TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
THIRTY-FIRST LEGISLATURE, 2021

ON THE FOLLOWING MEASURE:
H.B. NO. 310, H.D. 2, RELATING TO HEALTH.

BEFORE THE:

SENATE COMMITTEES ON HEALTH AND ON HUMAN SERVICES

DATE: Thursday, March 18, 2021 **TIME:** 3:15 p.m.

LOCATION: State Capitol, Room 225, Via Videoconference

TESTIFIER(S): Clare E. Connors, Attorney General, or
Ian T. Tsuda, Deputy Attorney General

Chairs Keohokalole and San Buenaventura and Members of the Committees:

The Department of the Attorney General (Department) provides the following comments.

The purposes of this bill are to (1) amend the definition of "imminently dangerous to self or others" to extend the timeframe for when a person is likely to become dangerous from 45 days to 90 days under section 334-1, Hawaii Revised Statutes (HRS), (2) amend section 334-59, HRS, to permit the involuntary treatment of a patient for up to 30 days, which includes the use of long-term injectable psychotropics, if the patient is diagnosed with a serious mental illness or severe substance use disorder and found to lack decisional capacity, as well as require that such patients be assessed to determine whether a guardian or surrogate is needed to make health care decisions for the patient, and (3) remove the definition of "imminently dangerous to self or others" under section 334-161(b), HRS, in relation to proceedings for Assisted Community Treatment. The Department remains concerned about the provision authorizing involuntary treatment of a patient due to a lack of decisional capacity, even if diagnosed with a serious mental illness or severe substance abuse disorder.

In order to involuntarily treat a patient, the Hawai'i Supreme Court in *State v. Kotis*, 91 Hawai'i 319, 334, 984 P.2d 78, 93 (1999), has held that there must exist facts demonstrating that: (1) an individual actually poses a danger to self or others, (2) treatment with medication is medically appropriate and in the individual's medical

interest, and (3) considering less intrusive alternatives, the treatment is necessary to forestall the danger posed by the individual. In this regard, the existing provisions in section 334-59, HRS, already permit authorized medical professionals to provide necessary treatment to individuals during emergency examination and hospitalization consistent with this holding. Subsection (a)(3) permits treatment to ensure the safe transportation of individuals to a licensed psychiatric facility or emergency hospitalization and subsection (b) permits treatment on an individual that has been delivered for emergency examination and treatment to a psychiatric facility or behavioral crisis center.

The provision permitting involuntary treatment with long-term injectable psychotropics does not satisfy the legal requirements for involuntary medication under *State v. Kotis* as it requires only a lack of decisional capacity and a diagnosis of severe mental illness or severe substance use abuse and will not withstand legal challenge. The addition of wording providing that a patient in these circumstances can be involuntarily treated for up to 30 days or until the patient regains decisional capacity, whichever comes first, does not cure this defect. For these reasons, the Department recommends that the new provisions added to section 334-59(d) by section 3 on page 3, line 17, through page 4, line 11, be deleted.

In addition, to "increase the likelihood" that patients will receive "timely and appropriate care and treatment," the word "shall" in section 334-59(d), on page 3, line 1 of the bill, should remain unchanged. As currently written, authorized medical professionals conducting emergency examinations that have reason to believe that a patient is mentally ill or suffering from substance abuse, is imminently dangerous to self or others, and is in need of care or treatment are required to direct the patient for emergency hospitalization at a hospital or psychiatric facility. The use of the word "shall" ensures that these medical professionals treat such individuals on an emergency basis when the criteria for emergency hospitalization are present. To effectuate the purpose of the bill, the Department recommends that the proposed amendment from "shall" to "may" in section 3 on page 3, line 1, be removed.

The Department respectfully requests that the Committees consider the recommended amendments.

Thank you for the opportunity to testify.

DEPARTMENT OF THE PROSECUTING ATTORNEY

CITY AND COUNTY OF HONOLULU

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THE HONORABLE JARRETT KEOHOKALOLE, CHAIR
SENATE COMMITTEE ON HEALTH

THE HONORABLE JOY A. SAN BUENAVENTURA, CHAIR
SENATE COMMITTEE ON HUMAN SERVICES

Thirty-First State Legislature
Regular Session of 2021
State of Hawai`i

March 18, 2021

RE: H.B. 310, H.D. 2; RELATING TO HEALTH.

Chair Keohokalole, Chair San Buenaventura, Vice-Chair Baker, Vice Chair Ihara, members of the Senate Committee on Health, and members of the Senate Committee on Human Services, the Department of the Prosecuting Attorney of the City and County of Honolulu ("Department") submits the following testimony, **supporting the intent** of H.B. 310, H.D. 2, with express concerns and one requested amendment.

The purpose of H.B. 310, H.D. 2, is to provide more timely and effective mental health treatment and support for those who need it. Specifically, this bill would: expand the definition of "imminently dangerous to self or others," from a period of 45 days to 90 days; make emergency hospitalization discretionary even if all criteria are met; and allow involuntary treatment of someone seen in an emergency department or subject to emergency hospitalization, who "lacks decisional capacity," which would also trigger an assessment for possible appointment of a surrogate or guardian.

While the Department's primary function is to fairly and effectively prosecute criminal offenses, our overarching concern is public safety and welfare. Thus, we appreciate the intent to slightly expand the definition of "imminently dangerous to self or others," and allow treatment of those who are emergency hospitalized, even if they are not of sound mind to make that decision for themselves. However, the Department is deeply concerned that someone who meets the criteria for emergency hospitalization—to the extent they are:

(1) Mentally ill or suffering from substance abuse;

(2) **Imminently dangerous to self or others**; and
(3) In need of care or treatment, or both;"

(see HRS §334-59(d); also H.B. 310, H.D. 2, at page 2, lines 16-18; emphasis added)—could potentially **not** be hospitalized, if this bill were to pass as currently written (H.B. 310, H.D. 2, page 3, line 1). If the Committee chooses to pass this bill, we respectfully **urge the Committees to delete the proposed amendment on page 3, line 1**.

The Department takes no position on other parts of this bill. We do note, however, that it seems rather incongruous that someone who was simply "seen in an emergency department," could then be "involuntarily treated for up to 30 days, including the use of long-term injectable pscyhotropics" (H.B. 310, H.D. 2, page 3, line 17, through page 4, line 11). We defer to Department of the Attorney General's constitutional analysis for that segment of the bill, and their recommendation to delete all proposed amendments therein.

For people who suffer from serious mental illness or substance abuse, who are also "imminently dangerous to self or others," the Department strongly believes that providing swift and appropriate mental health treatment—while safeguarding their constitutional rights—is both the most humane and safest approach for that person and for everyone around them.

Based on all of the foregoing reasons, the Department of the Prosecuting Attorney of the City and County of Honolulu supports the intent of H.B. 345, H.D. 2, with the noted concerns and requested amendment. Thank you for the opportunity to testify on this matter.

STATE OF HAWAIʻI
OFFICE OF THE PUBLIC DEFENDER

**Testimony of the Office of the Public Defender,
State of Hawaiʻi to the Senate Committee on Health
and Senate Committee on Human Services**

March 18, 2021

H.B. No. 310 HD2: RELATING TO MENTAL HEALTH

Chairs Keohokalole and San Buenaventura, Vice Chairs Baker and Ihara, and Members of the Committees:

We respectfully oppose passage of H.B. No. 310 HD2, which would greatly broaden the term of "imminently dangerous to self and others." It also proposes to unconstitutionally authorize the involuntary treatment of up to thirty days of patients who are subject to emergency hospitalization.

1. Forty-five days to ninety days

Currently, "imminently dangerous to self or others" means that, without intervention, the person will likely become dangerous to self or dangerous to others within the next forty-five days. Without any justification, this measure seeks to amend the definition by increasing the number of days from forty-five days to ninety days. Neither professional psychiatric opinions nor data has been offered to support the necessity to amend the definition.

Previously, the Department of the Attorney General's (DAG) submitted written testimony relying on HRS chapter 587A, also known as the Child Protective Act, which defined "imminent harm" as "without intervention within the next ninety days, there is reasonable cause to believe that harm to the child will occur or reoccur." The definition used in a "child protective" context has no application in the context of an "involuntary hospitalization."

The U.S. Supreme Court (Addington v. Texas, 441 U.S. 418, 99 S.Ct. 1804, 60 L. Ed. 2d 323 (1979) and Hawaiʻi appellate courts (In re Doe, 102 Hawaiʻi 528, 78 P.3d 341 (App. 2003)) have held that civil commitment proceedings subject individuals to a "significant deprivation of liberty" which requires due process protections. Arbitrarily extending the period of imminent dangerousness to forty-five to ninety days without any objective justification other than to ease the burden on the State to

establish imminency is directly contrary to the principles espoused by the courts. There has been no showing that broadening the definition by increasing the number of days from forty-five days to ninety days will fulfill the intent of the statute to protect communities and provide necessary treatment to individuals posing a danger to themselves or others. Rather, this proposed legislation would increase the potential of a person, guilty of no crime, having their liberty taken away to be housed in a locked mental facility against their will.

2. Authorizing involuntary treatment of individuals subject to emergency hospitalization for up to thirty days

H.B. No. 310 HD2 also allows individuals who are subject to emergency hospitalization to be "involuntarily treated" until a psychiatrist or advanced practice registered nurse (APRN) "determines that the patient has regained decisional capacity." The underlying purpose of this legislation is to provide an expeditious means of treating individuals who are subject to emergency hospitalization and forcibly medicating them with the use of long-term injectable psychotropics without proper judicial review and in violation of the individual's significant due process rights.

At the outset, the term "decisional capacity" is problematic and likely unconstitutional as violative of due process and equal protection. The term is entirely subjective, not defined by the statute, and its interpretation left solely to the discretion of the psychiatrist or APRN.

Further, allowing the involuntary administration of medication (i.e., "treatment") without affording the individual due process violates Hawai'i and federal case law. The Hawai'i Supreme Court in State v. Kotis, 91 Hawai'i 319, 984 P.2d 78 (1999), citing the U.S. Supreme Court's decision in Riggins v. Nevada, 504 U.S. 127, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992), recognized that ***the forcible administration of antipsychotic drugs constitutes a "substantial" intrusion on an individual's bodily integrity and liberty***. The Hawai'i Supreme Court and the U.S. Supreme Court both concluded that the following specific findings must be made before an individual (an incarcerated person in Kotis) may be involuntarily medicated with antipsychotic drugs:

> (1) the defendant actually poses a danger of physical harm to himself or others;

(2) treatment with antipsychotic medication is medically appropriate; and

(3) considering less intrusive alternatives, the treatment is essential to forestall the danger posed by the defendant.

This is the same standard that is currently applied when the DAG files involuntary medication petitions on persons who are involuntarily committed. Therefore, ***H.B. No. 310 HD2 would bypass the constitutional protections established by the United States Supreme Court and the Hawai'i Supreme Court*** and allows a psychiatrist or APRN to involuntarily medicate an individual for up to thirty days. A statute which acts in disregard of constitutional protections to allow the involuntary administration of medication for an unspecified time without objective criteria or court intervention would be found unconstitutional by the courts. The current procedure utilized by the DAG of filing petitions for involuntary civil commitment and involuntary medication can achieve the same result as H.B. No. 310 HD2 without sacrificing the significant constitutional rights of individuals.

Thank you for the opportunity to comment on this measure.

HB-310-HD-2
Submitted on: 3/16/2021 1:10:38 PM
Testimony for HTH on 3/18/2021 3:15:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Louis Erteschik	Testifying for Hawaii Disability Rights Center	Comments	No

Comments:

We continue to see this as a well-intentioned bill that is a work in progress, but still has some legal and drafting issues that need to be addressed. While we are not specifically opposed to Section 2 of this bill, we question what it will accomplish. The current law of "45 days" was a compromise the legislature reached a few years ago and the provision does not seem to have been an issue since then. The term "imminently dangerous" traditionally meant what the term implies-something that will occur relatively soon. When the current law was amended, the Attorney General at that time was advocating for a 90 day window. We suggested at that time that perhaps a 30 day timeline might be appropriate. The legislature compromised on 45.This is a policy decision and if the legislature believes that the additional time will bring more people into treatment then perhaps that is sufficiently beneficial to amend the law. Will the 90 day window really provide a better outlook for an examiner? We are not convinced that is so, but we don't discount that possibility. On the other hand, there are stakeholders who will likely oppose the changes more strenuously than we do, and if this provision were ever to be tested in the courts, as a matter of constitutional law we continue to believe that a longer time window may be harder to justify.

The language of Section 3 has been improved over the original bill but still raises several questions. We understand that the intent is to allow for the use of longer acting psychotropic medication. Currently, hospitals tend to stabilize individuals and "send them on their way", merely to see them again shortly. Eliminating the cycle of the revolving door is a worthwhile goal certainly. However, the language here is still loose and open ended. "Decisional capacity" is not defined for purposes of this chapter, unless the intent is for it to have the same definition as found elsewhere in the Hawaii Revised Statutes. The form of involuntary treatment is said to include the use of longer lasting psychotropic medication, but it is not clear what else it might include or exclude. Significantly, there is no trigger for a judicial proceeding, and this raises legal and constitutional concerns. We also note the testimony of the Department of the Attorney General who opines that this provision violates the Kotis ruling.

Regarding the assessment for the appointment of a surrogate or a guardian, we are open to this as a possible way to provide treatment, though we are not certain how exactly it would work or how effective it would be. We don't believe this provision of the law has been used in this context previously, and it is not clear how long it would take to

find a surrogate and whether the person could be held at the hospital while all that was occurring. So, we have a lot of unanswered questions. However, as stated at the outset we see this as a work in progress, and we do remain willing and committed to being part of a constructive discussion.

THE INSTITUTE FOR HUMAN SERVICES, INC.
Ending the Cycle of Homelessness

State Senate Committee on Health
Hearing on Thursday, 3/18/21 at 3:15 p.m.
Senator Joy A. San Buenaventura, Chair
Senator Les Ihara, Jr., Vice Chair

From: Connie Mitchell, MS, APRN
Executive Director
IHS, The Institute for Human Services, Inc.

Re: Testimony in Support of HB310 HD2, Emergency hospitalization and mental health treatment

IHS, The Institute for Human Services has been a critical safety net of our community for over 42 years, providing a full spectrum of services to help those in our community experiencing homelessness. **IHS stands in strong support of HB310, HD2.** However, we would like to recommend that no edit be made to the definition for imminent danger found on page 2, line 6, restoring language to "45 days"

The changes put forth by this bill on emergency treatment and hospitalization are necessary to halt the revolving door at our emergency rooms that receive seriously mentally ill persons or those afflicted with co-occurring substance use disorders like methamphetamine addiction.They would also strike a balance between the need for responsive treatment needed by mentally ill persons disabled by their behavioral health conditions and their right to due process.

HB310 HD2's inclusion of an evaluation of the presenting patient's need for a surrogate decision maker or eligibility for guardianship is welcomed as a way to expedite a process for petitions for Assisted Community Treatment or guardianship, should either be appropriate.

It is acknowledged that some legal perspectives may find the short term (30 days) emergency treatment of persons without a consent to treat unconstitutional, without further judicial review. Instead, it could alternatively be seen as an accommodation to the patient, impaired by his/her mental illness, for the right to treatment. Such an accommodation is in accord with the American Disabilities Act (ADA).

- Title II of the ADA requires that "**State and local governments give people with disabilities an equal opportunity to benefit from all of their programs,** services, and activities (e.g. public education, employment, transportation, recreation, **health care, social services,** courts, voting, and town meetings).
- The ADA goes on to indicate that governments: **"are required to make reasonable**

modifications to policies, practices, and procedures where necessary to avoid discrimination…"

Mental illness and severe substance abuse can rightly be considered a disabling "high impact neurological condition" very similar to those who suffer chronic pain. Sadly, the brain dysfunction experienced with severe mental illness and substance abuse can rob a person of their ability to think clearly, to manage their emotions and to plan and execute what they intend. Ironically, these three functions are all required components of competently exercising civil liberties..

This bill can curtail the burgeoning costs associated with repeated medical and judicial interventions with homeless individuals who simply need effective treatment for their conditions. Without this bill, our police, social services, and emergency rooms will continue to incur high costs in shuttling homeless individuals through a system that fails to provide them effective means to regain their functionality and make productive decisions for themselves.

Currently, seriously mentally ill persons who may be brought to an emergency room on an oral *ex parte* court order, might be treated with oral medications or even injections to calm them. This bill could clarify that administration of a long-acting injectable antipsychotic medication in an emergency situation is not only acceptable. but in many cases, (particularly with homeless persons who cannot be administered daily medications) best practice to help restore decisional capacity, cognition, memory, organized thought, executive function and judgment to make possible the full extent of the individuals civil liberties.

Instead, what we observe when a patient refuses behavioral health treatment, is that they are often released back into the community until the next time they are found endangering themselves or others, and returned to the hospital or arrested and incarcerated.. Or worse yet, people realize that nothing will happen and the individual is left to languish on the streets until a medical emergency once again prompts an EMS call to transport to the emergency department or the person dies of medical conditions that go untreated..

Over 100 of our homeless residents are dying on our streets each year, at an average age of only 53-54. Deaths of homeless people continue to climb on Oahu | Honolulu Star-Advertiser In other words, they lose 25-30 years of their expected lifespan due to the very real dangers of living on the street. These dangers are most vivid when a person suffering from severe mental illness or substance abuse no longer has decisional capacity for life-saving medical intervention and self preservation. Abandoning these individuals to their "freedom" to live on the streets while severely disabled is a death sentence for many of them. And yet, they are someone's son or daughter, parent or loved one, and they deserve the same caring and curative treatment as would be offered to those with other life-threatening medical conditions.

In summary, this bill strikes an appropriate balance by allowing a short duration of involuntary treatment for these incapacitated persons, to help stabilize them and allow them to regain their decisional capacity. In so doing, we can help avoid the very real dangers of irreversible disability and death that these severely ill persons face if they are left on their own on the streets.

Please pass HB310, HD2 or some version that includes an **efficien**t way forward in treating mentally ill and substance addicted persons who have already demonstrated unhealthy and dangerous behavior in the community and brought to an emergency room. They have a right to treatment, despite having no capacity to consent.

Thank you for considering my testimony, offered on behalf of IHS and the many homeless mentally ill people we continue to serve and protect across our island.Testimony

remembering to take their medications on a daily basis, as is the case with someone who is especially homeless. Injectable, long-acting antipsychotic medications can last 30 -90 days, administered after it is determined that the individual is not allergic to the medication.

The temporary period of 90 days for legal permission to treat over objection affords a sufficient time for the person to benefit significantly from the medication so as to regain a greater capacity to make decisions or for a petition for guardianship or assisted community treatment order to be submitted to the court if it should be required to continue treatment. This 90-day period of time is only a fraction of the time that a successful petition for assisted community order would authorize for treatment over objection.

The portion of disabled homeless persons for whom this kind of treatment is significant, but not the majority. Medication, in and of itself, is not the only treatment that persons suffering severe mental illness or co-occurring substance use disorders need to recover. Psychosocial rehabilitation, housing and a supportive community is critical to helping an individual recover their purpose in life, their abilities to contribute and to enjoy the liberties afforded all of us in this state. The ability of a person to participate and engage in treatment is severely limited if the individual is not stabilized with antipsychotic medication as it stands now, the people most likely to benefit from emergency treatment described in this bill, are subject to "deliberate indifference" by our healthcare and legal system left to fend for themselves with no hope for escaping the traumatic experience of living homeless on the streets.

Please pass HB310 and afford people the hope and treatment they deserve and to which they have a right. You will be transforming many lives with your action.

Thank you for considering my testimony, offered on behalf of IHS and the many homeless mentally ill people we continue to assertively outreach across our island.

Sincerely,

Connie Mitchell

Hawai'i Psychological Association

For a Healthy Hawai'i

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COMMITTEE ON HEALTH
Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair

COMMITTEE ON HUMAN SERVICES
Senator Joy A. San Buenaventura, Chair
Senator Les Ihara, Jr., Vice Chair

DATE: Thursday, March 18, 2021- 3:15PM - VIDEO CONFERENCE - Room 225
Testimony in Support with Comments on HB310 SD2 RELATING TO HEALTH Suggesting Amendments

The Hawai'i Psychological Association (HPA) supports and provides these comments on HB310 SD2, which expands the definition of "imminently dangerous to self or others" in Chapter 334 of Hawaii Revised Statutes pertaining to mental health, mental illness, drug addiction, and alcoholism; and provides greater autonomy and authority for qualified mental health professionals to determine if a surrogate or guardian needs to be appointed to make appropriate health care decisions for the patient.

As a foundational matter, HPA believes it is ultimately more humane to involuntarily medicate those who need treatment, rather than continue their cycle of homelessness, victimization, jail and prison.

HPA believes that psychologists are fully qualified and equipped to determine if a surrogate or guardian needs to be appointed to make appropriate health care decisions for a mentally ill patient; and proposes the bill be amended on page 4, line 16:

> "A patient who is seen in an emergency department or hospitalized on an emergency basis pursuant to this subsection, diagnosed with a serious mental illness or severe substance use disorder pursuant to subsection (b), and found to be lacking decisional capacity by a psychiatrist, **psychologist**, or by an advanced practice registered nurse having prescriptive authority and who holds an accredited national certification in an advanced practice registered nurse psychiatric specialization, shall be assessed to determine whether a surrogate under section 327E-5 or a guardian under article V of chapter 560 is needed to make appropriate health care decisions for the patient."

HPA also notes that by extending the time period of imminent dangerousness from 45 to 90 days, as is done in Section 2 of the bill, it is easier to medicate or hospitalize those who become dangerous after they stop medication. This is significant because oftentimes it takes many months for a person to decompensate and become dangerous after their medication loses their effectiveness.

Accordingly, this bill is a step forward in achieving safer, more effective treatment and humane conditions for the mentally ill. However, it does not address the lack of civil commitment psychiatric capacity at community hospitals. Thus, to fully effectuate the spirit of this bill, institutional capacity must be addressed. Homelessness and criminalization of the mentally ill is highly correlated with deinstitutionalization, a lack of psychiatric hospital beds, *and* overly strict civil commitment criteria.

Thank you for the opportunity to provide input into this important bill.

Sincerely,

Alex Lichton, Ph.D.

Alex Lichton, Ph.D.
Chair, HPA Legislative Action Committee

THE QUEEN'S HEALTH SYSTEMS

To: The Honorable Jarrett Keohokalole, Chair
The Honorable Rosalyn H. Baker, Vice Chair
Members, Senate Committee on Health

The Honorable Joy A. San Buenaventura, Chair
The Honorable Les Ihara, Jr., Vice Chair
Members, Senate Committee on Human Services

From: Sondra Leiggi-Brandon, Vice President, Behavioral Health, The Queen's Medical Center
Colette Masunaga, Director, Government Relations & External Affairs, The Queen's Health Systems

Date: March 17, 2021

Re: Comments Re: HB310, HD2: Relating to Health

The Queen's Health Systems (Queen's) is a nonprofit corporation that provides expanded health care capabilities to the people of Hawai'i and the Pacific Basin. Since the founding of the first Queen's hospital in 1859 by Queen Emma and King Kamehameha IV, it has been our mission to provide quality health care services in perpetuity for Native Hawaiians and all of the people of Hawai'i. Over the years, the organization has grown to four hospitals, and more than 1,500 affiliated physicians and providers statewide. As the preeminent health care system in Hawai'i, Queen's strives to provide superior patient care that is constantly advancing through education and research.

Queen's appreciates the opportunity to provide comments with concerns on HB310 HD2, Relating to Health. The measure seeks to revised the definition of "imminently dangerous to self or others" and amend HRS334-59 (d) relating to emergency hospitalization by creating a provision in the statute that allows for the involuntary treatment of individuals who have been hospitalized pursuant to this section with a serious mental illness or severe "substance use disorder" and found to lack decisional capacity for a duration determined by the clinician. While Queen's believes and is committed to addressing the needs of those suffering from serious mental health disorders in our community, we have concerns with this bill in its current form and offer the following comments.

The bill seeks to amend the definition of "imminently dangerous to self or others" by stating that a person will likely become dangerous to self or others within the next ninety days' vs forty-five days. We are concerned about the extended period of hospitalization set forth since it would be difficult to determine if an individual would meet that definition. <u>We would request that the committee preserve the definition in current statute.</u>

We note that over half of the MH-1 transports to The Queen's Medical Center, Punchbowl campus, do not meet the criteria for involuntary hospitalization and could be treated at alternative sites to

the Emergency Department. Which is why there is an urgent need to increase community resources to provide such services for those who are in crisis but may not rise to the level of requiring inpatient care. Queen's continues to work with the Department of Health on the statewide Mental Health Emergency Worker (MHEW) program to strengthen the continuum of care for patients by effectively screen individuals in crisis and triage them to receiving sites and services as needed.

Additionally, the proposed bill could have unintended consequences on medical decisions related to involuntary treatment beyond emergency situations and impact patients on medical floors within our hospitals who lack decisional capacity and have a severe substance use disorder. Finally, we would note that the proposed measure does not provide for an expedited order to treat process, but rather allows the clinician full decision making ability regarding involuntary treatment.

Queen's appreciates the intent of the measure to facilitate greater access to treatment. Thank you for the opportunity to provide testimony expressing our concerns with HB310, HD2.

Testimony of Keith Y. Amemiya in Support of HB310, HD2
State Senate Committees on Health and Human Services
Hearing on Thursday, 3/18/2021, 3:15 p.m.

I write in strong support of HB310, HD2, which will assist in providing critical treatment for many of our homeless residents.

Like many families across the State, we have a loved one (my mother) who suffers from mental illness. And, although she fortunately has never ended up being homeless, there were several times that she came close to being so, in part because of the unavailability to utilize the medication and other treatment that she needed.

Based upon the above and the other supportive testimony provided, I respectfully request the passage of HB310, HD2.

Mahalo for the opportunity to submit written testimony.

DAVID Y. IGE
GOVERNOR OF HAWAII

ELIZABETH A. CHAR, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
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Testimony COMMENTING on H.B. 310 H.D. 2
RELATING TO HEALTH

SENATOR JARRETT KEOHOKALOLE, CHAIR
SENATE COMMITTEE ON HEALTH

SENATOR JOY A. SAN BUENAVENTURA, CHAIR
SENATE COMMITTEE ON HUMAN SERVICES

Hearing Date: 3/18/2021 Hearing Time: 3:15 p.m.

Department Position: The Department of Health ("Department") respectfully offers comments.

Department Testimony: The subject matter of this measure intersects with the scope of the Department's Behavioral Health Administration (BHA) whose statutory mandate is to assure a comprehensive statewide behavioral health care system by leveraging and coordinating public, private and community resources. Through the BHA, the Department is committed to carrying out this mandate by reducing silos, ensuring behavioral health care is readily accessible, and person-centered.

The Department is committed to addressing the needs of individuals who live with behavioral health issues, and are in need of services when experiencing a crisis and there is an imminent risk of danger to self or others, including those who lack decision making capacity. This commitment includes developing and implementing a crisis continuum of care that includes a statewide Mental Health Emergency Worker (MHEW) program, crisis stabilization services, emergency examination, coordinating emergency admissions, and, where appropriate, pursuing involuntary commitment.

This measure revisits the timeframe for which a person can be determined as imminently dangerous from 45 days to 90 days and attempts to address the involuntary treatment of a patient who is determined to be imminently dangerous. The issue of the timeframe was discussed at length during previous sessions and within the context of the Involuntary Hospitalization Task Force, and it appeared that most stakeholders believed that the timeframe identified in statute was generally less salient than the process by which the initial and longer term response and treatment were managed.

The Department believes that the timeliness of response discussed in Section 1 is not the issue. Rather, that the mechanisms allowing for appropriate disposition and treatment after a person is appropriately assessed and treated in the emergency room or in a hospital represents the crux of need in the continuum of care for the individuals this measure seeks to support.

Over the last year and a half, and despite the advent and challenges of the COVID-19 pandemic, we put significant effort into addressing this gap. In collaboration with the Mental Health Task Force, the working groups of Act 90 and Act 263, Session Laws of Hawaii 2019, and specifically with the MH-1 work group, recommendations include, but are not limited to:

1. Developing a coordinated entry system for mental health and substance abuse services.
2. Implementing “sub-acute stabilization beds” designed to provide a safe place where individuals who are “not ill enough” to be psychiatrically admitted but who are not stable enough to be successful in other less intense community placements may be admitted to.
3. Developing a crisis diversion center on the Hawaii State Hospital grounds that will evolve into a secure diversion center for the individuals this measure seeks to support.

4. Expanding the use of Intensive Case Management services that provide rapid response and engagement with persons who may have been discharged from the emergency department but need continued support and placement into short-term stabilization beds.

We are proud of the efforts and work that has been done in a short period of time by the Department and its community partners and believe that together, we have demonstrated "proof of concept" for these efforts through, for example, the Temporary Quarantine and Isolation Center (TQIC) in Iwilei for individuals identified as homeless and mentally ill who either were exposed to someone who tested positive for COVID-19 with no residence to quarantine or who themselves were confirmed as having tested positive for COVID-19 with no residence to safely isolate.

The evaluation of this community team effort shows that not only was this TQIC design an integral piece of successfully supporting individuals through their COVID-19 exposure, but also that the positive outcomes realized for some of our most chronically homeless and mentally ill citizens demonstrates a need to continue to resource these efforts.

In regards to involuntary treatment, the Department feels strongly that we need to continue to dialogue the concept that an individual who is severely psychotic, whether through mental illness, substance abuse, or both, can be in a state of "unconsciousness" similar to that of an individual who is unconscious because of a physical cause. The ability to render immediate treatment and aid to those who live with one or more of these behavioral health issues without their explicit consent, such as with cardiopulmonary resuscitation (CPR), is important to us. We continue to strive for a balance with individuals suffering from acute serious mental illness (SMI) where they can be treated during a time where they are, for all intents and purposes "unconscious", but still assure that their right to self-determination will be honored.

We do not believe that this measure, as written, adequately strikes that balance. However, we do believe that requiring an assessment to determine whether a surrogate or guardian is needed to make appropriate health care decisions for a person when there is a lack of decisional capacity supports the balance.

We remain committed to working with stakeholders to refine the current statute including continuing collaboration with state agency and community partners through the Mental Health Task Force.

We humbly ask the legislature to consider the programmatic and policy efforts that have been undertaken in the last year that collectively provide a foundation for continued active response to the most vulnerable individuals in our state.

For reference, the definition of an MH-1 is generally understood to mean a Mental Health Emergency Worker (MHEW) authorized involuntary transport, pursuant to section 334-59(a)(1), of a person in crisis by either law enforcement and/or emergency medical services personnel to receive an emergency examination and possible emergency hospitalization.

For context and clarification, we enclose a detailed outline of the processes for involuntary commitment that are currently in place.

Offered Amendments: None

Thank you for the opportunity to testify on this measure.

Fiscal Implications: Undetermined.

Summary of MH Law Forms

Authorization of transport for emergency examination initiated by law enforcement officer

MH-1

Form completed by a police officer after consultation with the Mental Health Emergency Worker (MHEW) leading to authorization of transport of a person in crisis to receive an emergency examination.

Authorization of transport for emergency examination - initiated by clinician/other

MH-2 (verbal request for ex-parte order)

A licensed physician, APRN, psychologist, attorney, member of the clergy, health or social service professional or any state or county employee in the course of his employment may apply to the court for an ex parte' (one-sided) order directing that a police officer or other suitable individual take a person into custody and deliver him/her to the nearest facility designated by the director for emergency examination.

MH-2a (order authorizing emergency examination and treatment)

Court order authorizing examination and treatment (after the petition is granted by the court).

Emergency Hospitalization

MH-4 (Certificate of Physician/Psychologist for Emergency Hospitalization)

Filled out by physician, psychologist, or APRN after a patient is brought to the ER (commonly via an MH-1 or MH-2 process) certifying justification for an up to a 48-hour emergency hospitalization.

Voluntary Admission

MH-5

Voluntary admission form signed upon admission by adult patients who agree to willingly be in the hospital. If an individual is assessed to be unable to consent to admission due to diminished decision-making capacity, he/she will be treated as an involuntary patient.

MH-5a

Voluntary admission form for minors done at the hospital. Family Court sends an officer to sign the patient in once the patient is in the hospital.

Involuntary Commitment

MH6

Petition for involuntary hospitalization.

MH6c (certificate of physician/psychologist for involuntary hospitalization)

Is the form that the physician or psychologist completes typically after the 48-hour time period expires on the emergency hospitalization (MH-4) and the patient continues to show signs of dangerousness to self or others and is in need of treatment for mental disorder.

A hearing must be held no later than 10 days from the date that the petition is filed. During the period prior to the hearing, the patient may only be involuntarily treated for emergencies. Lawyers for the hospitals are from the Department of the Attorney General and for the patients are commonly from the Public Defender's office. Maximum confinement pursuant to the first commitment order is 90 days; a 90 day and then a 180 day extension can be granted following subsequent court hearings.

HB310 HD2 Involuntary Commitment for Substance Abuse and Mental Illness

COMMITTEE ON HEALTH:

- Sen. Jarrett Keohokalole, Chair; Sen. Rosalyn Baker, Vice Chair

COMMITTEE ON HUMAN SERVICES:

- Sen. Joy San Buenaventura, Chair; Sen. Les Ihara, Vice Chair

Thursday, Mar. 18, 2021: 3:45: Videoconference

Hina Mauka Supports H1310 HD2:

ALOHA CHAIR, VICE CHAIR AND DISTINGUISHED COMMITTEE MEMBERS. My name is Alan Johnson. I am the CEO of Hina Mauka, providing services for substance use disorder and mental health including programs for prevention, adult addiction treatment, adolescent treatment, case management, and withdrawal management. Helping people on Oahu and Kauai.

37 states now include chronic substance abuse with mental health disorders.

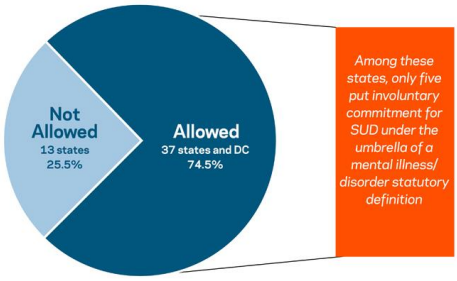

Figure 1. Legal Provision for Involuntary Commitment for Substance Use Disorders among U.S. states and DC (N=51)[8]

For individuals with severe substance use disorder, several states are now implementing involuntary commitment laws for the first time or proposing changes to existing laws that would remove barriers to make commitment less difficult.

The substance abuse treatment gap between the need and access stems from stigma, lack of available effective treatment and the inability of some individuals to seek treatment voluntarily.[1]

- Relatives and loved ones of an individual with a substance use disorder often feel helpless and disempowered when that individual is unable, due to an impaired brain, to make the rational decision to undergo and complete addiction treatment.

[1] Hazelden Betty Ford Foundation: Involuntary Commitment for Substance Use Disorders: https://www.hazeldenbettyford.org/education/bcr/addiction-research/involuntary-commitment-edt-717

- Situations can escalate to the point where relatives and loved ones feel unsafe or are afraid that the individual with the substance use disorder is at great risk for overdose and/or death.
- Involuntary commitment laws for substance use disorder can be be a way to initiate the treatment these individuals need to avoid death and ultimately re-establish productive and healthy lives.

Involuntary Commitment 90 days. Several states have changed the commitment to 90 days because a criticism of some current civil commitment laws is that the current time for concern for individuals is insufficient.

What Does it Take for Civil Commitment?

1. Casey's Law in Kentucky allows family members to exercise civil commitment if the disorder and risk have clearly grown severe and grave. It's allowed if the family can demonstrate a desperate situation such as after multiple overdoses and the loss of home, job, children, car, insurance, self-esteem and hope," Family members report "The only thing left to lose is their loved one's life. That is the right the family is trying to protect—their loved one's right to live."

2. Almost all states now allow a family member to petition the court to get an individual involuntarily committed to drug and alcohol addiction treatment. Most states allow a spouse, guardian, relative, medical professional or administrator of the treatment facility to petition the court for involuntary commitment. However, some states will allow a friend or any responsible person to petition, and in at least one state, police officers are allowed to do so.

What Treatment is Best. People with severe substance use disorder are often recommended residential treatment that can ultimately transition, or step down, to outpatient treatment and other lower levels of care. Such determinations are made by professionals based on criteria established by the American Society of Addiction Medicine.[2] Addiction is like other chronic illnesses in that the sooner it is recognized and the longer it is treated, the better the chances of recovery.

We appreciate the opportunity to provide testimony and are available for questions.

[2] Mee-Lee, D. E. (2013). The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions. Rockville, MD: American Society of Addiction Medicine.

HB-310-HD-2
Submitted on: 3/16/2021 2:38:09 AM
Testimony for HTH on 3/18/2021 3:15:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Jennifer Azuma Chrupalyk	Individual	Support	No

Comments:

Support with reservations. In other municipalites who allow this to occur, there are a ton of cases where an abuser provoked the temporary insanity of another individual to benefit from the increased ability to rob the other person of their rights while the said victim has now been documented as having lost their mind. The said documentation decreases the lawful protection of said victim, thus causing a long list of problems. Perhaps you might want to consider tighter specifications on this bill, prior to passing it - such as imposing criminal charges if the person who commited the said individual, is lying to violate the said individual‘s rights.

Testimony of Ellen Godbey Carson in Support of HB310, HD2
State Senate Committees on Health & Human Services
Hearing on Thursday, 3/18/2021 at 3:15 p.m.

I write in support of HB310, HD2, which will assist in providing life-saving treatment for our most vulnerable homeless residents.

While I write as an individual, I have served as President and director of Institute for Human Services, President of the Hawaii State Bar Association, and member of the Church of the Crossroads Peace and Justice Mission Team, spending many years helping Hawaii find better systemic ways to address its dual crises of homelessness and lack of affordable housing.

Over 100 of our homeless residents are dying on our streets each year, at an average age of only 54. Deaths of homeless people continue to climb on Oahu | Honolulu Star-Advertiser In other words, they lose 25-30 years of their expected lifespan due to the very real dangers of living on the street. This bill addresses those most at risk of dying on our streets, people who have severe mental illness or substance abuse and no longer have decisional capacity for life-saving medical intervention and self-preservation. Abandoning these individuals to their "freedom" to live on the streets while severely disabled is a death sentence for many of them. And yet, they are someone's son or daughter, parent or loved one, and they deserve the same caring and curative treatment as would be offered to those with other life-threatening medical conditions.

This bill can finally curtail the high costs associated with repeated medical and judicial interventions with our most seriously ill homeless residents, who most need more effective treatment options for their conditions. This bill will allow use of long-term psychotropic medication and other treatment to help those most in need. Without this bill, our police, social services, and emergency rooms will continue to incur high costs in shuttling homeless individuals through a system that fails to provide them effective means to regain their functionality and make productive decisions for themselves.

This bill strikes an appropriate balance of legal rights, by allowing a short duration of involuntary treatment for these incapacitated persons, to help stabilize them and allow them to regain their decisional capacity. In so doing, we can help avoid the very real dangers of irreversible disability and death that these severely ill persons face if they are left on their own on the streets.

Please pass HB310, HD2.

HB-310-HD-2
Submitted on: 3/16/2021 7:00:21 PM
Testimony for HTH on 3/18/2021 3:15:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Leimomi Khan	Individual	Support	No

Comments:

Support. Quoting one other testifier, "For people who suffer from serious mental illness or substance abuse, who are also “imminently dangerous to self or others,” providing swift and appropriate mental health treatment—while safeguarding their constitutional rights—is both the most humane and safest approach for that person and for everyone around them."

HB-310-HD-2
Submitted on: 3/16/2021 7:53:49 PM
Testimony for HTH on 3/18/2021 3:15:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Thaddeus Pham	Individual	Oppose	No

Comments:

Aloha HTH/HMS Committees,

I oppose HB310.

Mahalo,

Thaddeus Pham (he/him)

March 17, 2021

Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair
Senate Committee on Health
Hawaii State Legislature
HB310 HD2: Relating to Health
Hearing: Wednesday, March 17, 2021
Location: Hawaii State Capitol

Support for HB310 HD2: Relating to Health

Aloha Senator Keohokalole, Senator Baker and Members of the Senate Committee on Health. My name is Stewart Silva and I am in strong support of HB310 HD2: Relating to Health. I firmly believe that through the passage of this bill any individual who is brought to an emergency department for evaluation, hospitalized in a psychiatric facility, under an emergency hospitalization or involuntary commitment order, or while being considered for assisted community treatment will greatly stand to gain from this bill approval.

I frequently visit the Chinatown area for business and leisure, and have observed many houseless individuals who need help. Whether its mental illness, substance abuse, or a mixture of both, these individuals when disturbing the peace have the police called on them only for them to be temporarily jailed and put back on the streets again; this cycle needs to end. While, I don't think there's a single solution to addressing the homeless problem, I do believe this is a necessary facet in the approach of getting us there.

Thank you for your favorable consideration of HS310 HD2,

Stewart J. Silva

HB-310-HD-2
Submitted on: 3/17/2021 1:55:43 PM
Testimony for HTH on 3/18/2021 3:15:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Lynne Unemori	Individual	Support	No

Comments:

COMMITTEE ON HEALTH
Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair

COMMITTEE ON HUMAN SERVICES
Senator Joy A. San Buenaventura, Chair
Senator Les Ihara, Jr., Vice Chair

TESTIMONY ON HB310, HD2 RELATING TO HEALTH

I am writing in SUPPORT of HB310, HD2. A major contributor to systemic homelessness in our community is the prevalence of severe mental illness, coupled with or compounded by substance abuse. It hampers the ability of so many on the street to comprehend and take advantage of treatments and services that could help them get on a path to recovery, safer living conditions and ultimately, a better life. This bill would make important changes to allow treatment for those who are mentally unable to make rational decisions about treatment. Enacting these changes can help to break the cycle of sending them back on the street untreated, likely ensuring continued homelessness, harm to themselves and potentially others, and possible prison.

HB310, HD2 thoughtfully contains specifications, including a time limit for these provisions and credentials of the health care professionals who would be allowed to determine that someone is lacking “decisional capacity,” so that compassionate, potentially life-saving care can be provided while still respecting civil liberties.

Please support this bill so these tools are available to help those who currently are unable able to help themselves.

Lynne Unemori
Community citizen and Institute for Human Services board member

Marya Grambs
140 Kaelepuu Drive. Kailua HI 96734
Ph 808.778.9178 email mgrambs@gmail.com

TO: Sen. Jarrett Keohokalole, Chair, and members, Committee on Health; and Sen. San Buenaventure, Chair, and members, Committee on Human Services
FR: Marya Grambs
RE: HB310/HD2; IN STRONG SUPPORT
Hearing: March 18, 2021 at 3:15 pm

Please think for a minute of Alzheimer's: If you found a person with Alzheimer's dementia confused and wandering on the streets, you wouldn't say, well, let's just talk to them for a little while and let them go back on the street; you would take care of them, regardless of what they said, because they have a brain disease! Severe psychosis is a brain disease not unlike dementia, according to Dr. Matthew State, Chair, Department of Psychiatry, University of California San Francisco. People suffering from this brain disease deserve no less help than we would afford people with Alzheimer's. Few people would argue that someone suffering from severe dementia has a human right to wander the streets in a state of confusion and delusion.

Enabling our hospitals to provide long-acting antipsychotic medication to people in the throes of acute psychosis makes sense and will save lives. I urge you to support this bill.

I know you will hear from people concerned about their civil liberties. I appreciate that concern; but I believe that it is a denial of one's civil liberties to consign people to lives of degradation, despair, and danger. I believe that people have a right to treatment, and that our current system deprives many of that right.

I have spent several years volunteering at an emergency homeless shelter. I have seen firsthand the terrible human toll severe mental illness and homelessness takes. It's devastating to witness people suffering from the scourge of psychosis - hallucinating, delusional, living in extremely degrading circumstances, unable to take care of themselves, vulnerable to being preyed upon - being discharged to the unhealthy and inhumane environment from which they came.

And the greatest tragedy is that they do not know they are ill so of course they don't want to take medication – would you take medication if you didn't think you were sick? This is a symptom of their illness. This symptom deprives them of the ability to make informed, rational decisions about treatment.

If, however, while they are in this incapacitated and delusional state, they can be given a long-acting antipsychotic medication, they have a fighting chance to escape this horrendous, soul-destroying cycle. There are now stabilization beds where they can become stable on the

medication and be supported to find services that will help them regain their health and become housed.

LATE

HB-310-HD-2
Submitted on: 3/17/2021 11:09:22 PM
Testimony for HTH on 3/18/2021 3:15:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
William Haning, MD	Individual	Comments	No

Comments:

HB310SD2

17 March 2021

W. Haning, MD

Testimony is provided ***as commentary on*** the measure.

Honored Chair and Members,

In reviewing both the proposed measure and the testimony accumulated to date, I am struck by the contradictory conclusions offered by, to my knowledge of them, intelligent people with good hearts. I do not believe I am patronizing; in each instance, the author's concern reads truly as the welfare or the civil rights and autonomy of the ill person.

When as is the case here that the testimonies are at such wide odds with each other, it commonly means that two or more principles are being incorrectly, mutually associated. The principles independently appear sensible, yet do not seem reconcilable. The association is a syllogism, and when it derives from incorrect assumptions, it is a false syllogism.

The best demonstration that there is a false syllogism buried somewhere in the testimony - and by extension, in the proposed statute - is that two opposing contentions *seem* equally worthy, and both generate strong, even indignant defenses. But the two are contradictory. For example, 1) people must not be forced to accept medication against their wishes; 2) people should not suffer by mental illness, directly or by causing others to suffer, when there is effective treatment available that includes medications.

Coercive care offends everyone; to varying degrees, at different times, and in different settings. It is not limited to hospitalization, although that is the setting with which it is most identified. But the necessity arises when illness sabotages good judgment. Similarly, the elements of comprehensive care very often include well-researched, carefully-administered medications; but we balk at forced administration of medications, even while we compel our children to accept antibiotics, immunizations,

setting of fractured bones, etc. The allusion to children is, again, not patronizing; children have bad judgment in such matters and we sensibly allow for that.

Summary: The proposal seeks to benefit the intended patients but does not appear to resolve two competing, separately legitimate viewpoints. It is an earnest and literate effort but, tiresome as this next conclusion may seem, it requires further study and development, already in train with the Mental Health Task Force. In this my views align most closely with those of the Deputy Director for Behavioral Health, State of Hawai`i, in earlier testimony.

Very respectfully,

William F. Haning, III, MD, DFASAM, DLFAPA

Professor emeritus, Psychiatry

President-elect, American Society of Addiction Medicine

TESTIMONY ON HOUSE BILL 477 HOUSE DRAFT 2 RELATING TO CANNABIS
By Jason Hanley
Senate Committee on Health
Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair

Senate Committee on Commerce and Consumer Protection
Senator Rosalyn H. Baker, Chair
Senator Stanley Chang, Vice Chair

Friday, March 19, 2021; 9:30 AM State Capitol, Videoconference

I DO NOT SUPPORT the proposed amendment to section 329-130(a) to limit the number of Plants per grow. I do not have the space or security at my place of residence to successfully grow my own medicine. My current grow site is at a designated agriculture lot and has many growers on it.

Many patients on the site use flower for cancer, multiple scelorosis, rheumatoid arthritis, post traumatic stress disorder, etc. We know first hand where our medicine comes from because we grow it ourselves. By limiting people's freedom to grow together, you effectively put people into a position where they must purchase medicine at a premium price ($400.00-$500.00 an ounce) from a dispensary. Other states with medical cannabis charge an average of $250.00 an ounce. That means that Oahu dispensaries are charging almost twice as much as normal for medical cannabis. This is unaffordable to patients.

DOH has submitted in testimony that by limiting the amount of cards per site will decrease the plant count resulting in a decrease in smell. Plenty of grow sites in the state are not near residential areas and take place on agricultural land, so this is a non-issue in those cases. Furthermore, the Department of Health has not provided any data that captures public preferences on the smell of cannabis plants. Simply receiving smell complaints does not account for the percentage of residents that enjoy the smell of plants. Further data should be collected to address this concern and offer reasonable solutions. It is also unfortunate that Hawaii's Department of Health would prioritize some people's "enjoyment of their properties" over others' access to life-changing medicine that they cultivate and enjoy on their legally controlled properties.

Regarding the testimony that "More than twenty (20) plants to be grown at a single site and will address existing large, unregulated cultivation sites. There are currently 98 sites that are registered to between 5-30 patients which could maintain 50-300 plants and at at least one site registered to 409 patients, a potential of 4,090 plants. According to patient registry data as of January 31, 2021, this limitation will impact only about 12% of registered patients."

Collaborative grow sites offer the benefits of things like: a secure location with fences and 24-hour security; sharing of resources such as a greenhouse to grow in, soil, and clean water; protocols for safe and clean medicine; education on how to grow, harvest and cure. Working together gives people a chance to have so much more than just visiting a dispensary to buy medicine. It's healing and empowering on multiple levels.

DOH claims that these type of sites are unregulated, but our site has been visited by both DOH and law enforcement repeatedly. It takes the inspectors no time at all to check plant labels and verify compliance of the grow site.

If the DOH is reporting 12% of registered cardholders include sites more than 5 people at a site, then there are approximately 2,400 card holders that would lose their rights to grow at their current site. This is a substantial portion of cardholders and could disproportionately affect people at economic disadvantages or those in rural areas.

Limiting 20 plants to a site, or two cards to a site, will only increase the compliance load for the DOH. If a site that has 400 cards must be divided into 200 sites by this proposed legislation, then DOH will have 199 more compliance checks to do. Plant tracking systems like BioTrack, which is mandated for use by dispensaries, could be implemented at any sized grow site to improve regulation. They could expedite compliance checks by allowing DOH to walk through a greenhouse using a scanner to quickly identify 329 card compliance in a computer system. The software costs about $500 a month. In order to make sure everyone is in compliance, our site is already using this type of system. One person out of compliance could affect everyone's rights to grow. It's a simple way to make sure everyone has their plants tagged and up to date.

Regarding "DOH has received ongoing and numerous complaints from both patients and the public regarding uncontrolled cultivations under the guise of home cultivation. These include: patients reporting that they felt coerced into signing their "growing rights" over to collectives; medical providers reporting that "growers" were soliciting patients outside their office offering to reimburse patients for the cost of their medical use certification in exchange for their "growing rights;" patients without designated caregivers being asked to provide "growers" with their driver's license."
It is the responsibility of the 329 cardholder to manage their card and obey the law. As a 329 cardholder, I have the ability to change my grow site at any given time through the DOH. The DOH has not provided any data showing numbers or trends for the above complaint in regards to coercion. If you must control the property where you grow as required by law, it's not surprising that landowners would require a driver's license or other form of ID to sign a lease. I suspect that overall abuse alluded to by DOH is rather low because most 329 card holders take their right to grow seriously. Cardholders realize that if they break the laws of the 329 card, they will loose their rights to grow.

Now I will follow up with the use of law enforcement to conduct compliance checks.

Working with law enforcement could be a reasonable solution to supporting more compliance check capacity. However, the state should develop specific protocols for how they take place. The line between narcotics investigations and compliance checks in Hawaii is not clear. Patients shouldn't be subject to threats or unprofessionalism from law enforcement staff, such as unwillingness to reveal their names or badges. Hawaii is a small community, and patients across the state have shared stories of very unorthodox interactions with law enforcement despite growing within the confines of the law as 329 cardholders.

A substantial portion of funding currently used for helicopter flyovers for enforcement of cannabis laws, which costs taxpayers an in the range of $1500/hour, could be redirected to the DOH or law enforcement staff hours to support compliance checks in coordination with DOH through their patient database. Currently, law enforcement is looking for grow sites through flyovers within residential and rural areas with no apparent engagement with DOH. Law enforcement uses a search-first, no-knock approach, invading people's privacy despite their legal, registered cardholder status. It's important to remember that people seeking relief from medical cannabis may suffer to a greater degree than the average healthy person from these types of interactions. There is no excuse for people who choose to cultivate without securing a license to do so. However the tactics for enforcement, in a state with a licensed medical cannabis program, are inappropriate and due for evaluation.

I thank you for the opportunity to provide testimony on this matter. Hawaii has a long history of agricultural monopolies that serve to benefit few people with ample means. We have an opportunity to build a thriving cannabis program in the state that serves communities, provides thousands of local jobs, and builds state revenue. Cannabis offers Hawaii a chance to serve as a model crop for a new era of agriculture that benefits the local people of Hawaii. Taking away individual rights to grow cannabis is a step in the wrong direction.

Mahalo!