BHDCJS Marijuana Subcommittee Recommendations

DRAFT

1. Mandate a thorough substance abuse evaluation be part of the presentencing investigation report (PSI) on all offenders and that it be made available to the court before a Judge rules on whether that person would be allowed to use medical marijuana via a "red card".

    a. RATIONALE: Substance use disorders are much higher in the criminal justice population than in the general population (60% vs 5%) and research has shown marijuana/hashish to be the drug used more than any other (77%). The current medical marijuana that is available has much higher levels of THC than has been shown by research to be helpful for any medical condition (> 10% vs < 10%) and most of the concentrates that are being used under the guise of "medicine" average 69% THC. There is a great deal of research demonstrating that marijuana with THC concentrations greater than 10% increase the risk for cognitive problems, addiction, psychosis, depression, anxiety, suicide, and violence. Probation officers report that as many as 70% of their clients immediately go for a medical marijuana card once they are put on probation, and they are using high doses of THC. Judges often just agree with it because they have been given a red card by a physician. However, it is extremely easy under the current system to get a red card and often there is no physical examination by the physician making the recommendation and no examination of medical records or discussion with the other prescribers working with the offender. And the physicians are not making the recommendations of what dose/strength/route to use and which products – even though that was spelled out in HB21-1317 as a requirement.

2. Mandate that the CDPHE Medical Marijuana Registry program list the name and contact information of the doctor making the recommendation for a person to receive a red card so that other prescribers working with the person can coordinate care. This would be the same as prescribers currently being able to know the name and contact information of the doctors prescribing any other scheduled medication through the PDMP. If Medical Marijuana approved through a red card is medicine, then it should be treated as medicine and in the best care of the patient.

    a. RATIONALE: There are many 'drug:drug' interactions between marijuana components and other prescription medications, some interactions that can result in lethal consequences. Prescribers are frequently put in a position of wanting to talk with the person who has made a recommendation for the patient to have a read card to discuss concerns about interactions that might occur between the medical marijuana and the prescription drug to be prescribed, however, the patient does not remember the name of the person because they saw them only one time for the card and it is impossible to discover who that person may be because to date CDPHE has considered that

confidential information. Similar to the PDMP which prescribers much query before prescribing any other scheduled medication, this is in the best interests of patient care.

3. Mandate that Methadone be included in the PDMP.

    a. RATIONALE: It is somewhat unfathomable why Methadone is not on the PDMP. Historically it may have been because of "stigma", however, buprenorphine (Suboxone) is on the PMDP, and its use is predominately for opioid use disorder. So, it can no longer be about stigma. Methadone is not a benign medication and it has numerous drug;drug interactions with potential lethal outcomes. When a prescriber plans to prescribe a scheduled medication like an opioid or benzodiazepine, they are mandated to query the PDMP first. However, many prescribers are unaware their patients are on Methadone Maintenance and do no learn that through the PDMP. This can become a very dangerous situation. Also, there are many medications, including psychiatric medications that can cause a prolongation of the QTc (heart rhythm problem). Methadone can cause a prolonged QTc and when combined with other medications that can cause this as well can lead to Torsade de Pointe or "sudden death". It is imperative that all prescribers know if their patients are on Methadone maintenance and if it was on the PDMP there would be no excuses for not knowing. Medical marijuana can also negatively interact with Methadone so prescribers recommending marijuana should also be able to check the PDMP for all potential problems that could arise from that recommendation.

4. If an offender does not have a medical marijuana red card before getting a criminal charge, then they will not be allowed to get a red card after getting a criminal charge that leads to conviction.

    a. RATIONALE: Improve success rates, post-adjudication.

5. Competency cases should have a mandated, thorough substance use evaluation.

    a. RATIONALE: Marijuana use has dramatically increased, and this is especially true in the criminal justice population. The strength of THC, the psychoactive component of marijuana, has dramatically increased and research demonstrates significantly increased problems with cognition, psychosis, and violence related to high THC use. Because THC is fat soluble, it remains in the system for some time and depending on the amount and frequency of use, it can cause problems for weeks after cessation of use. Frequently there is no evaluation done, including urine drug screen when the person is first apprehended and put in jail, therefore there is no knowledge if the behavior that evidence incompetence has anything to do with substance use. This situation could be helped by mandating that all persons charged with a violent crime, have a urine drug screen to include THC and a thorough substance use evaluation prior to being found incompetent and place of the list for competency evals. Often, given time, the person can recover from the drug effects if in a controlled environment without access to drugs and receiving appropriate medical care.