

FISCAL IMPLICATIONS

AODA reports the bill could add to the number of laboratory analyses, prosecutions, and potential incarceration, of persons possessing or distributing any of the prohibited substances. Similarly, PDD comments that because the number and type of prosecutions can vary based on the additions of these substances, the fiscal impact may be severe for PDD, without providing any specific figures. A similar increase in costs to AOC would likely follow. In light of any such increase, NMCD suggested in its earlier analysis that this bill could ultimately produce moderate to substantial increases in the state's prison population and/or probation/parole caseloads. The average cost to incarcerate a male inmate is \$38,537 per year in a state-owned and operated prison, and the average annual cost in a privately operated prison is \$29,386 (where primarily only level III or medium custody inmates are housed). The cost per client in Probation and Parole for a standard supervision program is \$2,678 per year, in Intensive Supervision programs is \$7,206 per year, and in Community Corrections is \$1,539 per year. The cost per client per year for female residential Community Corrections programs is \$30,135 and for males is \$22,197, although these programs usually last only six months for an offender. NMCD also suggested additional monies may be required to pay for urinalysis testing for synthetic marijuana for probationers and parolees, and ultimately summarizes its estimated operating budget impact as being minimal to moderate. In its earlier analysis, DPS also reported in a \$20 thousand per year increase to purchase the appropriate standards.

In light of advice from the Pharmacy Board of RLD (RLD/PB) that all of the substances being added to Schedule I are already there given that Board's statutory authority to adopt rules adding to that Schedule (see Significant Issues), it appears that costs of prosecution, defense, testing and adjudication, as well as probation, incarceration, and parole may be absorbed already in existing operating budgets amounts and no amounts are presented in the table above.

However, the removal of marijuana in the Senate Judiciary Committee Substitute from the list of controlled substances could result in fewer prosecutions and a resulting decrease in defense, judicial, and prison costs. Absent further information, no amounts reflecting that potential decrease is shown in the table.

SIGNIFICANT ISSUES

This substitute bill, by removing all references to marijuana from Schedule I of the Controlled Substances Act, attempts to decriminalize it. However, as the AODA, AGO and other agencies advised in their analyses of SJR 10, which seeks to legalize recreational marijuana, the possession, production, distribution and sale of marijuana is illegal under federal law. As AGO commented:

Federal law criminalizes growing, distributing, or possessing marijuana. It is also a federal crime to provide places for growing, distributing, or storing marijuana or to use a telephone to buy or sell marijuana. Federal law makes all of these crimes felonies except possessing marijuana, which is a misdemeanor. Federal law allows limited use of marijuana for medical research, but does not allow medicinal use of marijuana.

Similarly, AODA commented in its analysis of that joint resolution:

The supremacy clause of the United States Constitution would override any contrary decision by the state. President Obama and Attorney General Holder have—so far--declined to prosecute persons using medical marijuana pursuant to state law or to prosecute persons possessing and using marijuana for recreational purposes under the Colorado law which took effect this year. But the President and his Attorney General, or any subsequent administration, could reverse course and prosecute persons possessing marijuana for federal crimes despite language in the New Mexico constitution that permits possession and use of marijuana and authorizes regulation of such activities as the production, processing, transportation, sale and taxation of marijuana.

In addition, the deletion of marijuana from the listing of controlled substances in Section 30-31-6, NMSA 1978 appears to set up a conflict between that law and the PB rule that adds controlled substances including marijuana to Schedule I pursuant to Subsection I of that section and Section 30-31-3 NMSA 1978. However, since the authority for the rule is granted in these statutes, to the extent it conflicts with the amendments contained in this substitute, the rule can be likened to an irreconcilable conflict between two statutes, in which case it appears the later-enacted statute—this committee substitute--would govern. See Section 12-2A-10(A), NMSA 1978. Further, to the extent other criminal statutes may refer to marijuana, it is questionable whether this bill would constitute later-enacted legislation that under this analysis and would be held to govern. Particularly, as the AODA notes, statutes such as those criminalizing distribution of marijuana to a minor and possession of marijuana do not rely on its listing in any schedule of the Controlled Substances Act. See Sections 30-31-21 and 30-31-23, NMSA 1978. Marijuana is also listed in Schedule II of the Controlled Substances Act. See Section 30-31-7(A)(1)(e), NMSA 1978.

But for the removal of marijuana, RLD/PB reports that all of the proposed additions to Schedule I set out in the bill are currently listed in schedule I of the Controlled Substances Act by board rule in 16.19.20.65 NMAC. Subsection A of section 30-31-3, NMSA 1978 gives the board the authority to add substances to the controlled substances schedules pursuant to the rule making procedures of the Uniform Licensing Act, Sections 61-1-29 through 61-1-31, NMSA 1978. Likewise, subsection F of section 30-31-6 incorporates “controlled substances added to Schedule I by rule adopted by the board pursuant to Section 30-31-3, NMSA 1978” into Schedule I.

In spite of these substances’ technical inclusion in Schedule I already, RLD/PB explains this bill might be beneficial: currently a person must review the controlled substances listed in regulation 16.19.20 NMAC to identify those additional substances not found in the Controlled Substances Act. This has led to confusion for the public, attorneys and law enforcement when trying to determine if a substance is scheduled. Even though these substances are already listed in schedule I, reproducing them in the Controlled Substances Act provides a listing that is a duplicate of the NMAC list of schedule I substances. This will simplify identifying controlled substances by providing one location where a person can find a complete enumeration of the entire schedule I controlled substances.

As to the other provisions of this bill that remain unchanged, AODA commented in its earlier analysis that the bill appears to be an attempt to broaden the definition of synthetic cannabinoids and other drugs so just changing the formula will not then make any related substance legal, but

an expert in chemistry will be needed to determine if the language in the bill will accomplish that. If the experts agree that it does, the bill will help eliminate possession and sale of a dangerous group of illegal drugs but, from experience, almost any time an expert offers an opinion there is another one who will provide a different, and frequently opposing, one.

AODA also noted the bill designates certain additional specific substances, in Sections D and E, as prohibited. If those are among the synthetic cannabinoids, or synthetic cathinones, the bill seeks to prohibit it seems possible their chemical formulation might be slightly altered to create a new compound to avoid prohibition of those types of drugs.

Similarly, AODA commented in its analysis of the original bill that duplicating administrative regulations with legislation could avoid any challenges later by someone who objected to the rule-making process for lack of notice, opportunity to be heard, or similar concerns.

PERFORMANCE IMPLICATIONS

In its earlier analysis, DPS expressed concerns that standards may not be readily available, and the time it may take to obtain those standards could delay cases for weeks to months. When appropriate standards are not available, the DPS Forensic Laboratory cannot report analytical results nor determine the accurate structure of the compound to know if it meets the regulatory description. Other agencies reported varying performance impacts that would arise out of increased prosecution of drug violations. However, these difficulties may be occurring now, given the inclusion of these substances in the RLD/PB regulation.

RELATIONSHIP

This bill relates to SJR 10, which authorizes possession and personal use of marijuana, subject to implementing legislation

OTHER SUBSTANTIVE ISSUES

As to the removal of marijuana from Schedule I, DOH comments:

Marijuana is not a benign substance. While the federal restrictions on marijuana have limited research into the effects (either positive or negative) of marijuana, a number of negative consequences of marijuana use are known. Among them:

- **Addiction/Dependence:** The lifetime risk of dependence is about 9% of marijuana users. While this is lower than the risks for nicotine, heroin, cocaine, and alcohol, it is not negligible (Bostwick, JM MD, “Blurred Boundaries: The Therapeutics and Politics of Medical Marijuana”, *Mayo Clin Proc.* 2012;87(2):172-186).
- **Addiction/Dependence** also entails a withdrawal syndrome (Greydanus, DE, Hawver EK, Greydanus, MM, and Merrick, J:” Marijuana: current concepts”, *Front Public Health.* 2013; 1: 42. Published online 2013 October 10, Bostwick, JM MD, “Blurred Boundaries: The Therapeutics and Politics of Medical Marijuana”, *Mayo Clin Proc.* 2012;87(2):172-186).

- Research studies have noted that cannabis users “demonstrate important deficits in prospective memory and executive functioning that exist beyond acute cannabis intoxication” (Greydanus, MM, and Merrick, J:” Marijuana: current concepts,” *Front Public Health*. 2013; 1: 42. Published online 2013 October 10). This appears to be a relatively subtle effect.
- Chronic use of cannabis is associated with increased rates of psychosis. Frequent cannabis use doubles the risk for schizophrenia and psychotic symptoms (Greydanus, MM, and Merrick, J:” Marijuana: current concepts”, *Front Public Health*. 2013; 1: 42. Published online 2013 October 10). The question of whether cannabis causes psychosis remains unresolved, but there is some evidence that it worsens the course of psychotic illness (Bostwick, JM MD, “Blurred Boundaries: The Therapeutics and Politics of Medical Marijuana”, *Mayo Clin Proc*. 2012;87(2):172-186).
- Marijuana use is associated with tobacco use. Almost three-quarters of current marijuana users in a 1997 survey smoked cigarettes – about 5.4 times the rate of non users (Richter KP, Kaur H, Resnicow K, Nazir N, Mosier MC, Ahluwalia JS.:” Cigarette smoking among marijuana users in the United States”, *Subst Abus*. 2004 Jun;25(2):35-43). The risks of smoking are well known.
- The risk of motor vehicle crashes involving death or injury is about two times as high for drivers under the influence of marijuana than for sober drivers. Tests used in the field for the detection of impaired drivers may not be precise enough to detect marijuana (Greydanus, MM, and Merrick, J:” Marijuana: current concepts”, *Front Public Health*. 2013; 1: 42. Published online 2013 October 10).

AODA provided this background information concerning the substances this substitute adds to the lists in Schedule I:

Synthetic cannabinoids, whose most common street names are “Spice,” or “K2” are chemically engineered substances meant to evoke effects similar to tetrahydrocannabinol (“THC”), the active ingredient in marijuana. The chemicals are applied (usually sprayed) on to plant materials, and when smoked or otherwise ingested they can produce a high similar to marijuana. Synthetic cannabinoids which were sprayed on plant material were first reported in the United States in 2008. Because their chemical formula is not the same as marijuana their usage can go undetected and they are often marketed in legal retail shops or on the internet--sometimes just called herbal incense or potpourri. A national study of youth drug-use trends in 2012 reported that one in nine high school seniors reported using synthetic cannabinoids within the past year.

A similar, parallel problem exists with synthetic cathinones which are man-made chemicals usually called “bath salts” when marketed but are related to amphetamines. Their effects are reported to be similar to cocaine and ecstasy. The risks to public health are significant because the contents and effects of both of these synthetic drugs are unpredictable due to a constantly changing variety of chemicals used in the manufacturing processes which lack quality controls and government regulatory oversight.

The Office of National Drug Control Policy (“ONDCP”) reports that synthetic cannabinoids’ effects include severe agitation and anxiety, nausea, vomiting, tachycardia (accelerated and racing heartbeat), elevated heart rate and blood pressure, tremors and seizures, hallucinations, dilated pupils and suicidal and other harmful thoughts or actions. They report that synthetic cathinone use is associated with increased heart rate and blood pressure, chest pain, extreme paranoia, hallucinations, delusion and violent behavior which causes users to harm themselves or others.

In 2010 there were no federal or state laws controlling these drugs. In 2011 the New Mexico legislature passed SB 134 to prohibit synthetic cannabinoids, and in 2012 the Synthetic Drug Abuse Prevention Act was passed by the Congress designating 26 types of the synthetic cannabinoids and cathinones as Schedule I controlled substances. However, the chemists making these drugs change the formula so it will not be covered by the existing law. ONDCP reports there were 51 new synthetic cannabinoids identified in 2012, compared to just two in 2009 because the chemists are changing compounds to avoid government attempts to make them illegal. In 2012 there were 31 new formulas for synthetic cathinones, compared to just four in 2009. The problem with trying to regulate drugs whose formulas are almost constantly changing is illustrated by the fact that despite the synthetic drug abuse act passed by Congress in 2012, the Drug Enforcement Administration (“DEA”) used its emergency scheduling authority just months later, in April 2013, to designate three more types of synthetic cannabinoids as Schedule I substances because of their hazards to public health.

DOH provided this additional information in its earlier analysis:

Most drug tests detect marijuana, but generally not synthetic cannabinoids (McGuinness & Newell, 2012). The 2012 U.S. Monitoring the Future Survey estimated that 8.8% of 15-16 year-olds and 11.3% of 17-18 year-olds had used synthetic cannabinoids in the past year, making it the most commonly used drug after marijuana for high school seniors (Johnston *et al.* 2013). As regulators nationally and at the state level have added specific compounds to the list of controlled substances, manufacturers have developed new compounds to replace those that have been banned (Fattore & Fratta 2011, Murphy *et al.*, 2013). These substances are variable in composition and potency, and little is known about the pharmacology, toxicology and safety of these compounds (Fattore & Fratta 2011).

Synthetic cannabinoids have been implicated in a number of negative health consequences. The number of emergency department visits related to synthetic cannabinoids more than doubled from 2010 to 2011 (Sacco & Finklea, 2013). Sixteen cases of acute kidney injury related to synthetic cannabinoids were reported across multiple states in 2012 (Murphy *et al.*, 2013). Additionally, severe illness was reported among 22 users of synthetic cannabinoids in Brunswick, GA in 2013. Six of these patients were admitted to the intensive care unit (Drenzek, *et al.*, 2013). In the Denver, CO area, more than 200 people visited emergency rooms in 2013 with altered mental status after using synthetic marijuana. Symptoms included high blood pressure, high heart rate, aggressive behavior, agitation and confusion. Of 127 cases where additional information was abstracted from medical records, sixteen were admitted to the hospital, ten of

those to intensive care (Ghosh, *et al.*, 2013). Because of the variability of concentration and substances, recreational use can lead to unintentional overdose (Nelson et al., 2014).

AOC added to the discussion concerning the effectiveness of existing drug testing when it reported that, given the nationwide surge in use of such synthetic cannabinoids, there are now drug tests available for a small range of these synthetic cannabinoids. Drug testing labs continue to work on tests to answer the demand from criminal justice and industry for reliable and affordable drug tests for the latest designer drugs.

ALTERNATIVES

RLD/PB reports it adds substances to the Act by rule once or twice each year. It also points out that while it can add and remove substances through the procedures specified under the Uniform Licensing Act, the addition or removal of substances in statute would require legislative action. PDD notes that the synthetic drug market is rapidly evolving, and that minor changes to the chemical composition of these substances can create new drugs not covered in the law. Thus, providing a mechanism such as that currently available through the RDL/PB rule-making authority may allow for a speedier process than inclusion in statutes.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Again, RLD/PB comments that all the proposed additions (including the now deleted marijuana) are currently listed in schedule I of the Controlled Substances Act by board rule 16.19.20.65 NMAC. If this bill is not enacted, these substances-- as well as marijuana--will still be regulated as schedule I controlled substances, and the prohibitions and other provisions contained in the Controlled Substances Act regarding these additional substances will continue to be enforceable.

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