Public Hearing of the Medical Advisory Board (MAB) to the NMDOH Medical Cannabis Program

Report and Recommendations to the Secretary of Health

Meeting Date: Friday, 3 November 2017 10AM-1PM

Meeting Location: Harold Runnels Building Auditorium, 1190 St. Francis Drive, Santa Fe, NM

Report prepared by Laura Brown, MD, MPH, MAB Chair-Elect and reviewed by MAB

A. Introductory Comments and Introduction of MCP Staff and Board Members

The meeting was called to order by Dr. Mitchell Simson, MD, outgoing chair of the Medical Advisory Board.

Board members present at the meeting:

1. **Laura Brown, MD, MPH, Family Medicine**
2. **Rachel Goodman, MD, Obstetrics/Gynecology**
3. **William Johnson, MD, Psychiatry**
4. **Belyn Schwartz, MD, Physical Medicine and Rehabilitation**
5. **Mitchell Simson, MD, Internal Medicine**

Present representing the Department of Health:

1. **Kenny Vigil, Director, Medical Cannabis Program**
2. **Andrea Sundberg, Program Coordinator, Medical Cannabis Program**
3. **Chris Woodward, JD, Office of General Counsel**
4. **Leah Roberts, MD, Medical Director, Medical Cannabis Program**
5. **Jenna Burt, Health Educator, Medical Cannabis Program**

Not present from the Department of Health:

1. **Maureen Small, MD, Medical Director, Medical Cannabis Program**

NMDOH MCP announced new program staff in attendance today, Dr. Leah Roberts and Ms. Jenna Burt, and noted that Dr. Maureen Small has resigned her position as Medical Director, with last day November 15, 2017.

Ongoing three vacant MAB positions include MD representatives from Oncology, Infectious Disease, and Neurology.

B. Medical Cannabis Program Update

Program Director Kenny Vigil noted that there were 48,000 persons actively enrolled in the medical cannabis program as of the end of September 2017, the most recent count available. This represents an increase of 13,091, or 38%, from the 34,909 enrollees noted at the April 2017 MAB public hearing.

Several members of the public expressed concern that a shortage of medical cannabis product exists.

Another concern raised was of lab results in BioTrack being removed from the system. Dr. Simson expressed concern about these allegations and asked Mr. Kenny Vigil to follow up at the next MAB meeting.

C. Actions of the Secretary of Health on the Recommendations of the Medical Advisory Board from the Public Hearing on 4 November 2016

In a document issued June 6 2017:
1) Secretary Gallagher declined to adopt the MAB's Nov 4 2016 recommendation to add Opioid Use Disorder to the list of medical qualifying conditions.

MAB Response:

- The Secretary's description of human data presented by Anita Briscoe as "anecdotal" is problematic, given the large number of NM patients Ms. Briscoe and other clinician colleagues have observed using medical cannabis successfully for their opioid use disorder treatment

- While many patients with opioid use disorder who also have chronic pain and/or PTSD could access medical cannabis for their chronic pain or PTSD as already-approved medical qualifying conditions, not all opioid use disorder patients have chronic pain or PTSD

• LECUA specifies that medical cannabis should be used to relieve suffering, that is, symptoms of medical conditions, which certainly applies in the case of medical cannabis relieving symptoms of opioid use disorder

• The Secretary's statement that "I am concerned that utilizing one addictive substance to treat dependence on another without reliable medical evidence and human research studies is problematic at best considering our current opiate epidemic" is misguided in that it ignores the lower rate of addiction seen with cannabis than with opioids (Institute of Medicine 1999 report cited in The Pot Book edited by Julie Holland MD 2010, p. 292) citing risks of dependency of cannabis at 9% vs. heroin at 23%). It also neglects the principles of harm reduction, when considering low risk of cannabis addiction when used to treat opioid use disorder versus untreated opioid use disorder, which can lead to opioid overdose and death

• The opioid-sparing effects of cannabis are well-documented in the medical literature over past decades, meaning that persons using cannabis need, and take, fewer prescription opioids, whether they are using opioids for chronic pain or opioid use disorder

• Full opioid agonists, or activators of the brain's opioid receptors, include hydrocodone, oxycodone, heroin, hydromorphone, methadone, fentanyl, and others—some of these substances are legal and legally prescribed, others are legal but illicitly used, and others are illicit, but all function in identical fashion pharmacologically

2) Secretary Gallagher declined to adopt the MAB's Nov 4 2016 recommendation to add Neurodegenerative Dementia and Alzheimer's Disease to the list of medical qualifying conditions.

MAB Response:

• Key reference: Eubanks et al. A Molecular Link Between the Active Component of Marijuana and Alzheimer's Disease Pathology." Molecular Pharmaceutics 3 (2006): 773-77. As quoted in The Pot Book`(edited by Julie Holland MD, 2010) p. 302:
"There are currently no Food and Drug Administration (FDA)-approved treatments or medications available that actually modify the disease course of AD (Alzheimer's Disease). There are only a few drugs (Aricept [donepezil] and Namenda [memantine] that have been FDA-approved to treat symptoms of the disease, but these drugs do not actually improve

the long-term prognosis. None of these drugs halt the formation of plaques in the brains of AD patients.
There is now ample evidence in the medical literature to indicate that cannabis may provide not only symptomatic relief to patients afflicted with AD, but it also actually limits the formation of new plaques in the brain. Thus, it appears that cannabis may actually slow down the progression of the disease. In a study done at Scripps Research Institute in California, researchers reported that delta9-THC, both in the test tube and in computer models, inhibited the enzyme responsible for the aggregation of amyloid plaque, which is the primary marker for AD, in a manner considerably superior to the FDA-approved AD drugs such as donepezil and tacrine (Cognex) [Eubanks et al. 2006]."

• 9 other studies, some including humans with Alzheimer's Disease, quoted in The Pot Book (pp. 302-303) show efficacy of medical cannabis in persons with AD

• 10 states already list Alzheimer's Disease and/or neurodegenerative disorders as medical qualifying condition for medical cannabis

3) Secretary Gallagher declined to adopt the MAB's Nov 4 2016 recommendation to permit Telemedicine-Certified Patients to those applying for medical cannabis program enrollment

MAB Response:

• Telemedicine has been available for 40 years and is widely acknowledged to be cost-effective in the delivery of health care, especially in rural areas

• A physical exam requiring actual contact between a clinician and patient seeking medical certification for medical cannabis is NOT required

• Telemedicine is supported by federal agencies Medicare and Medicaid, and New Mexico is 1 of 22 states with Category 01 status, "with supportive policy landscape, that not only accommodates telemedicine adoption, but also usage" (www.marijuanadoctors.com--accessed 1/12/18)

• 7 states already allow patients to access medical cannabis services via telemedicine

• The Secretary's comment in her decision 6/6/17 that "…patients must return to their prescribing physician before their prescription is renewed" is inaccurate; patients' refill prescription requests are often handled over telephone, not in person

• Opioid prescription-related clinician visits do not require in-person contact, so holding medical cannabis certification to a more-stringent in-person requirement is unethical and improper given the greater risks associated with opioid prescriptions than with medical cannabis certification

4) Secretary Gallagher declined to address the request from the public to increase plant count or the MAB's recommendation to address increase the plant count.

MAB Response:

• The Secretary's 6/6/17 response to this request is as follows:
"The request to increase the plant count limit for licensed nonprofit medical cannabis producers is not a petition within the terms of the statue or the rule, and also does not fall within the state responsibilities of the Advisory Board. Accordingly, I am declining to address the request or the Advisory Board's recommendation concerning it."
This is an inaccurate assessment, given NMSA statute describing the role of the Advisory Board:
"E. recommend quantities of cannabis that are necessary to constitute an adequate supply for qualified patients and primary caregivers."
Given robust growth in patients enrolled in NMDOH MCP with fixed supply of medical cannabis available, it is obvious that a shortage, or "inadequate supply" of medical cannabis, could be expected. Petitions related to "adequate supply" would certainly be relevant to addressing this shortage, and therefore part of the MAB scope.

D. Actions of the Secretary of Health on the Recommendations of the Medical Advisory Board from the Public Hearing on 7 April 2017

In a document issued October 26 2017:

1) Secretary Gallagher declined to adopt the MAB's April 7 2017 recommendation to add Autism to the list of medical qualifying conditions.

MAB Response:

• 2 states already list Autism in their lists of medical cannabis qualifying conditions

• Many current medications used to address the symptoms and signs associated with autism have notable adverse effects, with risks, including overdose and death, greater than those of medical cannabis; or lack clinical efficacy

2) Secretary Gallagher declined to adopt the MAB's April 7 2017 recommendation to add Attention Deficit Hyperactivity Disorder (ADHD) to the list of medical qualifying conditions

MAB Response:

• 5 medical references including human studies listed in The Pot Book (cited above; pp. 290-291) support the efficacious use of medical cannabis in the treatment of ADHD

• Standard treatment of ADHD with prescribed controlled substance stimulants associated with higher rates of addiction than cannabis

• Use of prescribed controlled substance stimulants associated with known risk of subsequent illicit methamphetamine use and addiction

• Other stimulant substances used by persons with ADHD to self-medicate, such as nicotine, cocaine, amphetamine, and methamphetamine more risky, with higher rates of addiction

3) Secretary Gallagher declined to adopt the MAB's April 7 2017 recommendation to add Anxiety to the list of medical qualifying conditions.

MAB Response:

• No medical/clinical reference is provided by the Secretary in her decision to decline the MAB recommendation to add anxiety to NM's list of medical qualifying conditions:
"More generally, I am concerned about the potential effects of cannabis on persons with anxiety disorders. The consumption of cannabis is known to generate anxiety, and if cannabis is used by someone who already suffers from an anxiety disorder, it is possible that their condition will be exacerbated."

• While acknowledging the risk of anxiety provoked by cannabis when delta-9-THC was administered intravenously, arguably an anxiety-provoking procedure among non-intravenous drug users in and of itself, Dr. Holland (The Pot Book, pp. 184-5) cites a meta-analysis review in which cannabis was not found to cause anxiety disorders. Another study cited by Dr. Holland suggests that only highly-psychosis-prone college students described cannabis as increasing their anxiety (Verdoux, 2005 cited in Holland, p. 184)

• Current standard treatment of anxiety with prescribed benzodiazepines is risky, given risk of benzodiazepine misuse, diversion, and addiction; as well as overdose and death, especially in combination with opioids and/or alcohol.

• Blessing E et al. (2015) note the efficacy of CBD as an anxiolytic (anxiety-reducing) treatment of several anxiety disorders, especially in a current context where other medications such as SSRIs, SNRS, MAO-I, TCA anti-depressants, 5-HT1A receptor agonists, anticonvulsants, and atypical anti-psychotics are noted to have limited efficacy, residual symptoms, and adverse effects which limit tolerability and adherence by persons with anxiety

• In response to the Secretary's comment that a National Academy of Science 2017 report found no "good-quality primary literature" of cannabis as effective anxiety treatment, one of the NAS panel members, Dr. Donald Abrams, a UCSF oncologist stated that "…the absence of

evidence of effectiveness does not equate to evidence of the absence of effectiveness" (Accessed online via PubMed 1/15/18)

4) Secretary Gallagher declined to adopt the MAB's April 7 2017 recommendation to add Depression to the list of medical qualifying conditions.

MAB Response:

• Human evidence in a 2006 study by Denson and Earleywine supports efficacy of cannabis for depressed persons (cited in The Pot Book p. 288)

• Hill and colleagues make connection between decreased endogenous cannabinoid levels and depression in making the case that cannabis could effectively treat depression (cited in The Pot Book p. 288)

• Lucas (2017) cites two medical references supporting the use of cannabis high in cannabidiol and low in THC in depression treatment

• Cochrane meta-analysis of current antidepressants indicates lack of anti-depressant efficacy over placebo in treatment of mild and moderate depression; and many current anti-depressants are associated with many major side effects which limit their acceptability to patients with depression

5) Secretary Gallagher declined to adopt the MAB's April 7 2017 recommendation to add Chronic Headaches to the list of medical qualifying conditions.

MAB Response:

• Russo (1998) cited in The Pot Book (pp. 333-334) published a historical review of use of cannabis treatment of headaches going back to sixth and seventh centuries, including the efficacious use of cannabis for migraine headaches

• Current chronic headache treatment with prescribed opioids associated with misuse, diversion, addiction, and subsequent overdose risk

• Even though cannabis was taken out of the U.S. Pharmacopeia in 1942 with subsequently fewer published human reports of cannabis efficacy, there is a medical study (Noyes and Baram 1974 cited in The Pot Book p. 334) finding chronic headache treatment with cannabis to be superior to ergotamine (pharmacological basis of current migraine headache medication) and aspirin

• NJ and CA already list migraine headaches on their lists of medical qualifying conditions, and CT has pending approval to add "intractable headache syndrome"

6) Secretary Gallagher declined to adopt the MAB's April 7 2017 recommendation to add Sleep Disorders to the list of medical qualifying conditions.

MAB Response:

• Commonly-prescribed medications to treat sleep disorders include benzodiazepines, and other controlled substance medications such as zolpidem which have benzodiazepine cross-reactivity; these medications are clearly associated with misuse, diversion, addiction, and overdose, especially when combined with opioid and/or alcohol. Thus, medical cannabis represents a far safer option for treatment of sleep disorders such as insomnia, snoring, and sleep apnea.

• Russo (2007; cited in The Pot Book, p. 326) published a review of cannabis-based medicine Sativex in successful treatment of sleep-related syndromes

• Cannabinol, a THC metabolite, is believed to be the key component of cannabis sleep disorder treatment

7) Secretary Gallagher declined to address the request or the MAB April 7 2017 recommendation regarding patient cannabis-growing collectives

MAB Response:

• See C4 above regarding MAB position on petitions related to adequate supply within MAB scope

8) Secretary Gallagher declined to adopt the April 7 2017 MAB recommendation regarding the proposed increase of the adequate supply and associated medical exception.

MAB Response:

- **See C4 above regarding MAB position on petitions related to adequate supply within MAB scope**
- **In response to the Secretary's 10/26/17 decision comment: "Significantly, in rendering this recommendation the Advisory Board did not rely upon or reference any identified standard regarding clinically appropriate dosage of cannabis, and I am not aware that any such standard exists or has been adopted within the medical community",**

a) Both Arizona and Illinois allow up to 2.5 ounces per 14-day limit, or approx 5 ounces per month, almost double New Mexico's current 8 oz/3-month limit

b) New York medical cannabis law specifies that the medical practitioner determines the amount of 30-day supply

(Accessed online 1/15/18 www.leafly.com)

- **Washington state permits possession of up to 24 ounces usable cannabis per 60-day period, or 12 ounces per month, vs. NM's 2.66 ounces per month limit**

9) Secretary Gallagher declined to adopt the April 7 2017 MAB recommendation regarding the proposal to remove the 70% THC concentration.

MAB Response:

- **Multiple states, including Massachusetts, Nevada, and Washington permit cannabis concentrate at the same time as other forms of cannabis; specifically up to 3.5, 5, and 21 grams respectively (accessed online 1/15/18)—with unspecified percentage THC**

- **No medical references or evidence are cited to substantiate the Secretary's assertion that "High concentrations of THC may involve a higher risk of negative health consequences for patients, particularly**

given that many patients experience compromised immunities as a result of their medical condition"

• Per Organica NM website, THC concentrates >70% permitted with medical exception, so clarification needed, and further research and surveillance of medical research needed regarding concentrates and extracts, including "dabbing"

Dr. Steve Jenison, former NMDOH Medical Cannabis Program Medical Director and Medical Cannabis Program Medical Advisory Board chair, asked the MAB at the Nov 3 2017 meeting if Secretary Gallagher had ever contacted MAB members regarding their public hearing recommendations. Dr. Rachel Goodman reported that she has never met with the Secretary since she was appointed to the Board.
Upon review of MAB notes, it appears that MAB members have not met with Secretary Gallagher at any time in her current role as Secretary. It appears that the last contact between a NM Secretary of Health and MAB occurred May and June 2015 with the late Secretary Retta Ward.

Ms. Lee DeFrancesca asked the MAB "how they felt about the Secretary ignoring their (MAB) recommendations", and Dr. Laura Brown and other MAB members acknowledged that it is frustrating. Mr. Bryan Krumm also expressed angered concern about the negative responses of Secretary Gallagher, an attorney, to physician-generated MAB recommendations.

In Secretary Gallagher's October 26 2017 response to April 7 2017 MAB recommendations, she states:

"The Advisory Board is comprised of several board-certified medical specialists who bring with them a wealth of knowledge and expertise regarding medical conditions and their treatments. However, in some instances, the Advisory Board's written reports have recommended in favor of or in opposition to a given petition without providing any detail as to why the Advisory Board reached their conclusion. In future reports, it would be helpful for the Advisory Board to emphasize the strengths and weaknesses of a petition, and to highlight whatever information (clinical studies, etc.) they consider to be the most salient."

This MAB report uses a different format to address the Secretary's concerns expressed above, including references and MAB expert comment as part of its response to the Secretary's positions.

Final note should be made in response to Secretary Gallagher's comment above that all MAB members are nationally board-certified in their respective fields, which is a requirement of serving on the NMDOH Medical Cannabis Program Medical Advisory Board.

It is also critically important to note that there were over 1000 pages of petitions for MAB members to review in the 1-2 months preceding the two 2017 public hearings. Outgoing chair Dr. Mitch Simson and other MAB members noted this at both meetings, and a recommendation was made publically to limit the number of petitions reviewed at each public hearing, and the number of pages per petition; and that all references be available in hard copy and/or article attachment link.

It is anticipated that such petition-related limits will greatly increase the capacity of the MAB to adequately review each petition and research the proposed medical qualifying condition addition and other pertinent issues brought to the MAB which are under their purview, such as adequate supply of medical cannabis in New Mexico.

D. Petitions Not Heard at November 3 2017 meeting

Outgoing chair Dr. Simson stated that Petitions 29, 30, 31, 32, 34, 35, 36 would not be considered as they are beyond the scope of the Medical Advisory Board.

MAB Comment:

Multiple comments from the public in attendance as well as MAB Board members were made regarding a current and worsening inadequate supply of medical cannabis, especially given the greatly-increased numbers of Medical Cannabis Program enrollees. As stated in Rule 7.34.28B, the MAB duties and responsibilities include: "recommend quantities of cannabis that are necessary to constitute an adequate supply for qualified patients and primary caregivers". Thus, as recommended previously in this report, it would appear that any and all petitions related to addressing the supply of medical cannabis to better constitute an "adequate supply" are well within the purview of the MAB. Thus, petitions such as 2017-29 LNPP Plant Count Increase" should be considered at public hearings. It is clear that as program enrollee numbers increase, a parallel increase in medical cannabis product will be necessary to re-gain "adequate supply" for New Mexico.

E. Petitions to Add New Diagnoses

1. 2017-24 Eczema and Psoriasis
MAB recommendation to add eczema and psoriasis as qualifying condition by 4-1 vote

MAB Comment:

- **Connecticut has already added Severe Psoriasis and Psoriatic Arthritis to its list of medical qualifying conditions, based on physician recommendation**

- **Medical literature review of use of topical and endogenous cannabis indicates successful treatment of eczema-associated and other forms of pruritis**

- **Chronic use of steroids for eczema treatment inadvisable given risk of systemic and cutaneous adverse effects**

- **Current psoriasis treatment with phototherapy associated with significant risks of nonmelanoma skin cancer and melanoma; psoriasis medications also associated with systemic adverse effects**

- **Medical cannabis found to have dermatological efficacy given concurrent anti-inflammatory effects**

- **LECUA specifies use of medical cannabis to "allow the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments" (NMSA 1978)**

2. 2017-25 Muscular Dystrophy

MAB recommendation to add muscular dystrophy as qualifying condition by 3-2 vote

MAB Comment:
- **Illinois, Louisiana, New Hampshire, Connecticut (pending approval of legislature) and New Jersey all have already added Muscular Dystrophy to their respective lists of medical qualifying conditions**

• No cure exists for Muscular Dystrophy (MD); palliative effects of medical cannabis reported not only for chronic pain but also for involuntary muscle contractions of MD

3. 2017-26 Polymyalgia Rheumatica

MAB recommendation to decline addition of polmyalgia rheumatica as a qualifying condition by 5-0 vote.

MAB Comment:

• Consensus among MAB that polymyalgia rheumatica adequately covered under already-existing Severe Chronic Pain and/or Inflammatory Autoimmune-Mediated Arthritis medical qualifying conditions

4. 2017-28 Seizures

MAB recommendation by 5-0 vote to add clarification on NMDOH MCP application that Seizure Disorder is included with Epilepsy, an existing medical qualifying condition; for example by listing as follows: "Seizure Disorder/Epilepsy" OR "Epilepsy (including Seizure Disorder)"

MAB Comment:

• "Epilepsy" is an outdated medical term rarely used, especially given associated stigma; vs. "seizure disorder" which is more widely-used currently

5. 2017-33 Pediatric Oncology and Cannabis Use for Antiemetic in State Hospitals
MAB recommendation by 5-0 vote to create NMDOH statement that MAB supports use of medical cannabis in hospital setting

MAB Comment:

• Key reference = "Medical marijuana…in the hospital?" ACP Hospitalist January 2017—accessed online 1/15/18):
1)"As of May 2016, state laws in Connecticut and Maine permit the use of medical marijuana by hospitalized patients and give some state-level protection for clinicians who administer it."

2) Medical cannabis use is permitted among Mayo Clinic's hospitals in Rochester, MN
3) In 2015 Minnesota Hospital Association developed sample policies hospitals may adopt regarding in-hospital use of medical cannabis

• Medical cannabis favored by many pediatric cancer providers, according to Yale Cancer Center

• Other countries, such as Israel, have permitted medical cannabis in hospitals for decades

6. 2017-37 Dysmenorrhea
MAB recommendation by 5-0 vote to decline addition of dysmenorrhea as a qualifying condition.

MAB Comment:

• Dysmenorrhea could potentially be covered under already-existing Severe Chronic Pain medical qualifying condition

• CBD, available without a medical cannabis card, could also be recommended for persons suffering from dysmenorrhea, as it is known to reduce pain and inflammation

7. 2017-20 Sleep Disorders
MAB recommendation by 4-0 vote to add sleep disorders as a qualifying condition.

MAB Comment:
• See previous comments made in this report section D6

• Not all persons with sleep disorders including insomnia and sleep apnea have another medical qualifying condition such as PTSD or Severe Chronic Pain

8. 2017-39 Degenerative Neurological Disorder and Neuroprotection
MAB recommendation by 5-0 vote to table current petition and to review previous petitions for next meeting

MAB Comment:

- See previous comments made in this report section C2

9. 2017-40 Cystic Fibrosis

MAB recommendation by 4-0 vote with 1 abstention to decline addition of cystic fibrosis as a qualifying condition.

MAB Comment:

- Persons with cystic fibrosis already covered by Severe Chronic Pain and/or Intractable Nausea/Vomiting medical qualifying conditions
- Connecticut has already specifically approved cystic fibrosis as medical qualifying condition for both adult and pediatric pts

10. 2017-4 ADD/ADHD and Tourette's Syndrome

MAB recommendation by 5-0 vote to approve addition of Tourette's Syndrome as a qualifying condition and to table ADD/ADHD discussion until next meeting

MAB Comment:

- Tourette's already a medical qualifying condition in Ohio, Minnesota, Illinois, Arkansas, and New Jersey (pending approval)

- 6 human studies, including a randomized controlled trial (RCT) cited in The Pot Book (Holland, MD, pp. 303-4) describe efficacious use of medical cannabis in reducing tic severity score (TSS) and improving global functioning

11. 2017-27 Post-Concussion Syndrome and TBI

MAB recommendation by 5-0 vote to decline addition of post-concussion syndrome and TBI as a qualifying condition.

MAB Comment:

- Timing of post-concussion signs, symptoms, and diagnosis and certification of diagnosis for medical cannabis problematic

• Research showing efficacy of medical cannabis in acute versus chronic TBI still inadequate, although TBI already medical qualifying condition in 4 states—Illinois, New Hampshire, Ohio, and Washington

12. 2017-38 Diabetes Mellitus
MAB recommendation by 4-0 vote with 1 abstention to decline addition of diabetes mellitus as a qualifying condition.

MAB Comment:

• Previous petition to add DM denied

13. 2017-41 All Forms of Arthritis
MAB recommendation by 4-0 vote with 1 abstention to decline addition of "All Forms of Arthritis" as a qualifying condition.

MAB Comment:

• Arthritis already covered by Severe Chronic Pain and/or Inflammatory Immune-Mediated Arthritis medical qualifying conditions

14. 2017-43 Substance Use Disorder
MAB recommendation by 4-1 vote to approve addition of Substance Use Disorder as a qualifying condition.

MAB Comment:

• Key reference: Reiman, A, "Cannabis as a Substitute for Alcohol and Other Drugs," Harm Reduction Journal (London, United Kingdom: December 2009):
Medical cannabis used as alternative to alcohol, prescription and illicit drugs given fewer adverse effects and better symptom management with medical cannabis. This process of "substitution of one psychoactive substance for another with the goal of reducing negative outcomes" represents harm reduction.

Key reference: Swartz, Ronald, "Medical marijuana users in substance abuse treatment," Harm Reduction Journal (London, United Kingdom: March 2010) Vol. 7, pp. 7-8.
"It is clear, however, that cannabis use did not compromise substance abuse treatment amongst the medical marijuana using group. In fact, medical marijuana users seemed to fare equal to or better than non-medical marijuana users in every important outcome category. Movement from more harmful to less harmful drugs is an improvement worthy of consideration by treatment providers and policymakers." Also noted that replacement of other more dangerous and costly drug use (example of economic cost of alcohol use in California estimated at $38 billion) with medical cannabis may lead to significant social and economic savings.

Key reference: O'Shaughnessy, WB "Emerging Clinical Applications of Cannabis." O'Shaughnessy's: The Journal of Cannabis in Clinical Practice. Winter/Spring 2007 cited in <u>The Pot Book</u> (Holland, 2010, p. 292)
"Multiple California clinicians responded to the O'Shaughnessy survey with tales of patients with prior out-of-control addictions who become stabilized on small amounts of cannabis. One physician reported more than 90 percent of his patients had reduced their alcohol consumption by using cannabis. From a medical and psychiatric perspective, the substitution of cannabis for other more toxic and addictive drugs is a good example of harm reduction."

Key reference: Meenakshi SS, "Can Cannabis Be Considered a Substitute Medication for Alcohol?" Alcohol and Alcoholism 2014; 49 (3): 292-298
"Perhaps more importantly, cannabis is both safer and potentially less addictive than benzodiazepines and other pharmaceuticals that have been evaluated as substitutes for alcohol."

Key reference: Lucas P et al. "Substituting cannabis for prescription drugs, alcohol, and other substances among medical cannabis patients: the impact of contextual factors" Drug and Alcohol Review 35: 326-333 (2016)
"87 percent patients reported substituting cannabis for other drugs that they had been using including prescription medication (80.3%), alcohol (51.7%) and illicit drugs (32.6 %)."

• Medical cannabis thus considered an "exit" drug used in substance use disorder treatment, not a "gateway" drug.

15. 2017-44 Opioid Use Disorder
MAB recommendation by 5-0 vote to approve addition of Opioid Use Disorder as a qualifying condition.

MAB Comment:
- **See previous comments in this report Section C1**

- **Key reference: Lucas P "Rationale for cannabis-based interventions in the opioid overdose crisis" Harm Reduction Journal (2017) 14: 58. Evidence-based rationale for medical cannabis inclusion in 3 areas: 1) prior to opioid introduction in the treatment of chronic pain; 2) as an opioid reduction strategy for those patients already using opioids; and 3) as an adjunct therapy to methadone or buprenorphine (Suboxone) medication-assisted treatment in order to increase treatment success rates.**

- **Quality supporting document for the opioid use disorder petition submitted by Dr. Steven Jenison, former NMDOH MCP Medical Director and MAB chair, with 82 citations.**

Important assertion made by Dr. Jenison in this document that:

> **"New Mexico added chronic pain as a qualifying condition for enrollment many years ago when the human clinical trials data were limited but when there was a compelling need to address the gross inadequacy of pain management through conventional treatments. At that time, there was strong pre-clinical evidence of efficacy, limited human clinical data and much anecdotal evidence to support adding chronic pain as a qualifying condition. It is time for New Mexico to move boldly and compassionately again by adding opioid dependence treatment to the list of conditions eligible for enrollment. It is supported by pre-clinical data, by a preponderance of reports by patients and practitioners and by emerging human clinical data. It is extremely likely that those benefits that have been seen through the use of medical cannabis in the treatment of pain will apply also to the treatment of opioid dependence. The two are closely related at many levels. In this time of crisis, with so many lives being lost and destroyed, we must not be dissuaded from acting when there is so much at stake. The risks of opioids are substantial and well known to us. The risks of cannabinoids are less—much less. We know this. It is entirely plausible that medical cannabis can be a tool in addressing the opioid dependence crisis and in saving lives. It is time to act."**

F. Election of New Chair

MAB vote 4-0 with 1 abstention to elect Dr. Laura Brown as new MAB Chair.
Dr. Brown accepted nomination and vote, and thanked Dr. Simson for his MAB Chair service over the past year.

Public comment taken throughout the petition hearing process.

Meeting adjourned without decision regarding date of next MAB meeting in spring 2018. MAB to be contacted by program staff to schedule next meeting.

Next MAB meeting now scheduled for Friday May 11 2018 10A-1P.