Marijuana .....70% No opinion/Don't know .....11%  
Oxycontin .....19%

**Q3** Would you be more or less likely to vote for your state legislator if he or she voted to allow the medical use of marijuana?

More likely .....52% Not sure .....21%  
Less likely .....27%

**Q4** Which do you believe is safer: marijuana or alcohol?

Marijuana .....47% No opinion/Don't know .....30%  
Alcohol .....23%

**Q5** Current New Hampshire law provides for a jail term of up to one year and a fine of up to \$2,000 for simple possession of marijuana. Would you support or oppose a change in the law to provide for a fine of up to \$100 without jail time or the threat of arrest for those who possess an ounce or less of marijuana for personal use?

Support .....62% Not sure .....11%  
Oppose .....27%

**Q6** Two states -- Colorado and Washington -- recently changed their laws to allow marijuana to be regulated and taxed similarly to alcohol, for legal use by adults age 21 and older. Would you support or oppose changing New Hampshire law to regulate and tax marijuana similarly to alcohol, where stores would be licensed to sell marijuana to adults 21 and older?

Support .....53% Not sure .....10%  
Oppose .....37%

**Q7** If you are a woman, press 1. If a man, press 2.

Woman .....50%  
Man .....50%

**Q8** If you are a Democrat, press 1. If a Republican, press 2. If you are an independent or identify with another party, press 3.

Democrat .....33%  
Republican .....29%  
Independent/Other .....38%

**Q9** If you are 18 to 34 years old, press 1. If 35 to 49, press 2. If 50 to 64, press 3. If you are 65 or older, press 4.

18 to 34 .....16%  
35 to 49 .....30%  
50 to 64 .....35%  
65 or older .....19%





**Crosstabs**

	Base	Gender	
		Woman	Man
<b>Support/Oppose Medical Marijuana</b>			
<b>Support</b>	68%	71%	65%
<b>Oppose</b>	26%	23%	30%
<b>Not sure</b>	5%	6%	5%

	Base	Gender	
		Woman	Man
<b>Safer Treatment: Marijuana or Oxycontin</b>			
<b>Marijuana</b>	70%	71%	68%
<b>Oxycontin</b>	19%	17%	21%
<b>No opinion/Don't     know</b>	11%	12%	11%

	Base	Gender	
		Woman	Man
<b>More/Less Likely to Vote for Pro- Marijuana Legislator</b>			
<b>More likely</b>	52%	52%	52%
<b>Less likely</b>	27%	23%	30%
<b>Not sure</b>	21%	24%	18%

	Base	Gender	
		Woman	Man
<b>Safer: Marijuana or Alcohol</b>			
<b>Marijuana</b>	47%	47%	46%
<b>Alcohol</b>	23%	16%	29%
<b>No opinion/Don't     know</b>	30%	37%	25%





**Crosstabs**

	Base	Gender	
		Woman	Man
<b>Support/Oppose Lower Fine, No Jail Time</b>			
Support	62%	62%	63%
Oppose	27%	24%	31%
Not sure	11%	14%	7%

	Base	Gender	
		Woman	Man
<b>Support/Oppose Regulating/Taxing Marijuana like Alcohol</b>			
Support	53%	49%	57%
Oppose	37%	38%	35%
Not sure	10%	13%	7%

	Base	Party		
		Democrat	Republican	Independent/Other
<b>Support/Oppose Medical Marijuana</b>				
Support	68%	80%	52%	71%
Oppose	26%	17%	40%	23%
Not sure	5%	3%	8%	6%

	Base	Party		
		Democrat	Republican	Independent/Other
<b>Safer Treatment: Marijuana or Oxycontin</b>				
Marijuana	70%	78%	58%	70%
Oxycontin	19%	15%	29%	15%
No opinion/Don't know	11%	6%	13%	15%





**Crosstabs**

	Base	Party		
		Democrat	Republican	Independent/Other
<b>More/Less Likely to Vote for Pro-Marijuana Legislator</b>				
More likely	52%	65%	37%	54%
Less likely	27%	18%	42%	23%
Not sure	21%	18%	21%	24%

	Base	Party		
		Democrat	Republican	Independent/Other
<b>Safer: Marijuana or Alcohol</b>				
Marijuana	47%	56%	37%	45%
Alcohol	23%	16%	32%	22%
No opinion/Don't know	30%	28%	31%	32%

	Base	Party		
		Democrat	Republican	Independent/Other
<b>Support/Oppose Lower Fine, No Jail Time</b>				
Support	62%	71%	50%	64%
Oppose	27%	21%	37%	25%
Not sure	11%	8%	12%	12%

	Base	Party		
		Democrat	Republican	Independent/Other
<b>Support/Oppose Regulating/Taxing Marijuana like Alcohol</b>				
Support	53%	60%	45%	53%
Oppose	37%	29%	49%	34%
Not sure	10%	11%	6%	13%





**Crosstabs**

	Base	Age			
		18 to 34	35 to 49	50 to 64	65 or older
<b>Support/Oppose Medical Marijuana</b>					
Support	68%	72%	62%	73%	66%
Oppose	26%	23%	32%	22%	29%
Not sure	5%	6%	5%	5%	5%

	Base	Age			
		18 to 34	35 to 49	50 to 64	65 or older
<b>Safer Treatment: Marijuana or Oxycontin</b>					
Marijuana	70%	75%	64%	75%	63%
Oxycontin	19%	18%	20%	16%	25%
No opinion/Don't know	11%	7%	16%	9%	12%

	Base	Age			
		18 to 34	35 to 49	50 to 64	65 or older
<b>More/Less Likely to Vote for Pro-Marijuana Legislator</b>					
More likely	52%	66%	42%	55%	51%
Less likely	27%	23%	31%	23%	29%
Not sure	21%	11%	27%	21%	20%

	Base	Age			
		18 to 34	35 to 49	50 to 64	65 or older
<b>Safer: Marijuana or Alcohol</b>					
Marijuana	47%	63%	38%	47%	44%
Alcohol	23%	23%	25%	20%	25%
No opinion/Don't know	30%	14%	38%	32%	31%





**Crosstabs**

	Base	Age			
		18 to 34	35 to 49	50 to 64	65 or older
<b>Support/Oppose Lower Fine, No Jail Time</b>					
Support	62%	65%	57%	68%	59%
Oppose	27%	31%	33%	21%	27%
Not sure	11%	4%	10%	12%	15%

	Base	Age			
		18 to 34	35 to 49	50 to 64	65 or older
<b>Support/Oppose Regulating/Taxing Marijuana like Alcohol</b>					
Support	53%	69%	51%	53%	43%
Oppose	37%	30%	39%	34%	45%
Not sure	10%	1%	10%	13%	12%





**Francis Paine**  
**19 Squam Lake Road**  
**Center Sandwich, NH 03227**  
**E-mail: fpainestam@gmail.com**  
**Phone: (603) 284-6433**  
**Mobile: (203) 952-1365**

---

I am a case study in the impact of chronic pain. It is not a life-threatening condition, but a comfort-threatening condition that prevents me from being all that I could be for myself, my family, and the community in which I live. It is a condition that I have lived with, with no substantive change, for almost twenty years, despite attempting every legal line of treatment known to me. It is my hope that at long last, a new (to me) course of treatment may finally be effective: perhaps with medical marijuana.

### Educational and Work Background

Prior to becoming disabled, I was always a high achiever and had lots of stamina, physical energy and intellectual capacity. Now 66 years old, I have been largely self-made, and have a strong background in international affairs, business, banking, music, not-for-profit operations, and intellectual history.

For high school, I was awarded a scholarship to the Pomfret School, a private boy's school in Pomfret, CT, where I was first introduced to the French language and literature, international affairs, creative writing, music, and intellectual history, interests that are all still with me. After I graduated from Pomfret, I was admitted to Stanford University, in Stanford, CA, where I pursued a course of study in Political Science, with an emphasis on international relations and studies of the communist system. I graduated from Stanford with an AB degree in Political Science, in January 1968.

In March 1968 (following my marriage in February of that year), I went on active duty with the U.S. Army Security Agency as a volunteer. The Army sent me to the Defense Language Institute, at the Presidio of Monterey, CA, for a 24 week course of study in the Portuguese language. I was first in my class with a mark of 97. This language study proved useful to me not only in the Army, but also in later years, when I had a need to travel to Brazil and Portugal on business.

Following my language study, the Army assigned me to the National Security Agency, Fort George G. Meade, MD. I served at the National Security Agency until December 1971, the remainder of my term of service. I attempted to volunteer to serve in Vietnam, but was informed that in order to do so, I would have to re-enlist. This I did not wish to do, so instead, I requested and was given a three month "early out" – in effect, a reduction of my term of service. My rank was Specialist 5 at my expiration term of service, and my discharge was honorable.

I had originally planned to attend law school upon reaching my expiration term of service. However, I was not admitted to any of the law schools that I had an interest in attending, and so I took what was intended to be a temporary job as a bank teller in Torrington, CT. In that job, I became interested in banking as a business, and saw an opportunity to develop a career in international banking.

**Francis Paine**  
**19 Squam Lake Road**  
**Center Sandwich, NH 03227**  
**E-mail: fpainestam@gmail.com**  
**Phone: (603) 284-6433**  
**Mobile: (203) 952-1365**

---

Accordingly, I requested and was granted transfer to a management training program at the Hartford National Bank's head office in Hartford. I spent the next approximately four years as a Senior Credit Analyst in its Credit Department. The bank was at that time new to international business, and I was a one of three people chosen to set up a credit analysis desk that would support the bank's international business.

While employed by Hartford National, I enrolled in the University of Connecticut's School of Business Administration in Hartford. At the time, this was the best rated business administration program in Connecticut. I pursued a Masters Degree in Business Administration, with a major in Finance. I completed the Masters Degree requirements in January 1976 with a straight A average, and was first in my class. I was given the Wall Street Journal Student Achievement Award, and elected to Beta Gamma Sigma, the national honorary association for students of business administration. By the later stages of the MBA program, I had realized that the possibilities for a significant international career in a Hartford bank would be very limited. I stayed until I had finished the degree, and then immediately began a search for an international banking position in New York City, where it appeared to me that the possibilities were much greater. This proved to be correct, and accordingly, the rest of my career had a New York base.

During the years 1976 to 1990, I was employed by three major international banking organizations, and spent about fifteen months attempting to establish my own merchant banking organization. Much of this time, my business involved providing banking services to the international commercial shipping industry. I was also engaged in shipping industry journalism, and wrote what is still regarded as the definitive book on the subject of financing ship purchases, as well as about twenty articles that were published in a major shipping industry bi-weekly magazine, and other well-known business magazines.

In my last banking job, I reverted to the credit risk management aspect of my background, and became the chief credit officer for North America for a London based merchant bank controlled by the central bank of Saudi Arabia, and managed by J. P. Morgan. I also, however, assisted the bank with its very small exposure to the shipping industry. In mid-1990, I was let go as part of a general downsizing, which led to an extended period during which, in common with thousands of other commercial bankers, I was unemployed.

In 1992, Congress, in response to the Bank of Credit & Commerce International scandals, enacted a bill that assigned regulatory responsibility for all foreign banks doing business in the United States to the Federal Reserve System. Since the bulk of these operations were in New York, the Federal Reserve Bank of New York (hereinafter "FRBNY") had a sudden requirement to staff up to meet these new responsibilities.

In the spring of 1992, FRBNY placed a recruitment advertisement in the Wall Street Journal. In response, it received approximately 22,000 resumes, reflecting the state of unemployment in the banking industry. FRBNY interviewed about 2,000 of these (including me), and hired about 200 (including me).

**Francis Paine**  
**19 Squam Lake Road**  
**Center Sandwich, NH 03227**  
**E-mail: fpainestam@gmail.com**  
**Phone: (603) 284-6433**  
**Mobile: (203) 952-1365**

---

I commenced my employment at FRBNY in November 1992 with the title of Senior Bank Examiner. My commission as an examiner for the Federal Reserve System, which I still had when I went on disability, was granted immediately, which was rather unusual. I was very proud of this: usually, people joining from the private sector are required to complete a course of study and pass a series of examinations before they are granted their commissions.

I spent most of the next 16 ½ years in various aspects of the supervision of foreign banks doing business in the U.S. My work fell into two major segments, more or less evenly divided in longevity. In the first segment, I was strictly a field examiner, performing varying aspects of bank examinations, including acting about 75% of the time as Examiner-in-Charge. In the second segment, my title was changed to that of Relationship Specialist, which meant that I was the principal interface between FRBNY and various and changing portfolios of foreign banks, and also with these banks' home country regulators. I was also the Examiner-in-Charge of the annual examinations of the banks under my responsibility, and, particularly in the later years, participated in annual visitations to the head offices of these banks.

In common with many other employees of FRBNY, I was in downtown New York City, only three blocks from "Ground Zero" during the 9/11/2001 attacks on the World Trade Center. I still experience image flashes from that experience.

Some significant examples of my accomplishments during this period at FBRNY were:

- a) playing a major role in the regulatory approval of a major Spanish bank's acquisition of a bank holding company in the southern U.S.;
- b) playing a leading role in the examinations and decision making concerning the presence of Iranian banks in the U.S., the result of which was that these banks were forced to close all active banking operations here;
- c) supervising and monitoring the operations of Turkish banks at a time when Turkey was suffering severe balance of payments problems;
- d) discovering major weaknesses in the anti-money laundering and accounting operations of an Asian bank, and supervising their correction;
- e) inducing a Canadian-owned broker-dealer to institute a credit risk management program, thus avoiding major losses;
- f) discovering anti-money laundering and operational controls weaknesses at a major Iberian bank, and supervising their correction;

**Francis Paine**  
**19 Squam Lake Road**  
**Center Sandwich, NH 03227**  
**E-mail: fpainestam@gmail.com**  
**Phone: (603) 284-6433**  
**Mobile: (203) 952-1365**

---

- g) identifying credit risk management weaknesses at two other Iberian banks, and supervising their correction;
- h) supervising Middle Eastern banks, particularly for anti-money laundering weaknesses, in the period following the September 11, 2001 attacks; and
- i) being one of the first examiners to assume responsibilities for foreign banks' entire U.S. operations, rather than just what was in New York City.

In addition to the forgoing, I was an active instructor in the training operations of the Federal Financial Institutions Examinations Council, a multi-agency training facility. The main course that I helped to teach, because of my heavy credit risk management experience, was the Credit Risk Analysis School, but I also taught (or assisted in teaching) courses on the examination of foreign banks (particularly the trade finance segment), and report writing.

#### The Beginnings of My Chronic Pain

This is the history, as best I can recollect it, of my pain problems. I first became aware of my chronic pain symptoms upon returning from a short business trip (for the purpose of a job interview) to Bahrain in the spring of 1994. I experience constant (though varying in intensity) pain in the midsection of my body, from hip to hip on a horizontal basis, and from levels 3 to 5 of my spinal cord on a vertical basis, as well as down into the middle of both buttocks. I have been treated for it by the medical profession for almost 19 years, and no practitioner has been willing diagnose it as anything other than just pain. I have unilaterally decided to refer to it as chronic pain syndrome ("CPS"). One doctor guessed that it was attributable to a very old injury sustained in a pick-up game of basketball in 1986. However, it is worth noting that one of my two sisters suffers from a very similar condition, and that a number of members of my extended family have experienced serious back problems, most having required major surgery. This suggests a genetic factor.

As noted above, the pain I experience has been continuous since then, and frequently fluctuates within the day: for example, the pain tends to worsen in the later part of the day, suggesting a cumulative effect. The level of pain also varies depending on what I attempt to do. Twisting motions of the torso, leaning over, excessive lifting, or excessive standing, for example, all tend to be followed by aggravated pain levels.

The pain management profession uses a scale of 1 to 10 (with 10 being the worst) to assess the level of pain at any given time. For me, when my pain is at a level 8, I am largely dysfunctional, and can only sit in an armchair and wait for the pain to ebb down. When I first became aware of the condition, I felt that my average pain level vacillated from 3 to 4, with "spikes" (what the pain management profession refers to as breakthrough pain) to 6 or 7. Now, I feel that my average pain level is between 7 and 9, with spikes to 10. At very high pain levels, the pain is frequently accompanied by nausea.

**Francis Paine**  
**19 Squam Lake Road**  
**Center Sandwich, NH 03227**  
**E-mail: fpainestam@gmail.com**  
**Phone: (603) 284-6433**  
**Mobile: (203) 952-1365**

---

Pain levels like these severely restrict what I can do without suffering pain. For example, I cannot stand for more than 15 minutes without significantly aggravating the pain level. Walking, being a vertical exercise, suffers from the same limit as standing. I cannot walk for more than 15 to 20 minutes before needing to rest from the pain. In addition, any twisting motion, such as is needed to look backwards while driving a car, inevitably makes me "pay the price", where I will experience a spike of pain following the motion. I also "pay the price" even when leaning slightly, such as when I am washing dishes or running a vacuum cleaner. Lifting a bag of groceries, is also problematic – though I have the muscular strength, this action always aggravates the pain. I have also found that stress aggravates my pain levels.

#### Treatment of My Chronic Pain Condition

This is the history, as best I can recollect it, of the treatment of my pain problems. In 1994, I sought advice and treatment from Dr. Neil Dreyer, my primary care physician in Stamford, CT. Dr. Dreyer prescribed an anti-inflammatory, which was not effective. Dr. Dreyer also prescribed a course of physical therapy. I completed the full physical therapy course, with no relief.

Subsequently, Dr. Dreyer referred me to Dr. Henry Rubinstein, an orthopedist in Stamford, CT, where I underwent three rounds of injection therapy into the right hip area, as well as x-rays and an MRI. The X-rays and MRI were inconclusive, and I did not experience any relief from the injections. Dr. Rubinstein referred me to another physician (whose name I cannot recall), for the purpose of administering epidurals. After undergoing three rounds of epidurals, I experienced only very limited relief and that too, was short term. I returned to Dr. Rubenstein, where we discussed the possibility of major back surgery as a means for reducing my pain. Dr. Rubenstein referred me to a neurologist, Dr. Evangelos Xistris, who did not offer any useful conclusions, but offered the opinion that surgery was not yet appropriate. Dr. Xistris then referred me to the Yale Pain Management Center (YPMC).

I met with Dr. Lloyd Saberski at YPMC, who diagnosed me with a damaged ilio lumbar ligament. Dr. Saberski recommended that I get new orthotics, and referred me to an osteopath, Dr. Ted Strayer. I had new orthotics made by Dr. Jeffrey Gross, a podiatrist. I undertook a course of treatment with Dr. Strayer, which consisted of three main things: a) a course of injection therapy (Lanocaine initially, then Lanocaine plus a steroid) into the right hip/buttock area, which was intended to relax what was perceived to be a hard/tight muscle or other mass; b) a course of massage therapy aimed at the hard/tight muscle or other mass; and c) prescription of Nortriptyline and Amitriptyline. None of these treatments was effective and by mutual agreement, the treatment was discontinued.

Thereafter, I went to a chiropractor, Dr. Brian MacKay, in Darien, CT, originally for treatment of migraine headaches, in which he specialized. We also discussed the back issues, and we tried for 18 months or so, a course of treatment consisting of: a) specialized physical therapy; b) massage; and c) chiropractic adjustments. These helped the migraines, but were ineffective for the back, and hence were stopped. Dr. MacKay was one of the first doctors in Connecticut to acquire DRS

**Francis Paine**  
**19 Squam Lake Road**  
**Center Sandwich, NH 03227**  
**E-mail: fpainestam@gmail.com**  
**Phone: (603) 284-6433**  
**Mobile: (203) 952-1365**

---

equipment,<sup>1</sup> and we tried a course of treatment with that. Instead of helping the problem, it exacerbated it, and once again, treatment was discontinued.

On the recommendation of a friend, I went to Jacques Depardieu's Center for Integrative Chinese Medicine in Darien, CT. With Mr. Depardieu, I undertook a course of herbal supplements, acupuncture, and acupressure. Mr. Depardieu detected the same hard/tight muscle or mass as Dr. Strayer. The acupressure, which is basically hard massage, was intended to relieve/relax it. The course of treatment was not effective, and by mutual agreement, treatment was discontinued.

By this time, I had been struggling with this problem – this pain – for almost ten years. In seeking possible new possible solutions, I read an article about spinal cord stimulators ("SCS"). After consulting further with Dr. Dreyer, I became a patient of The Pain Management Center of Stamford, and came under the care of Dr. David Xiong. Dr. Xiong explained that the SCS could only be prescribed as a sort of last resort, after other options had failed. We proceeded on a course of treatment that involved injections of Lanocaine and steroid into the right hip/buttock general area, and prescription of an anti-inflammatory. These were ineffective. We then moved to the prescription of narcotic pain relievers to manage the pain symptoms.

At this point, having tried, as far as I knew, every other option than surgery, I sought a consultation with Dr. Corey Rosenstein, a neurosurgeon, in the fall of 2004, in order to assess whether the surgical option had reasonable prospects of success. After appropriate diagnostic measures (x-ray, MRI, etc.), he and his partner for such surgeries, Dr. Rudolph Taddonio, opined that they thought I was good candidate for successful spinal disk fusion surgery at L-3, L-4, and L-5. The operation was successfully conducted on November 16, 2004. The results were mixed: I no longer had neurologic pain spasms in my legs, but the lower back pain was unchanged.

At the end of the post-surgical period, I resumed the treatment of the pain symptoms with narcotics under Dr. Xiong's supervision. Sometime in the spring of 2006, Dr. Xiong suggested that we could now try the SCS. I got a second, favorable opinion from another pain management specialist, and we did a trial implantation in May of that year, with promising results. The SCS was implanted on July 13, 2006.

For about six weeks, the SCS worked quite effectively, and I was able to significantly reduce my dosage of the narcotics. However, after those six weeks, I found that the SCS, rather than masking the pain as it was supposed to, was instead increasing the pain to the degree that I had to turn it off. Without its help, I again needed the narcotics to control the pain symptoms. I tried many things over the following year to try to get the SCS to work properly, all without success. In the summer or early fall of 2007, Dr. Xiong arranged for the equipment to be formally re-evaluated by the company that manufactured it, Medtronic. The Medtronic technician, in conjunction with specialists in Medtronic's offices, concluded that the wires had moved, and one or both of them

---

<sup>1</sup> The DRS system is a non-surgical form of disc decompression therapy, which has been shown to sometimes provide back pain relief. The DRS system, which was approved by the FDA in the mid-1990s, uses a traction device to remove pressure from the discs and joints in the lower back.

**Francis Paine**  
**19 Squam Lake Road**  
**Center Sandwich, NH 03227**  
**E-mail: fpainestam@gmail.com**  
**Phone: (603) 284-6433**  
**Mobile: (203) 952-1365**

---

was/were pressing on a nerve. X-rays subsequently confirmed this analysis. At that point we had two options: a) remove the SCS; or b) attempt to adjust the wires. I opted for a), as, now knowing the sensitivity of the device, I was not inclined to adjust wires that might have to be re-adjusted periodically in the future. Dr. Xiong removed the SCS on November 12, 2007.

In the summer of 2008, Dr. Xiong left the TPMC to start his own practice. On the advice of my employer's Medical Department, I went to Dr. Douglas Schottenstein at Seaport Orthopedics Associates ("SOA"), in New York City. Shortly thereafter, Dr. Schottenstein left SOA to start his own practice, and I made the decision to move to his new practice along with him. Dr. Schottenstein believed that I was a good candidate for a procedure known as radio frequency ablation. We did two rounds of facet injections that were intended to be diagnostic. According to Dr. Schottenstein, if two out of three of these facet injection procedures were "effective," then I would be considered a candidate for the radio frequency ablation. Ablation apparently involves the use of needles to apply heat to the nerves, thereby also improving the comfort level, but for a much longer period than the trial procedure. As the first two facet injection procedures were in fact "effective," we moved forward with the ablation procedure. We did one side on January 14, 2009 and the other on January 30, 2009. There was no positive effect.

After having gone on Short-Term Disability in April 2009, I requested and received referrals to appropriate medical specialists in Stamford. Dr. Dreyer referred me to Dr. Emmy Lu, a pain management specialist, of Orthopedic Associates of Stamford. I met with her, generally at least once a month, for medication reviews and other matters, mainly trigger point injections. In particular, she radically revised my medication, which now consists of a combination of a mild dosage of Methadone, a moderate dosage of Nucynta for "breakthrough" pain, and Savella. In addition, at her suggestion, I began taking turmeric and ginger root supplements for their anti-inflammatory value. Dr. Lu's perception was that my previous program was "top-heavy" with narcotics. The revised program has been at least as effective as what preceded it, but with reduced side effects. In addition to the medication and an exercise program consisting primarily of walking, I have been introduced to the concept of meditation, and usually meditate for 30-60 minutes daily. Last, but not least, Dr. Lu recommended that I re-consider the notion of a spinal chord stimulator. I agreed, and in November of 2010, a SCS was again implanted. I still have it, and find that it somewhat reduces the pain levels.

Chronic pain is known for being depressive. Starting in October 2008, I had [usually] weekly meetings with Leslie Freedman, Ph.D., a psychotherapist having particular expertise in chronic pain cases. This continued until May 2012, when I moved to New Hampshire.

Upon reaching retirement age, my disability status (see below) with FRBNY was amended to "Retired", and with my wife's decision to also retire, we decided to move away from Fairfield County in Connecticut. We successfully sold our house in Stamford, CT, and bought another house in the historic district of Center Sandwich, NH. We closed the purchase on May 8, 2012, and moved in two days later. Since then, the responsibility for my pain management has been assumed by PainMD, in North Conway, in the person of Ms. Kelly DeFeo. The treatment regime under her

**Francis Paine**  
**19 Squam Lake Road**  
**Center Sandwich, NH 03227**  
**E-mail: fpainestam@gmail.com**  
**Phone: (603) 284-6433**  
**Mobile: (203) 952-1365**

---

care has been little changed, except that she has added a muscle relaxer called Tizanidine HCL to the medication list.

#### Working Through the Pain at FRBNY

In the fall of 2008, the deterioration become such that I was experiencing pain levels of 8 or worse two or more times every week. When these days fell on working days, I began to miss days of work, or was forced to leave early. I informed my Team Leader what was happening, and we agreed on a shorthand way of communicating: for example, a voice mail or e-mail message that said "Level 8-home" meant the pain was making me nauseous, and I was staying home or leaving early (whichever the case was). I also informed FRBNY's Medical Department of the situation, and made arrangements to use an armchair in a quiet place there if the condition became really bad during the course of a day.

I was only able to do this as long as I was able to complete an acceptable level of work, at least in comparison to my colleagues. I was an exceptionally efficient worker, and thus even at a reduced level of productivity I was able, for a while, to continue completing an acceptable level of work. At a certain point, though, this became impossible. I did not wish to go on disability, and inquired as to whether there were positions in which I could continue to contribute, despite my condition, on a part-time or telecommuting basis. I was informed that there were no such positions available.

In the first quarter of 2009, because of continuing deterioration in the chronic pain condition, I applied and was approved for FRBNY's short term (one year) disability program. I started on the program on April 16, 2009, and one year later, it was converted to the long term disability program. The latter program continued until I retired. Since going on disability, my activities since have been limited to a small amount of volunteer singing, reading, managing the contractors my wife and I have employed to prepare our house for sale, and one short trip out of the country (more on this below). Since moving to New Hampshire, I have found an ensemble to sing with, and have joined the Board of Trustees (as Treasurer) of Advice to the Players, a not-for-profit professional Shakespearean drama company. I would like to be in a position to contribute more to the lovely community I now live in, but my pain condition has so far prevented me from doing so.

As part of my job duties, I have traveled to twenty-three foreign countries (some of them multiple times), including (but not limited to) the United Kingdom, France, Germany, The Netherlands, Sweden, Greece, Canada, Brazil, Argentina and Chile. In addition, in 1992 I was honored by being selected to be the first and only American Eisenhower Exchange Fellow to Greece. There has also been domestic travel. It would be hard to describe me as anything other than an experienced traveler, and travel has been an integral part of my work, as well as something that I have always wanted to do. My pain condition has limited my ability to stand for any length of time, and made it impossible to sleep comfortably in a bed. Thus, the condition has very much restricted my ability to travel.



**Francis Paine**  
**19 Squam Lake Road**  
**Center Sandwich, NH 03227**  
**E-mail: fpainestam@gmail.com**  
**Phone: (603) 284-6433**  
**Mobile: (203) 952-1365**

---

I continued to work through the pain for almost 15 years. Many people, including medical practitioners, have commented that they don't know how I managed to keep working as long as I did. As the condition deteriorated, I found that my ability to concentrate was impaired, and that it took me longer and longer to accomplish even small tasks. My energy level has also declined. I was eventually forced to cut back my activity levels. Work was the last thing to be cut. First, I cut back on my musical activities, and then I cut back on my not-for-profit activities. Since exercise helped me to continue working, I delayed cutting it as long as I could. The frequency with which I began experiencing level 8 pain finally forced me to limit that too.

### Trip to Guatemala

This short trip was to Guatemala at my own expense under the sponsorship of Sister Parish, Inc., a not-for-profit, non-denominational organization that brokers relationships between church parishes in the U.S. and parishes in Guatemala and El Salvador. The trip involved minimal physical exertion, or other stresses upon the area of my chronic pain condition. I went on this trip with the approval of the principal doctors that have been treating my chronic pain condition, and because it was my feeling that I might not be able to travel abroad again.

### Side Effects of Treatment and Other Medical Issues

In the second half of 2009, I became concerned about my memory, as I had the subjective impression that I was having excessive memory lapses. On the recommendation of my psychotherapist, I underwent some neuro-psychological testing. The tests revealed that my memory function was not impaired. However, they also revealed that I was having difficulty accessing my memory, and "pulling out" the information I needed. The tester referred to this as my "executive function". As I understand it, the "bottom line" was that while the memory itself was sound, my ability to use it had been impaired. The tester speculated that this unexpected finding was a side effect of my multi-year regimen of narcotics, especially the previous nine months or so of Methadone.

I have become aware over the last few years that my ability to multi-task, and to read and understand certain material, such as dense or "heavy" literature, has become impaired. I speculate that the cause, once again, is the narcotics regimen.

I have developed, mainly over the last few years, a tendency to sweat profusely without apparent cause. I queried my pain management specialist about this, and she expressed the opinion that, once again, the cause was the narcotics/Methadone regimen. This profuse sweating, coupled with my inability to stand comfortably for more than a few minutes, has imposed severe limitations on my ability to experience anything like a normal social life. Also, most regular users of narcotics experience constipation as a side effect. Having been on a narcotics regimen for at least six years now, this has been a constant problem for me.

**Francis Paine**  
**19 Squam Lake Road**  
**Center Sandwich, NH 03227**  
**E-mail: fpainestam@gmail.com**  
**Phone: (603) 284-6433**  
**Mobile: (203) 952-1365**

---

For quite a number of years, I have had a case of Gastro-Esophageal Reflux Disorder ("GERD"). It has been controlled via twice-daily doses of Omeprazole, and later on, daily doses of Dexilant, and appears to be under control. However, in the early stages of GERD, before it was diagnosed, I was subject to periodic reflux of stomach acid up into my esophagus. The esophageal tissue does not have the ability to withstand this kind of acid "attack", with the result that the tissue changes form and swells, a condition called Barrett's Esophagus. The impact of the acid on the esophageal tissue is permanent, and in extreme cases can become cancerous. My gastroenterologist has been monitoring the condition closely via periodic upper endoscopies, with biopsies. My understanding is that the present condition is very low level pre-cancerous, but deteriorated somewhat from preceding upper endoscopies.

I have a tendency towards skin cancer, mainly on my face. My dermatologist is aware, and is monitoring me actively via skin inspections at least annually, and more frequently when I find spots on my skin that I suspect may be cancerous or pre-cancerous. Luckily, all but one suspicious skin spot have been pre-cancerous and/or benign. The discovery of malignant cells in one case resulted in our increasing the frequency of skin inspections, and there have been no further such discoveries. Though the condition is not considered serious, the prospect of malignant cells is emotionally serious.

I have painful knees. My left knee, in particular, has been subject to three rounds of corrective surgery over the years. Over the last two or three years, the right knee has become painful as well. I have consulted with an orthopedist, who prescribed anti-inflammatory medications and physical therapy of various sorts, with no perceptible improvement. He has stated that we have tried everything corrective possible short of full knee replacements and it seems likely that at some point I will have to have one or both knees replaced.

#### My Life and Limitations as They are Today

I am unable to contribute in a meaningful way to the physical requirements of our household, which puts an enormous load on my wife, who did them in addition to continuing working at her job. I am unable to sleep comfortably in a bed, and usually sleep in an armchair. Therefore, I do not sleep well, thus exacerbating the fatigue that results from the long term cumulative effect of pain. In addition, sleeping in the armchair is a major drawback when it comes to the normal course of married life.

I have always been physically active. At the Pomfret School, I played football, basketball (Captain of my junior varsity team), and tennis, and ran intramurally. In running intramurally, I came within a ½ second of breaking the school record in the indoor quarter and half miles. While in college, I worked during two summers as a teaching tennis professional, and I continued to play tennis through my military time, and the first few years as a banker. I took up running, and eventually, principally in the 1980s, began to participate in road races. In 1985, 1986 (twice) and 1988, I trained for and successfully completed four marathons, variously in New York City (twice); Stamford, CT; and London. In the early 1990s, a succession of minor foot injuries forced me to

**Francis Paine**  
**19 Squam Lake Road**  
**Center Sandwich, NH 03227**  
**E-mail: fpainestam@gmail.com**  
**Phone: (603) 284-6433**  
**Mobile: (203) 952-1365**

---

stop running, but I took up membership in the New York Sports Club. However, I have had to discontinue this program also, as my condition has continued to deteriorate as a result of increasing chronic pain. Until the early years of this decade, I was also accustomed to do heavy work around the houses that my wife and I lived in: work such as lawn mowing and snow shoveling. The increasing pain levels that resulted after these efforts caused me to stop about seven/eight years ago.

I began singing when I was in the chorus at the Pomfret School. In the fall of 1992, I auditioned for and was accepted by the Collegiate Chorale, one of New York City's best known volunteer choral societies, as a baritone. I sang with the Collegiate Chorale for two seasons, and was its Treasurer in the second season. In the second season, I expanded my musical activity to include the choruses of two regional opera companies, and a church choir as a paid soloist and bass section leader. In my third season, I left the Collegiate Chorale, but joined Musica Plenti, first as a baritone, and more recently as a bass baritone. Musica Plenti is a vocal chamber ensemble (usually a dozen voices, both men and women). I also continued for several years with church choirs, one of them as a paid soloist and section leader, and with the opera companies, as a chorister, and occasionally in minor principal roles. As the chronic pain condition worsened, and because I could no longer move well on stage, I first gave up the opera companies, before then giving up the church choirs. Musica Plenti has now ceased operations. In New Hampshire, I have joined an ensemble called the Mountain Lake Chorale, a group similar to Musica Plenti.

Throughout my career, I have also been active as an officer and/or director of various not-for-profit organizations. As part of my shipping industry involvement, I was variously a director, Treasurer, and committee chair for the Connecticut Maritime Association, the largest trade association for commercial shipping people in the United States. I also became, variously, the Treasurer and a director of several performing arts groups, including the vocal chamber ensemble that I sang with, and a small regional opera company. My ability to do this is now limited to Advice to the Players.

For approximately the last thirty years, my wife and I have been active owners of golden retrievers. Ten of the twelve dogs we have had were senior in age, which we adopted through Yankee Golden Retriever Rescue, in Hudson, Massachusetts. I have, when asked, assisted Yankee with its service operations, particularly as a home visitor: someone who visits the homes of prospective adopters to make recommendations as to their suitability as adopters. My chronic pain condition has made it impossible for me to continue doing this.

This chronic pain condition has ruptured my life. I used to be a man of major intellectual and physical capabilities, working at a job for which I was eminently well trained and suited. I was a "doer", who prided himself on the high quality of his work, and the value of that work to his employer, his country, and the world at large. I was also a man of valuable capabilities outside his job, in the not-for-profit field, the arts, and dog rescue just to name a few. As I approached retirement age, I was looking forward to perhaps providing some valuable consulting services to the commercial banking industry, continuing with music, and writing for publication.

**Francis Paine**  
**19 Squam Lake Road**  
**Center Sandwich, NH 03227**  
**E-mail: fpainestam@gmail.com**  
**Phone: (603) 284-6433**  
**Mobile: (203) 952-1365**

---

Instead, my much lessened productivity, diminution of energy (much of which is spent struggling with pain), declining cognitive abilities, deteriorated ability to process "heavy" written material, and side effects of treatment, have made me unable to work. As someone who has always been active and "a doer", this "come down" is very hard to accept.

In addition, my deterioration has been hard on my marriage. My ability to contribute to household matters requiring physical capabilities means that my wife has to carry an inordinate burden, as we have no children to carry part of it. The fact that I cannot sleep comfortably in a bed is a major blow to married life, and my inability to participate in normal social life (due to inability to stand for any length of time, and prolific sweating) is perhaps harder on her than on me.

In addition, even the things I can do, such as the handling of our financial bookkeeping and tax preparation, take far longer, and use up far more energy than they used to. Even the preparation of this document took me almost three weeks, whereas a few years ago it would have required only 2-3 days.

Despite all this, I still hope that I will find a way to reduce my chronic pain at least to the point that I can be less dependent on prescribed narcotic medications, and hence be productive again, both professionally and avocationally, as well in my marriage.

# **THE WMUR GRANITE STATE POLL**

## **THE UNIVERSITY OF NEW HAMPSHIRE SURVEY CENTER**

February 12, 2013

### **HIGH SUPPORT FOR MEDICAL MARIJUANA, OPINIONS DIVIDED ABOUT NORTHERN PASS**

By: Andrew E. Smith, Ph.D.  
Chad S. Novak, M.A.  
UNH Survey Center  
[www.unh.edu/survey-center](http://www.unh.edu/survey-center)  
603/862-2226

DURHAM, NH - There is strong support for legalizing marijuana for medical use in New Hampshire but Granite Staters are divided over legalization for recreational use. Opposition to the Northern Pass project has increased somewhat, but New Hampshire is still divided over the project.

These findings are based on the latest **WMUR Granite State Poll**,\* conducted by the University of New Hampshire Survey Center. Five hundred and eighty-one (581) randomly selected New Hampshire adults were interviewed by landline and cellular telephone between January 30 and February 5, 2013. The margin of sampling error for the survey is +/- 4.1 percent.

#### **Marijuana Legalization**

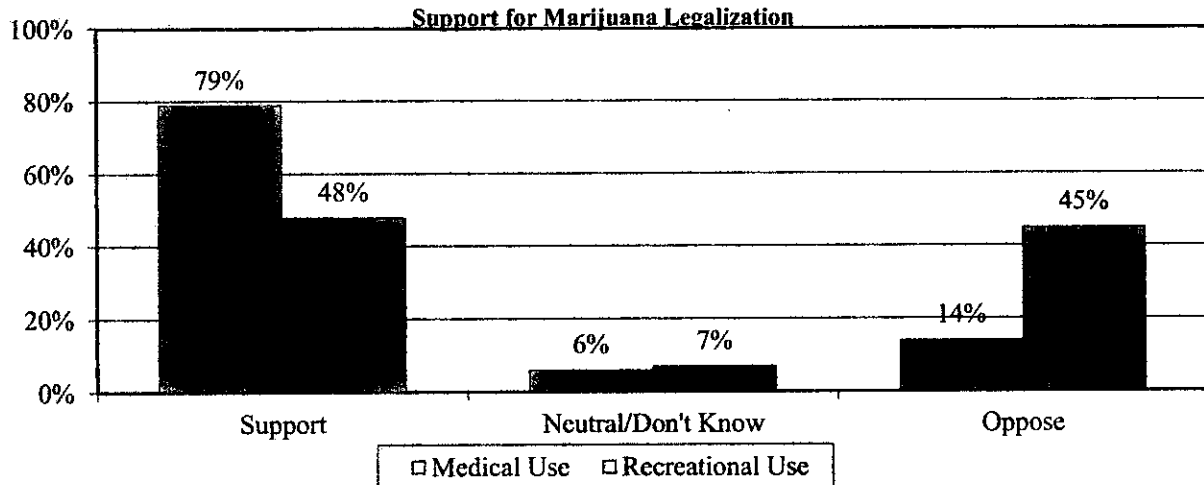
In November, voters in several states passed initiatives legalizing marijuana for medical use, including Massachusetts. Additionally, voters in Washington and Colorado passed ballot measures that would legalize marijuana for personal recreational use. In response to these popular initiatives, the federal Department of Justice is reconsidering how or if it will enforce federal marijuana laws. A bill that would legalize marijuana for medical use passed the New Hampshire legislature in 2011, but was vetoed by then Governor Lynch. Recently, Governor Maggie Hassan has signaled that she would support a medical marijuana bill.

In New Hampshire, there is strong support for legalizing marijuana for medical purposes with 79% saying they would support medical marijuana (57% strongly and 22% somewhat), only 14% oppose this (11% strongly and 3% somewhat), and 6% are neutral or don't know. Support for medical marijuana legalization is strongest among liberals (93%) and Democrats (89%). And while majorities support legalization of medical marijuana, opposition is highest among Republicans (27%), Tea Party supporters (24%), and conservatives (21%).

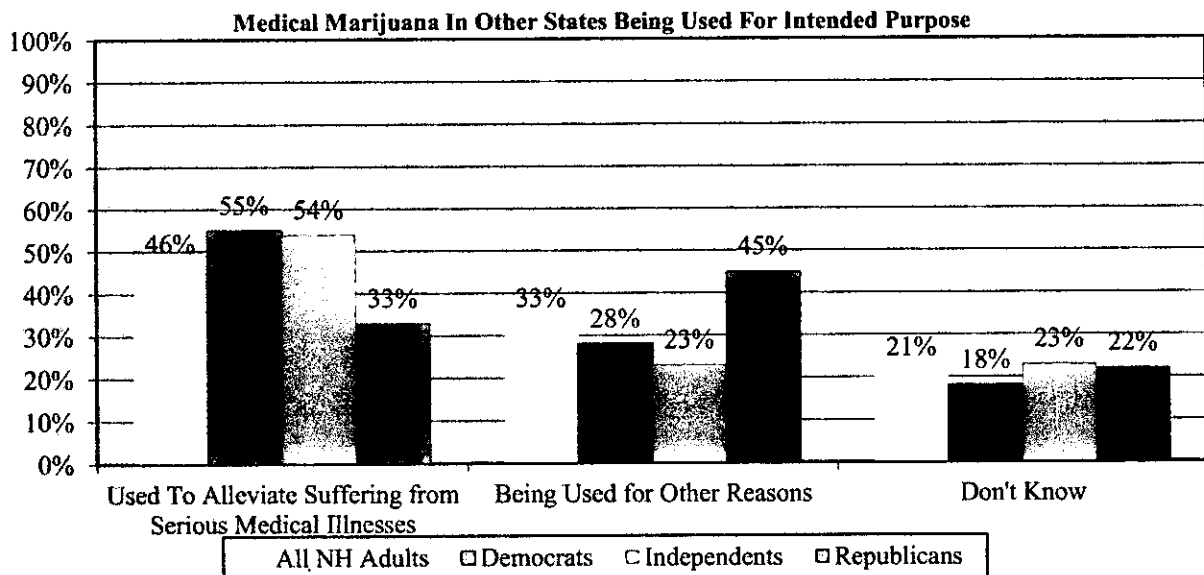
Support for legalization of marijuana for recreational use is significantly lower -- 48% of New Hampshire adults support legalization for recreational use (31% strongly and 17% somewhat), 45% oppose (37% strongly and 8% somewhat), and 7% are neutral or don't know. Support for recreational marijuana legalization is strongest among liberals (70%), Democrats (62%), listeners of NH Public Radio (66%), and Boston Globe readers (65%). Opposition is strongest among Republicans (59%), conservatives (59%), Tea Party supporters (60%), and older adults (56%).

---

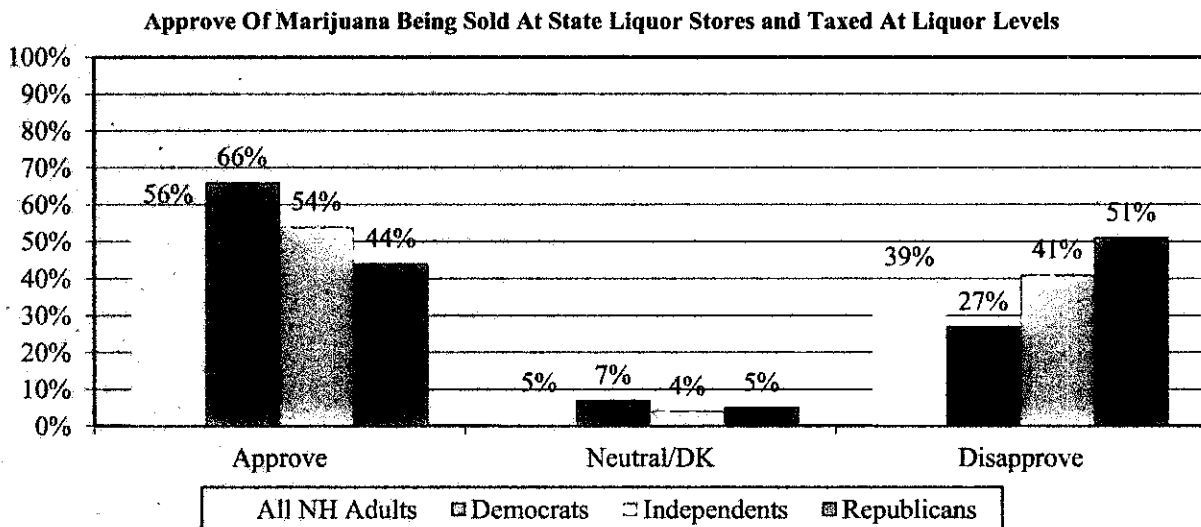
\* We ask that this copyrighted information be referred to as *the Granite State Poll*, sponsored by WMUR-TV, and conducted by the University of New Hampshire Survey Center.



However, there is suspicion among New Hampshire adults about whether marijuana legalization in other states has been used for primarily medical purposes, 46% think that it is being used for its intended medical purposes, but 33% think it is being used for other purposes and 21% are not sure. Democrats and independents are most likely to believe that it is being used for medical purposes while Republicans are more suspicious.

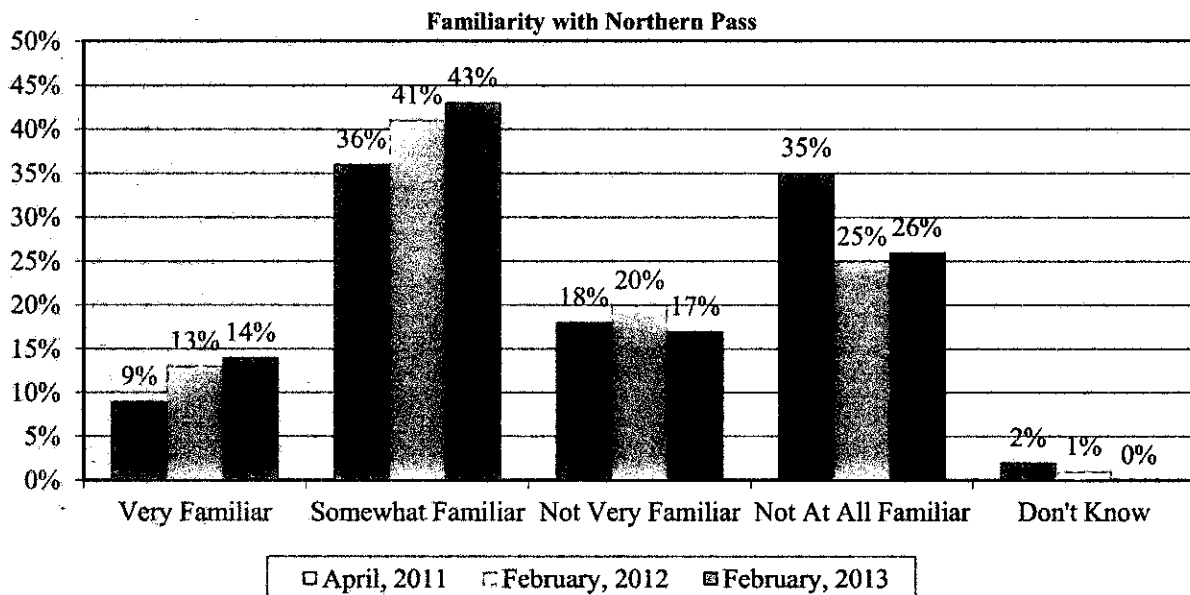


An additional question was asked to determine if New Hampshire supports the concept of treating the sale of marijuana like the state handles the sale of alcohol. More than half of Granite Staters (56%) approve of the selling marijuana at state liquor stores and taxing it at rates similar to how alcohol is taxed, 39% oppose this idea, and 5% are unsure. Democrats are most likely to support this concept while Republicans are most likely to oppose.

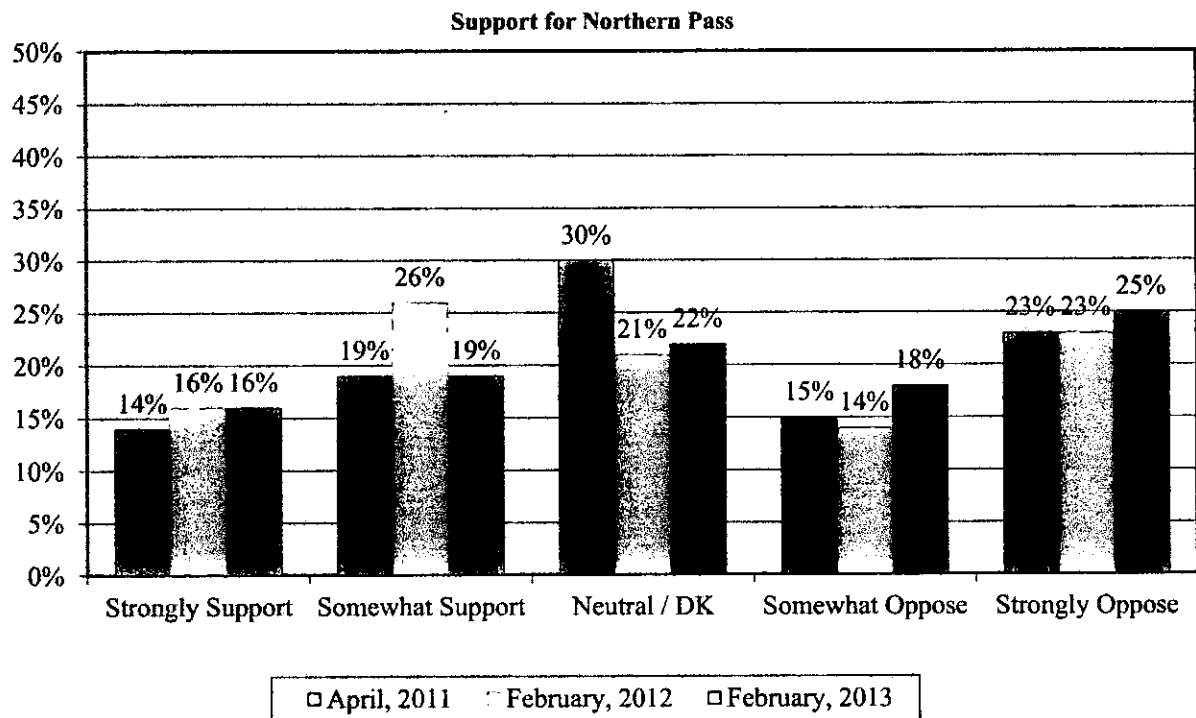


#### Northern Pass

Another controversial issue facing the state is the proposed "Northern Pass" project which would bring hydro-power electricity from Canada through New Hampshire on high tension wires. However, many New Hampshire residents, particularly those in the North Country, have expressed strong opposition to the project. Despite the publicity over Northern Pass, awareness is still fairly low. Only 14% of New Hampshire adults say they are very familiar with Northern Pass, 43% are somewhat familiar, 17% are not very familiar, and 26% are not familiar at all. Awareness has remained largely stable in the past year.



When asked if they support or oppose Northern Pass, attitudes remain mixed. Currently, 35% of New Hampshire adults who are familiar with Northern Pass support the project (16% strongly support and 19% somewhat support), 43% oppose the project (25% strongly oppose and 18% somewhat oppose), and 22% are neutral or don't know enough to say. There has been a slight drop in support for Northern Pass since last February.





### Granite State Poll Methodology

These findings are based on the latest WMUR Granite State Poll, conducted by the University of New Hampshire Survey Center. Five hundred and eighty-one (581) randomly selected New Hampshire adults were interviewed by landline and cellular telephone between January 30 and February 5, 2013. The margin of sampling error for the survey is +/- 4.1 percent.

The data have been weighted to adjust for numbers of adults and telephone lines within households, respondent sex, and region of the state. In addition to potential sampling error, all surveys have other potential sources of non-sampling error including question order effects, question wording effects, and non-response.

### Marijuana Legalization

"Let's change topics again..."

"Do you support or oppose allowing doctors in New Hampshire to prescribe small amounts of marijuana for patients suffering from serious illnesses?"

	<u>Feb. '13</u>
Strongly Support	57%
Somewhat Support	22%
Neutral	5%
Somewhat Oppose	3%
Strongly Oppose	11%
Don't Know	1%
(N=)	(578)

"Do you support or oppose legalizing the possession of small amounts of marijuana for personal recreational use in New Hampshire?"

	<u>Feb. '13</u>
Strongly Support	31%
Somewhat Support	17%
Neutral	6%
Somewhat Oppose	8%
Strongly Oppose	37%
Don't Know	1%
(N=)	(578)

"As you may know, several other states allow doctors to prescribe small amounts of marijuana to patients suffering from serious illnesses. Do you think most of the marijuana that is purchased through state authorized medical marijuana programs is being used to alleviate suffering from serious medical illnesses, or do you think most of it is being used for other reasons?"

	<u>Feb. '13</u>
Alleviate suffering from serious medical illnesses	46%
Being used for other reasons	33%
Don't Know	21%
(N=)	(575)

"If small amounts of marijuana were legalized for personal use in New Hampshire, would you approve or disapprove of marijuana being sold at state liquor stores and taxed at levels similar to alcohol or tobacco?"

	<u>Feb. '13</u>
Strongly Approve	40%
Somewhat Approve	16%
Neutral	3%
Somewhat Disapprove	6%
Strongly Disapprove	33%
Don't Know	2%
(N=)	(577)

#### Northern Pass

"Let's change the subject again."

"How familiar are you with an electrical transmission project called the Northern Pass project? Would you say you are very familiar with it ... somewhat familiar ... not very familiar ... or not at all familiar?"

	<u>Apr. '11</u>	<u>Feb. '12</u>	<u>Feb. '13</u>
Very Familiar	9%	13%	14%
Somewhat Familiar	36%	41%	43%
Not Very Familiar	18%	20%	17%
Not At All Familiar	35%	25%	26%
Don't Know / No Opinion	2%	1%	0%
(N=)	(502)	(527)	(580)

"Based on what you have seen or heard, would you say you support or oppose the Northern Pass project?"

"Is that strongly or just somewhat?"

	<u>Apr. '11</u>	<u>Feb. '12</u>	<u>Feb. '13</u>
Strongly Support	14%	16%	16%
Somewhat Support	19%	26%	19%
Neutral/Don't Know	30%	21%	22%
Somewhat Oppose	15%	14%	18%
Strongly Oppose	23%	23%	25%
(N=)	(316)	(383)	(428)

# Support/Oppose Marijuana For Medical Use

STATEWIDE	Strongly Support 57%	Somewhat Support 22%	Neutral 5%	Somewhat Oppose 3%	Strongly Oppose 11%	Don't Know 1%	(N=) 578
Registered Democrat	76%	13%	4%	0%	7%	0%	151
Registered Undeclared	59%	24%	6%	4%	6%	1%	237
Registered Republican	35%	30%	3%	7%	23%	3%	147
Democrat	74%	15%	5%	2%	3%	1%	239
Independent	59%	24%	4%	4%	7%	2%	114
Republican	39%	28%	4%	5%	22%	1%	214
Liberal	79%	14%	5%	0%	2%	0%	138
Moderate	58%	19%	6%	5%	11%	2%	231
Conservative	43%	32%	2%	4%	17%	1%	177
Support Tea Party	45%	26%	3%	3%	21%	2%	113
Neutral	44%	29%	7%	6%	12%	3%	173
Oppose Tea Party	71%	16%	5%	3%	5%	1%	261
Union household	72%	13%	3%	5%	5%	2%	63
Non union	55%	23%	5%	3%	12%	1%	511
Read Union Leader	52%	23%	5%	2%	17%	1%	166
Read Boston Globe	67%	19%	8%	2%	4%	0%	77
Watch WMUR	55%	24%	5%	4%	12%	1%	391
Listen to NHPR	71%	16%	3%	2%	7%	1%	196
18 to 34	61%	14%	7%	4%	11%	3%	87
35 to 49	55%	27%	4%	2%	12%	0%	133
50 to 64	63%	17%	4%	5%	9%	1%	181
65 and over	51%	26%	5%	4%	13%	2%	160
Male	52%	25%	6%	4%	13%	1%	284
Female	63%	19%	4%	3%	9%	2%	294
High school or less	54%	23%	2%	4%	16%	2%	118
Some college	57%	20%	6%	3%	13%	3%	116
College graduate	62%	20%	4%	5%	8%	1%	222
Post graduate	53%	26%	7%	2%	10%	1%	120
Attend services 1 or more/week	44%	21%	8%	5%	18%	3%	137
1 2 times a month	49%	30%	5%	5%	11%	1%	69
Less often	60%	25%	3%	3%	8%	1%	156
Never	64%	19%	4%	2%	9%	1%	205
North Country	74%	13%	8%	1%	3%	0%	44
Central / Lakes	51%	21%	5%	5%	16%	3%	103
Connecticut Valley	65%	20%	4%	3%	5%	3%	90
Mass Border	56%	23%	5%	3%	12%	1%	161
Seacoast	52%	29%	5%	3%	10%	1%	88
Manchester Area	57%	22%	3%	4%	15%	0%	92
First Cong. Dist.	53%	26%	5%	3%	13%	0%	253
Second Cong. Dist.	61%	19%	5%	4%	10%	2%	325

# Support/Oppose Marijuana For Recreational Use

	<u>Strongly Support</u> 31%	<u>Somewhat Support</u> 17%	<u>Neutral</u> 6%	<u>Somewhat Oppose</u> 8%	<u>Strongly Oppose</u> 37%	<u>Don't Know</u> 1%	<u>(N=)</u> 580
<b>STATEWIDE</b>							
Registered Democrat	43%	20%	4%	6%	26%	1%	151
Registered Undeclared	32%	20%	9%	6%	33%	0%	238
Registered Republican	19%	13%	4%	13%	49%	1%	147
Democrat	42%	20%	6%	6%	26%	0%	239
Independent	30%	21%	4%	7%	36%	2%	115
Republican	22%	13%	6%	11%	48%	0%	214
Liberal	48%	22%	6%	5%	18%	1%	138
Moderate	32%	16%	8%	7%	37%	1%	231
Conservative	20%	16%	4%	12%	47%	0%	177
Support Tea Party	21%	14%	5%	11%	49%	0%	113
Neutral	23%	14%	7%	9%	46%	1%	174
Oppose Tea Party	41%	21%	6%	6%	25%	1%	261
Union household	33%	16%	6%	8%	34%	2%	65
Non union	31%	17%	6%	8%	37%	0%	512
Read Union Leader	30%	14%	3%	9%	43%	1%	168
Read Boston Globe	42%	23%	2%	9%	23%	1%	77
Watch WMUR	29%	16%	6%	8%	41%	0%	393
Listen to NHPR	43%	23%	4%	6%	24%	0%	196
18 to 34	46%	11%	9%	8%	26%	0%	87
35 to 49	36%	21%	3%	7%	32%	1%	133
50 to 64	32%	19%	6%	7%	35%	1%	181
65 and over	19%	18%	7%	10%	46%	0%	160
Male	36%	18%	5%	10%	30%	1%	284
Female	27%	16%	7%	6%	43%	1%	296
High school or less	37%	12%	5%	2%	45%	0%	119
Some college	33%	13%	6%	11%	36%	0%	117
College graduate	29%	19%	5%	10%	36%	1%	222
Post graduate	29%	24%	8%	8%	31%	1%	120
Attend services 1 or more/week	13%	11%	6%	7%	61%	1%	139
1 2 times a month	27%	15%	3%	14%	41%	0%	69
Less often	31%	23%	8%	8%	28%	1%	156
Never	44%	19%	6%	6%	25%	0%	205
North Country	42%	12%	6%	9%	31%	0%	44
Central / Lakes	30%	16%	3%	7%	44%	1%	105
Connecticut Valley	42%	18%	7%	11%	21%	2%	90
Mass Border	22%	22%	9%	8%	38%	0%	161
Seacoast	24%	21%	4%	8%	42%	1%	88
Manchester Area	42%	8%	5%	6%	39%	0%	92
First Cong. Dist.	28%	19%	6%	7%	39%	0%	253
Second Cong. Dist.	34%	16%	6%	9%	35%	1%	327

**Medical Marijuana In Other States Being Used for Medicinal Purposes or Other Purposes**

<b>STATEWIDE</b>	<b><u>Alleviate Suffering From Serious Medical Illnesses</u></b> 46%	<b><u>Being Used For Other Reasons</u></b> 33%	<b><u>Don't Know</u></b> 21%	<b><u>(N=)</u></b> 575
Registered Democrat	54%	29%	17%	148
Registered Undeclared	49%	28%	23%	238
Registered Republican	33%	46%	21%	146
Democrat	55%	28%	18%	236
Independent	54%	23%	23%	115
Republican	33%	45%	22%	213
Liberal	57%	27%	16%	136
Moderate	44%	33%	23%	230
Conservative	40%	39%	22%	176
Support Tea Party	40%	40%	21%	113
Neutral	36%	38%	26%	172
Oppose Tea Party	54%	29%	17%	258
Union household	52%	31%	17%	64
Non union	45%	34%	21%	508
Read Union Leader	41%	41%	18%	168
Read Boston Globe	51%	28%	20%	77
Watch WMUR	47%	33%	20%	390
Listen to NHPR	52%	31%	18%	194
18 to 34	47%	41%	12%	87
35 to 49	50%	33%	17%	133
50 to 64	51%	29%	21%	180
65 and over	37%	34%	29%	159
Male	43%	41%	16%	282
Female	49%	26%	25%	293
High school or less	48%	32%	20%	119
Some college	38%	41%	21%	116
College graduate	50%	30%	20%	220
Post graduate	45%	32%	23%	119
Attend services 1 or more/week	44%	35%	21%	135
1 2 times a month	45%	32%	22%	69
Less often	44%	37%	19%	156
Never	48%	30%	22%	204
North Country	69%	20%	11%	44
Central / Lakes	40%	40%	20%	105
Connecticut Valley	46%	31%	23%	89
Mass Border	45%	31%	24%	158
Seacoast	45%	36%	19%	87
Manchester Area	44%	36%	20%	92
First Cong. Dist.	42%	37%	20%	252
Second Cong. Dist.	49%	30%	21%	324

# **Approve/Disapprove of Marijuana Being Sold At State Liquor Stores**

	<u><b>Strongly Approve</b></u> 40%	<u><b>Somewhat Approve</b></u> 16%	<u><b>Neutral</b></u> 3%	<u><b>Somewhat Disapprove</b></u> 6%	<u><b>Strongly Disapprove</b></u> 33%	<u><b>Don't Know</b></u> 2%	<u><b>(N=)</b></u> 577
<b>STATEWIDE</b>							
Registered Democrat	48%	18%	3%	6%	23%	3%	150
Registered Undeclared	42%	16%	4%	5%	31%	2%	237
Registered Republican	29%	16%	2%	7%	46%	1%	146
Democrat	48%	18%	4%	4%	23%	3%	238
Independent	43%	11%	3%	8%	33%	1%	114
Republican	28%	16%	3%	6%	45%	2%	213
Liberal	59%	17%	4%	5%	14%	1%	137
Moderate	45%	12%	3%	6%	32%	3%	231
Conservative	20%	20%	4%	6%	46%	4%	176
Support Tea Party	31%	17%	3%	5%	43%	2%	113
Neutral	30%	19%	3%	8%	38%	3%	172
Oppose Tea Party	50%	15%	4%	5%	24%	3%	260
Union household	45%	10%	2%	5%	34%	5%	65
Non union	39%	17%	3%	6%	33%	2%	509
Read Union Leader	38%	12%	1%	4%	41%	4%	167
Read Boston Globe	52%	13%	1%	5%	28%	1%	77
Watch WMUR	37%	16%	2%	6%	37%	2%	393
Listen to NHPR	49%	17%	2%	6%	25%	1%	194
18 to 34	46%	13%	4%	3%	33%	1%	87
35 to 49	42%	19%	2%	8%	24%	5%	133
50 to 64	45%	14%	3%	5%	30%	2%	180
65 and over	28%	17%	4%	7%	43%	1%	158
Male	44%	19%	2%	6%	27%	2%	284
Female	36%	12%	4%	6%	39%	3%	293
High school or less	38%	8%	5%	4%	43%	3%	119
Some college	42%	12%	2%	4%	36%	3%	117
College graduate	38%	19%	3%	9%	30%	2%	222
Post graduate	41%	21%	3%	6%	28%	2%	117
Attend services 1 or more/week	22%	17%	4%	2%	52%	3%	137
1 2 times a month	34%	17%	3%	6%	39%	1%	69
Less often	46%	16%	2%	6%	27%	3%	156
Never	49%	15%	4%	8%	23%	2%	203
North Country	46%	14%	6%	2%	33%	0%	44
Central / Lakes	33%	19%	2%	7%	38%	1%	105
Connecticut Valley	45%	16%	5%	9%	22%	4%	88
Mass Border	36%	15%	6%	5%	38%	1%	160
Seacoast	41%	17%	1%	5%	35%	1%	88
Manchester Area	44%	14%	0%	7%	28%	7%	91
First Cong. Dist.	40%	16%	2%	7%	31%	3%	250
Second Cong. Dist.	39%	15%	4%	6%	35%	2%	326

# Familiar with Northern Pass

	<u>Very Familiar</u> 14%	<u>Somewhat Familiar</u> 43%	<u>Not Very Familiar</u> 17%	<u>Not At All Familiar</u> 26%	<u>Don't Know</u> 0%	<u>(N=)</u> 580
<b>STATEWIDE</b>						
Registered Democrat	12%	44%	21%	23%	0%	151
Registered Undeclared	16%	44%	14%	27%	0%	238
Registered Republican	15%	45%	20%	19%	0%	147
Democrat	16%	44%	16%	24%	0%	239
Independent	12%	46%	19%	23%	1%	115
Republican	14%	40%	17%	29%	0%	214
Liberal	14%	44%	18%	24%	0%	138
Moderate	14%	43%	16%	26%	0%	231
Conservative	14%	44%	17%	24%	1%	177
Support Tea Party	14%	47%	13%	27%	0%	113
Neutral	11%	39%	23%	26%	1%	174
Oppose Tea Party	17%	45%	16%	22%	0%	261
Union household	17%	39%	22%	22%	0%	65
Non union	14%	43%	17%	26%	0%	512
Read Union Leader	18%	45%	17%	19%	0%	168
Read Boston Globe	16%	39%	19%	26%	0%	77
Watch WMUR	16%	44%	18%	22%	0%	393
Listen to NHPR	17%	47%	12%	23%	1%	196
18 to 34	5%	34%	16%	43%	1%	87
35 to 49	12%	45%	19%	24%	0%	133
50 to 64	16%	48%	16%	20%	0%	181
65 and over	19%	41%	17%	23%	0%	160
Male	19%	43%	16%	21%	0%	284
Female	9%	42%	19%	30%	0%	296
High school or less	11%	35%	12%	43%	0%	119
Some college	12%	49%	13%	25%	1%	117
College graduate	15%	42%	22%	22%	0%	222
Post graduate	18%	46%	19%	17%	0%	120
Attend services 1 or more/week	16%	35%	18%	31%	0%	139
1 2 times a month	15%	48%	14%	22%	2%	69
Less often	12%	44%	22%	22%	0%	156
Never	15%	44%	15%	25%	0%	205
North Country	27%	50%	13%	9%	0%	44
Central / Lakes	21%	51%	16%	12%	0%	105
Connecticut Valley	17%	41%	17%	25%	0%	90
Mass Border	7%	41%	15%	37%	0%	161
Seacoast	17%	38%	13%	33%	0%	88
Manchester Area	7%	40%	30%	22%	1%	92
First Cong. Dist.	14%	43%	18%	24%	0%	253
Second Cong. Dist.	14%	42%	17%	27%	0%	327

**Support/Oppose Northern Pass**

	<b>Strongly Support 16%</b>	<b>Somewhat Support 19%</b>	<b>Neutral/ Don't Know 22%</b>	<b>Somewhat Oppose 18%</b>	<b>Strongly Oppose 25%</b>	<b>(N=) 428</b>
<b>STATEWIDE</b>						
Registered Democrat	10%	12%	26%	23%	29%	114
Registered Undeclared	19%	17%	22%	18%	25%	175
Registered Republican	17%	27%	16%	17%	23%	118
Democrat	11%	15%	25%	21%	28%	180
Independent	18%	21%	25%	12%	24%	88
Republican	21%	22%	16%	20%	22%	151
Liberal	9%	18%	23%	24%	25%	103
Moderate	17%	18%	26%	16%	24%	170
Conservative	20%	22%	15%	18%	24%	133
Support Tea Party	20%	24%	13%	20%	23%	82
Neutral	14%	23%	23%	19%	21%	128
Oppose Tea Party	15%	16%	24%	17%	28%	200
Union household	14%	9%	34%	22%	20%	49
Non union	16%	20%	20%	18%	25%	377
Read Union Leader	21%	20%	24%	16%	20%	136
Read Boston Globe	19%	20%	27%	8%	26%	57
Watch WMUR	18%	19%	20%	18%	25%	303
Listen to NHPR	12%	19%	20%	20%	28%	151
18 to 34	18%	17%	18%	22%	25%	48
35 to 49	15%	22%	23%	18%	22%	101
50 to 64	16%	19%	22%	19%	25%	142
65 and over	18%	17%	20%	17%	27%	122
Male	20%	23%	14%	16%	27%	220
Female	12%	15%	29%	21%	22%	208
High school or less	28%	14%	22%	14%	22%	67
Some college	17%	22%	14%	23%	25%	87
College graduate	13%	19%	25%	17%	25%	174
Post graduate	12%	20%	21%	20%	26%	98
Attend services 1 or more/week	10%	21%	30%	13%	27%	94
1 2 times a month	31%	28%	20%	7%	14%	53
Less often	16%	22%	21%	21%	20%	121
Never	15%	12%	18%	25%	30%	153
North Country	9%	10%	9%	30%	42%	40
Central / Lakes	16%	19%	22%	20%	23%	93
Connecticut Valley	19%	12%	24%	12%	34%	67
Mass Border	16%	28%	21%	17%	17%	98
Seacoast	17%	21%	16%	20%	26%	59
Manchester Area	18%	16%	32%	16%	18%	71
First Cong. Dist.	19%	18%	20%	22%	22%	190
Second Cong. Dist.	15%	20%	23%	16%	27%	238



# Voting Sheets

**HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS**

**EXECUTIVE SESSION on HB 573-FN**

**BILL TITLE:** relative to the use of marijuana for medicinal purposes.

**DATE:** March 7, 2013

**LOB ROOM:** 205

**Amendments:**

Sponsor: Rep. Wright

OLS Document #: 2013 0797h

Sponsor: Rep.

OLS Document #:

Sponsor: Rep.

OLS Document #:

**Motions:** OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Stephen Schmidt

Seconded by Rep. Mariellen MacKay

Vote: 15-0 (Please attach record of roll call vote.)

**Motions:** OTR, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Stephen Schmidt

Seconded by Rep. Mariellen MacKay

Vote: 14-1 (Please attach record of roll call vote.)

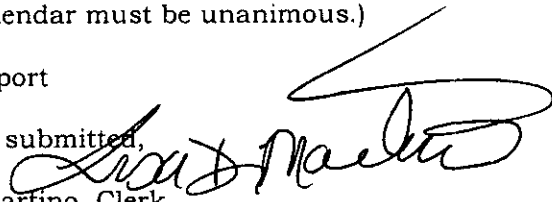
**CONSENT CALENDAR VOTE: NO**

(Vote to place on Consent Calendar must be unanimous.)

**Statement of Intent:** Refer to Committee Report

Respectfully submitted,

Rep. Lisa DiMartino, Clerk



Did not have  
Executive Session  
sheet in  
folder

~~HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS~~

~~SUBCOMMITTEE WORK SESSION ON HB 573-FN~~

~~Executive Session~~  
BILL TITLE: relative to the use of marijuana for medicinal purposes.

DATE: March 5, 2013

Subcommittee Members: Reps. Schmidt, LeBrun, Emerson, Ahearn and Culbert

Comments and Recommendations: Continuation of Subcommittee hearing. Amendment recommendation scheduled for March 6, 2013 at Session Lunch Break.

Amendments:

Sponsor: Rep. <i>wright</i>	OLS Document #: <i>2013-0797h</i>
Sponsor: Rep.	OLS Document #:
Sponsor: Rep.	OLS Document #:

Motions: OTP, OTP/A ITL, Retained (Please circle one.)

Moved by Rep. *Schmidt*  
Seconded by Rep. *Mariellen MacKay*  
Vote:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.  
Seconded by Rep.  
Vote:

*RC*

Respectfully submitted,

*[Signature]*  
Rep. Stephen Schmidt  
Subcommittee Chairman/Clerk

*Lisa Di Marzio*



STATE OF NEW HAMPSHIRE  
OFFICE OF THE HOUSE CLERK

2/21/2013 3:26:37 PM  
Roll Call Committee Registers  
Report

2013 SESSION

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

Bill #: 573 FN Title: relative to the use of carbamides for therapeutic purposes  
PH Date: 02 21 / 2013 Exec Session Date: 3 17 / 13  
Motion: Amendment Amendment #: 2013-0797h

MEMBER	YEAS	NAYS
MacKay, James R, Chairman	✓	
Harding, Laurie , V Chairman	✓	
French, Barbara C	✓	
<del>Tilton, Jay K</del> <u>MacKay</u>	✓	
<del>Andrews-Ahearn, E. Elaine</del>		
DiMartino, Lisa , Clerk	✓	
<del>Helmstetter, Barbara S</del>		
<del>Hunt, Jane J,</del>		
Sherman, Thomas M	✓	
Ticehurst, Susan J	✓	
McMahon, Charles E	✓	
Emerson, Susan ,	✓	
Kotowski, Frank R, <u>Warden</u>	✓	
<del>Martel, Andre A</del>		
LeBrun, Donald L	✓	
Culbert, Patrick L	✓	
Meaney, Richard E	✓	
Nelson, Bill G	✓	
Schmidt, Stephen J	✓	
TOTAL VOTE:	15	0



STATE OF NEW HAMPSHIRE  
OFFICE OF THE HOUSE CLERK

1/10/2013 8:47:26 AM  
Roll Call Committee Registers  
Report

2013 SESSION

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

Bill #: HB 573-FN Title: Relative to the use of marijuana for medicinal purposes.

PH Date: 02 / 21 / 2013

Exec Session Date: 3 / 7 / 13

Motion: OTPA

Amendment #: \_\_\_\_\_

\*name change  
relative to the use  
of cannabis for  
therapeutic  
purposes

MEMBER	YEAS	NAYS
MacKay, James R, Chairman	✓	
Harding, Laurie , V Chairman	✓	
French, Barbara C	✓	
<del>Donovan, Thomas E</del>		
<del>Tilton, Joy K</del> <u>MacKay</u>	✓	
<del>Andrews-Ahearn, E. Elaine</del>		
DiMartino, Lisa	✓	
<del>Helmstetter, Barbara S</del>		
<del>Hunt, Jane J, Clerk</del>		
Sherman, Thomas M	✓	
Ticehurst, Susan J	✓	
McMahon, Charles E	✓	
Emerson, Susan ,	✓	
<del>Kotowski, Frank R,</del> <u>Wardem</u>	✓	
<del>Martel, Andre A</del>		
LeBrun, Donald L	✓	
Culbert, Patrick L	✓	
Meaney, Richard E	✓	
Nelson, Bill G		✓
Schmidt, Stephen J	✓	
TOTAL VOTE:	14	1

# Committee Report

**REGULAR CALENDAR**

**March 13, 2013**

**HOUSE OF REPRESENTATIVES**

**REPORT OF COMMITTEE**

**The Committee on HEALTH, HUMAN SERVICES &  
ELDERLY AFFAIRS to which was referred HB573-FN,**

**AN ACT relative to the use of marijuana for medicinal  
purposes. Having considered the same, report the same  
with the following amendment, and the  
recommendation that the bill OUGHT TO PASS WITH  
AMENDMENT.**

**Rep. Stephen J Schmidt**

**FOR THE COMMITTEE**

## COMMITTEE REPORT

Committee:	HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS
Bill Number:	HB573-FN
Title:	relative to the use of marijuana for medicinal purposes.
Date:	March 7, 2013
Consent Calendar:	NO
Recommendation:	OUGHT TO PASS WITH AMENDMENT

### STATEMENT OF INTENT

This bill provides that New Hampshire citizens who are diagnosed with a terminal, severely debilitating or chronic condition as defined in the law may be eligible to obtain therapeutic cannabis to relieve their pain and suffering. The law requires that a prospective patient establish a relationship with a health care provider for a minimum of three months. The health care provider must document that traditional medications have proven to be ineffective and failed to alleviate their pain and suffering. No health care provider will be required to participate in the program nor certify the use of therapeutic cannabis.

The bill ensures that the use of therapeutic cannabis will be restricted to New Hampshire patients. Visitors with a valid medical use card from their home state will not be eligible to purchase or cultivate cannabis in New Hampshire. They will be protected from local or state prosecution if the cannabis in their possession does not exceed the amount allowed under New Hampshire law.

The therapeutic cannabis program will be administered by the Health and Human Services Department (The Department). In addition, the program will be evaluated by the creation of a "Therapeutic Use of Cannabis Advisory Council". This council will be comprised of members of the New Hampshire House, Senate, Health and Human Services Department, Patients, Health care providers, Law enforcement and Hospitals. This council will report to the Health and Human Services Oversight Committee and will evaluate all aspects of the bill to ensure that access to and use of cannabis is provided only to persons authorized for such purposes and report out any recommendations or deficiencies for either departmental or legislative correction. Lastly, the council will be required to prepare a report on the 5th year anniversary of the bill's passage opining as to whether the program should be continued or repealed and stating the reasons for their opinion.

The committee concluded that the bill as proposed will provide relief to those chronically or terminally ill New Hampshire patients not responding to traditional

Original: House Clerk

Cc: Committee Bill File



medications while also providing a high level of control ensuring that therapeutic cannabis is strictly limited to those New Hampshire patients qualified.

Rep. Stephen Schmidt

Vote 14-1.

Rep. Stephen J Schmidt  
FOR THE COMMITTEE

Original: House Clerk  
Cc: Committee Bill File

## **REGULAR CALENDAR**

### **HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS**

**HB573-FN, relative to the use of marijuana for medicinal purposes. OUGHT TO PASS WITH AMENDMENT.**

Rep. Stephen J Schmidt for HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS. This bill provides that New Hampshire citizens who are diagnosed with a terminal, severely debilitating or chronic condition as defined in the law may be eligible to obtain therapeutic cannabis to relieve their pain and suffering. The law requires that a prospective patient establish a relationship with a health care provider for a minimum of three months. The health care provider must document that traditional medications have proven to be ineffective and failed to alleviate their pain and suffering. No health care provider will be required to participate in the program nor certify the use of therapeutic cannabis.

The bill ensures that the use of therapeutic cannabis will be restricted to New Hampshire patients. Visitors with a valid medical use card from their home state will not be eligible to purchase or cultivate cannabis in New Hampshire. They will be protected from local or state prosecution if the cannabis in their possession does not exceed the amount allowed under New Hampshire law.

The therapeutic cannabis program will be administered by the Health and Human Services Department (The Department). In addition, the program will be evaluated by the creation of a "Therapeutic Use of Cannabis Advisory Council". This council will be comprised of members of the New Hampshire House, Senate, Health and Human Services Department, Patients, Health care providers, Law enforcement and Hospitals. This council will report to the Health and Human Services Oversight Committee and will evaluate all aspects of the bill to ensure that access to and use of cannabis is provided only to persons authorized for such purposes and report out any recommendations or deficiencies for either departmental or legislative correction. Lastly, the council will be required to prepare a report on the 5th year anniversary of the bill's passage opining as to whether the program should be continued or repealed and stating the reasons for their opinion.

The committee concluded that the bill as proposed will provide relief to those chronically or terminally ill New Hampshire patients not responding to traditional medications while also providing a high level of control ensuring that therapeutic cannabis is strictly limited to those New Hampshire patients qualified.

Rep. Stephen Schmidt **Vote 14-1.**

Original: House Clerk

Cc: Committee Bill File

HB 573 relative to the use of marijuana for medicinal purposes.

This bill provides that New Hampshire citizens who are diagnosed with a terminal, severely debilitating or chronic condition as defined in the law may be eligible to obtain therapeutic cannabis to relieve their pain and suffering. The law requires that a prospective patient establish a relationship with a health care provider for a minimum of three months. The health care provider must document that traditional medications have proven to be ineffective and failed to alleviate their pain and suffering. No health care provider will be required to participate in the program nor certify the use of therapeutic cannabis.

The bill ensures that the use of therapeutic cannabis will be restricted to New Hampshire patients. Visitors with a valid medical use card from their home state will not be eligible to purchase or cultivate cannabis in New Hampshire. They will be protected from local or state prosecution if the cannabis in their possession does not exceed the amount allowed under New Hampshire law.

The therapeutic cannabis program will be administered by the Health and Human Services Department (The Department). In addition, the program will be evaluated by the creation of a "Therapeutic Use of Cannabis Advisory Council". This council will be comprised of members of the New Hampshire House, Senate, Health and Human Services Department, Patients, Health care providers, Law enforcement and Hospitals. This council will report to the Health and Human Services Oversight Committee and will evaluate all aspects of the bill to ensure that access to and use of cannabis is provided only to persons authorized for such purposes and report out any recommendations or deficiencies for either departmental or legislative correction. Lastly, the council will be required to prepare a report on the 5<sup>th</sup> year anniversary of the bill's passage opining as to whether the program should be continued or repealed and stating the reasons for their opinion.

The committee concluded that the bill as proposed will provide relief to those chronically or terminally ill New Hampshire patients not responding to traditional medications while also providing a high level of control ensuring that therapeutic cannabis is strictly limited to those New Hampshire patients qualified.

Rep. Stephen Schmidt

A handwritten signature in black ink, appearing to read "Stephen Schmidt", is written over the printed name.

## Health, Human Services and Elderly Affairs

HB 573, relative to the use of Cannabis for therapeutic purposes.

Ought to pass with amendment

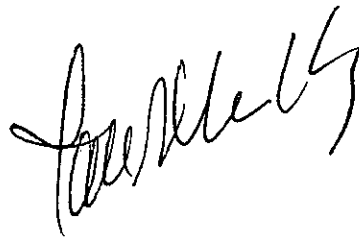
Rep. Stephen Schmidt for Health, Human Services and Elderly Affairs:  
This bill provides that New Hampshire citizens who are diagnosed with a terminal, severely debilitating or chronic condition as defined in the law may be eligible to obtain therapeutic cannabis to relieve their pain and suffering. The law requires that a prospective patient establish a relationship with a health care provider for a minimum of three months. The health care provider must document that traditional medications have proven to be ineffective and failed to alleviate their pain and suffering. No health care provider will be required to ~~neither~~ participate in the program nor certify the use of therapeutic cannabis.

The bill ensures that the use of therapeutic cannabis will be restricted to New Hampshire patients. Visitors with a valid medical use card from their home state will not be eligible to purchase or cultivate cannabis in New Hampshire. They will be protected from local or state prosecution if the cannabis in their possession does not exceed the amount allowed under New Hampshire law.

The therapeutic cannabis program will be administered by the Health and Human Services Department (The Department). In addition, the program will be evaluated by the creation of a "Therapeutic Use of Cannabis Advisory Council". This council will be comprised of members of the New Hampshire House, Senate, Health and Human Services Department, Patients, Health care providers, Law enforcement and Hospitals. This council will report to the Health and Human Services Oversight Committee and will evaluate all aspects of the bill to ensure

that access to and use of cannabis is provided only to persons authorized for such purposes and report out any recommendations or deficiencies for either departmental or legislative correction. Lastly, the council will be required to prepare a report on the 5<sup>th</sup> year anniversary of the bill's passage opining as to whether the program should be continued or repealed and stating the reasons for their opinion.

The committee concluded that the bill as proposed will provide relief to those chronically or terminally ill New Hampshire patients not responding to traditional medications while also providing a high level of control ensuring that therapeutic cannabis is strictly limited to those New Hampshire patients qualified.

A handwritten signature in black ink, appearing to read "Frankie G.", is written in a cursive style.

## COMMITTEE REPORT

COMMITTEE: Health, Human Services and Elderly  
BILL NUMBER: HB 573-FN  
TITLE: Relative to the use of marijuana for medicinal purposes.  
DATE: March 7, 2013 CONSENT CALENDAR: YES ☐ NO ☒

☐ OUGHT TO PASS

☒ OUGHT TO PASS W/ AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ INTERIM STUDY (Available only 2<sup>nd</sup> year of biennium)

Amendment No.

2013-0797h

### STATEMENT OF INTENT:

See Attached Blur!

COMMITTEE VOTE: Y 4 - N 1

RESPECTFULLY SUBMITTED,

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

Rep. Steph Schmitt

For the Committee