MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Seventh Session
April 8, 2013

The Committee on Health and Human Services was called to order by Chair Marilyn Dondero Loop at 12:45 p.m. on Monday, April 8, 2013, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at nelis.leg.state.nv.us/77th2013. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman Marilyn Dondero Loop, Chair
Assemblywoman Ellen B. Spiegel, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Wesley Duncan
Assemblyman Andy Eisen
Assemblywoman Michele Fiore
Assemblyman John Hambrick
Assemblyman Joseph M. Hogan
Assemblyman Andrew Martin
Assemblyman James Oscarson
Assemblywoman Peggy Pierce
Assemblyman Michael Sprinkle

COMMITTEE MEMBERS ABSENT:

Assemblyman Pat Hickey (excused)

GUEST LEGISLATORS PRESENT:

Assemblyman Lynn D. Stewart, Clark County Assembly District No. 22
Assemblyman William C. Horne, Clark County Assembly District No. 34
Assemblyman Cresent Hardy, Clark County Assembly District No. 19

STAFF MEMBERS PRESENT:

Kirsten Bugenig, Committee Policy Analyst
Risa Lang, Committee Counsel
Terry Horgan, Committee Secretary
Macy Young, Committee Assistant

OTHERS PRESENT:

The Honorable William O. Voy, Family Division, Eighth Judicial District Court
Kristina Ragost, Director of Advocacy, Treatment Advocacy Center
The Honorable Linda Marie Bell, Eighth Judicial District Court
Arthur (A.J.) Delap, representing the Las Vegas Metropolitan Police Department
Jon Norheim, Hearing Master, Eighth Judicial District Court
Donna Marie Shibovich, representing the National Alliance on Mental Illness, Nevada Chapter
Joe Tyler, representing the National Alliance on Mental Illness, Nevada Chapter
Christy Craig, Office of the Public Defender, Clark County
Dan Musgrove, representing West Care Nevada and The Valley Health System
Eric Spratley, representing the Washoe County Sheriff's Office
John Jones Jr, representing the Nevada District Attorneys' Association
Frank Reagan, Chair, Southern Nevada Adult Mental Health Coalition; Captain, Field Services Section, Las Vegas Metropolitan Police Department
Robert Lynn Horne, M.D., Private Citizen, Clark County
Deacon Tim O'Callaghan, Private Citizen, Las Vegas, Nevada
Robert Bennett, Private Citizen, Carson City, Nevada
Jack Mayes, Executive Director, Nevada Disability Advocacy and Law Center
Vanessa Spinazola, representing the American Civil Liberties Union of Nevada
Coni Kalinowski, M.D., Faculty Member, University of Nevada School of Medicine; Medical Director, Mojave Mental Health
Jason Schwartz, Director of Community Sports Services, Mojave Mental Health
Tracey D. Green, M.D., Nevada State Health Officer, Health Division, Department of Health and Human Services; Medical Director, Division of Mental Health and Developmental Services, Department of Health and Human Services

Steve Yeager, Office of the Public Defender, Clark County
Chris Frey, Washoe County Public Defender's Office
Brett Kandt, Special Deputy Attorney General, Office of the Attorney General; representing the Nevada Prosecution Advisory Council
Brian Rutledge, Chief Deputy District Attorney; Head, Vehicular Crimes Unit, Office of the District Attorney, Clark County
Chuck Callaway, representing the Las Vegas Metropolitan Police Department
Jim Holmes, representing the Northern Nevada DUI Taskforce

Chair Dondero Loop:
[Roll was taken. Committee procedures and protocol were explained.] We will start today with Assembly Bill 287.

Assembly Bill 287: Authorizes the involuntary court-ordered admission of certain persons with mental illness to programs of community-based or outpatient services under certain circumstances. (BDR 39-163)

Assemblyman Lynn D. Stewart, Clark County Assembly District No. 22:
This bill deals with mentally ill individuals who have a documented history of violence. It is patterned after Kendra's Law, which was passed in 1999 in New York after Kendra Webdale was pushed from a subway platform into the path of a train by a mentally ill individual. Kendra died at the age of 32.

The New York law has proven very successful, as pointed out by the Executive Director of the Nevada Psychiatric Association, Dr. Lesley Dickson, in her letter to you (Exhibit C). After the passage of this law, the homeless rate among mentally ill individuals in New York State dropped by 74 percent. The rehospitalization rate was down by 77 percent; and arrests of the mentally ill dropped by 83 percent. Forty-four other states have passed a version of Kendra's Law; Nevada is one of only six states that has not.

This bill has been introduced in two previous legislative sessions and was met with opposition by various groups. To address their concerns, we held meetings with those groups beginning last fall. I very much appreciate the input from those who participated including the Metropolitan Police Department, various judges, the state Attorney General's mental health department, various mental health groups, as well as the American Civil Liberties Union (ACLU) of Nevada, and a member of your Committee, Dr. Andy Eisen. We have attempted to address the input and concerns from these groups in Assembly Bill 287. Assembly Bill 287 is concerned with the challenges of dealing with mentally ill individuals who have a documented history of violence brought about by their failure to take prescribed medication or treatment for their illness.

The Honorable William O. Voy, Family Division, Eighth Judicial District Court:
This bill attempts to address a hardcore group of individuals who we deal with on almost a monthly basis. There are several hundred patients in Clark County who keep repeating. To some extent, mental health is a revolving door, but the group we are trying to address with this bill are those who are clogging up our inpatient bed space. They are coming back through the system; we have to go through the cumbersome task of recommitting them as adult inpatients when they become psychotic and acute again. When they come through again, this bill gives us another tool to commit them as outpatients. They are going to get stabilized and released—and some of them relatively shortly. This allows us to take a step back. Instead of releasing someone and giving that person an appointment at the med clinic within 30 days to re-up his or her medication, we are going to mandate that the individual show up. If that person does not show up, law enforcement is going to pick him up and bring him to the med appointment to get his medicine. With the support of both law enforcement, the court, the public defenders, the district attorneys, and adult mental health, we have come to the point where we need this additional tool. Some jurisdictions have rolled this out with mixed results. Not all those jurisdictions had the commitment of both the court and law enforcement, the mental health system, and the other players. Through Assemblyman Stewart's efforts, he got that commitment. This allows us to save those valuable bed days.

What happens is they come in, it takes a few weeks to stabilize them, they are back out. When they do not show up for the med appointment they decompensate, and 30 days later they are in county law enforcement again in a very dangerous situation. Or, at a minimum, we are picking them back up and going through the whole process all over again and taking up more bed days. This allows law enforcement to encounter that patient on day 1 off their psychotropic medication versus day 30. I suggest from a clinical standpoint, a safer course of action is to encounter someone in that situation on day 1 versus day 30. The bill allows for another avenue. We are committed to working this program to make a difference, because for years, nothing has. The revolving door does not stop. This bill allows us a tool to attempt to accomplish that task.

Assemblyman Andy Eisen, Clark County Assembly District No. 21:
Both Nevada law and medical practice acknowledge that, in some circumstances at some times, there are some patients whose mental health issues affect them severely enough that they are not in a position to make determinations about what is in their best interests. Under current law, the only mechanism that is in place for these patients to be entered into a treatment program involuntarily is for them to be admitted to an inpatient facility.

Aside from being an expensive prospect, it is not always medically in the best interests of the patient. It is disorienting in the best of circumstances to be admitted to an inpatient facility, and it is intimidating and frightening.

The principle behind this bill is not to open the door to allow for more patients to be involuntarily admitted to a program of treatment. It is to create another opportunity for involuntary treatment that does not involve admission to an inpatient facility. It would either be a community-based or outpatient program into which a patient could be enrolled and monitored; granted, involuntarily, but it is actually a step down from the intensity of the involuntary admission that exists under current law.

On page 10 of the bill, section 13, subsection 2, paragraph (g) reads, "The program of community-based or outpatient services is the least restrictive treatment which is in the best interest of the person." To me, that is an essential point in this bill. The effort here is to identify a treatment program for these patients that is the least restrictive possible. It is not an attempt to reach further into the community and pull people into involuntary treatment. It is to identify those who currently would be identified for involuntary treatment and be able to deliver that treatment in a manner that is less restrictive, less intimidating, less frightening, less expensive, and more effective overall.

Chair Dondero Loop:
I know we are going to hear from someone by telephone. Were you going to wait until later?

Assemblyman Stewart:
It is Kristina Ragosta who belongs to a national organization that advocates for mental health.

Kristina Ragosta, Director of Advocacy, Treatment Advocacy Center:
[Ms. Ragosta submitted written testimony in support of A.B. 287 (Exhibit D).] We are a national nonprofit. From our perspective, the state of Nevada has one of the most restrictive mental health treatment laws in the country. It is worth highlighting a few statistics. Currently in the state of Nevada, a person with severe mental illness is ten times more likely to be in one of your jails or prisons versus one of your psychiatric hospitals. This is a less restrictive alternative to hospitalization. While it will not solve all the issues with the mental health system in Nevada, it is a critical tool that the state is missing. While we recognize the State's concern about funding services, it is noteworthy that legislatures passing measures for assisted outpatient treatment have rarely included specific funding allocations with that authorizing legislation. Typical of this practice, no funding was attached in four states that passed similar laws in

the last decade including Florida, Michigan, Louisiana, and Maine. The reason for not directly funding these laws stems from the view that they are not discrete programs that require direct funding; rather, they are legal mechanisms that make more efficient use of existing services for people who meet the law's eligibility standard. One very recent study demonstrated that assisted outpatient treatment produced a 50 percent cost savings in the first year of implementation in the state of New York, and I know this bill is largely based on the same criteria.

Chair Dondero Loop:
Is there anyone on the Committee who has a question at this time?

Assemblywoman Spiegel:
In your written testimony, you state that there are some provisions in the bill that are problematic. Could you tell us what those are?

Kristina Ragosta:
I brought them to the attention of Assemblyman Stewart and they may be addressed at a different point in time. One issue is that the criteria in the law was mirrored after New York's law known as Kendra's Law. There is a six-month provision that I think was misinterpreted by the drafter. The specific provision has created a lot of confusion in the state. It has been clarified by some other case law, and I am happy to send some specific details on that.

The other issue was with some of the noncompliance provisions in the bill. I believe that is section 18 in the current draft. It has to do with practical implementation of the law.

Chair Dondero Loop:
It sounds as though you have some questions about the way the bill was drafted.

Assemblyman Stewart:
We have a proposed amendment that I believe addresses Ms. Ragosta's concerns (Exhibit E).

Judge William Voy:
I believe that amendment addresses most of the concerns Ms. Ragosta had.

The Honorable Linda Marie Bell, Eighth Judicial District Court:
I am the judge who handles all the competency determinations in the criminal division of the court. Anytime there is a question about someone's ability to stand trial, that case is transferred to me. My staff arranges for evaluations,

and we make a determination about whether the person is competent and can return and be tried, or whether he or she needs to go to Lake's Crossing Center for restoration of competence.

I estimate that I have three to five people a month who are found incompetent without the probability of competence being restored. That is, they are unable to go forward and be tried. At that point, the person is sent from Lake's Crossing down to Rawson-Neal Psychiatric Hospital. I sign an order of civil commitment or dismissal. As soon as there is a release plan from Rawson-Neal, usually a period of three to six weeks, the person is released and we no longer have the ability to monitor how they are doing. Some of the crimes involved are tremendously serious. It is really critical for our criminal justice system and for the safety of our community to have some intermediate steps so that we can ensure that the people I see are not caught in that revolving door of leaving the system, being off medication, not having any treatment, committing other crimes, and coming back. It is frustrating that we do not have any kind of intermediate step. It is all or nothing, and I encourage you to pass this bill.

Arthur (A.J.) Delap, representing the Las Vegas Metropolitan Police Department: I want to express our sincere gratitude for hearing this bill today. On behalf of the Las Vegas Metropolitan Police Department (Metro), we feel there is great merit to this bill. We have worked these past many months with Assemblyman Stewart on creating legislation that we think we can effectively participate in.

As working police officers, we routinely come back around to the same people in various stages of their mental stability, over and over again. It is a volatile situation under some circumstances for officers who are at the tip of the spear when dealing with these folks who need help. They are not necessarily criminals, but they may be committing what is perceived to be a criminal act or behaving erratically. Our officers are routinely tasked with being the first responders out to these locations. Often these are people we have had dealings with in the past—sometimes over many years. Sometimes the situation is very volatile. It can be violent, and in some instances it can be deadly. It is quite a responsibility for the officer to deal with these folks in those situations. It is frustrating. We would like to see an opportunity for the folks who can be stabilized and who have shown that they can be stabilized. However, they have a difficult time adhering to their treatment programs. Without having any kind of commitment requirement in place that can direct them to comply with a treatment program, they have a tendency to fall off of that program, and then the decompensation process begins. It will not be long before 9-1-1 is being called and police are responding. Based on the circumstance, we are going to protect ourselves and the members of the community. We are going to try to

protect that individual as best we can, but those are volatile situations and so many times they could be avoided if that person was receiving the type of mental care he or she needed and possibly responded to in the past.

Based on those thoughts, our administration found great merit in this measure. We currently have a transportation team that works out of the Clark County Detention Center. They would conduct the pickups of these individuals. It would be based on a civil pickup order. It is a nonpursuit order, which means that we are not going to chase the person down or use means we would normally use to apprehend a criminal. These officers receive special training in this area so they are more aware of the issues and concerns.

We have begun tracking the number of times we issue the Legal 2000 on people. By doing that, we know we are identifying people who we routinely take into custody under the Legal 2000 parameters. Many times we can see a pattern as they become more and more violent based on the narrative of that Legal 2000. We believe this type of legislation could help mitigate some of the issues there as well.

Chair Dondero Loop:
Are there questions from the Committee?

Assemblyman Sprinkle:
I am looking at page 4, in the area of line 13, where it talks about recommitting. It says that notification needs to be given up to three days in advance to the judge. If there is potential for imminent violence or harm, it sounds as though one-day notice is sufficient. If there is concern to the point where you are looking at involuntarily taking someone once again, three days seems like an awfully long time to wait for the warrant or order to be issued once again from the judge. A lot can happen in three days. Could you give me your thoughts on that?

Judge Linda Bell:
If a person is in an emergency, that time period is shortened. Obviously, the Legal 2000 process is always available if there is a true psychiatric emergency. This allows for the process to proceed. If someone is not taking their medication, then the court can be contacted and they can be picked up within a few days.

A.J. Delap:
The pickup order is the last resort. There may be other mechanisms where the person could be contacted once the attendance factor is noticed. You could have the psychiatric caseworker make contact with that person on his own

accord and inquire as to why the individual is not attending; see if a conversation could coax the individual into attending. Ultimately, the process would take three days so the courts could vet it and issue the proper order for the pickup.

Assemblyman Sprinkle:
I am not sure about the language here and I will read it: ". . . that the conditional release is no longer appropriate because that person presents a clear and present danger of harm to himself or herself or others." If that is what you are trying to get at when you are now going to go out and pick them back up, three days seems like an awfully long time to wait. Why would we not just order the Legal 2000 and get them off the streets immediately?

Judge William Voy:
Most of the patients in this program are getting intravenous (IV) medication. It goes for 30 days at a time. The decompensation period takes a while. On day 1, they miss their appointment for their medication. As was previously said, you may have a psychiatric caseworker contact them, tell them their appointment was missed and that they need to be at that appointment the next day. The decompensation does not happen overnight; most times it takes a period of time. After day 3, they probably have gotten, or are going to get, real close to the other definition of imminent threat—to where they were when they were acting psychotic or almost even acute. That is why the different time tables are in the bill. They want to build rapport with that patient at that clinic, so you do not want to call the Las Vegas Metropolitan Police Department (Metro) every time they miss an appointment. You give them time to develop a relationship; however, when push comes to shove, you have to have them brought in.

Assemblyman Sprinkle:
There is an assumption that if they continue to not take their meds, this is the point they are going to get to. That is the intent of this language, and not that they are actually in a crisis state at that point.

Judge William Voy:
Not at that point, right.

Assemblyman Eisen:
The only reason someone would be engaged in a program like this is because, without treatment, they would present a risk of harm to themselves or others. The difference between the minimum of three days on one measure and no more than one day on the other measure, is the difference between that risk

and an imminent threat of something bad happening. That is when things are expected to move much more quickly.

Assemblyman Hambrick:
Mr. DeLap said that Metro has a unit that goes out. In a month's time, how many times would that happen in Clark County?

Judge William Voy:
Under existing law, if you have a family member who is mentally ill, you can petition the court directly for a pickup order. It is a probable-cause type of petition similar to an arrest warrant. The affidavit is reviewed by me. If I find probable cause, that order is sent to the Metro transport division. They meet the family member at the scene where the other family member is, pick up that person and bring them to a mental health facility. There it is determined whether or not they really need to go through the process and meet the standard for commitment. If so, then the process takes over.

Right now, we probably only have two a week. The population we are targeting here are people who have already been committed. It has already been established that if they are off their medication they are going to meet that criteria. They are going to be in imminent danger. In Clark County, there are probably 200 patients who would fall under this. If they had to show up for the med clinic on a monthly basis—the most important step as far as stabilizing a patient—you are conceivably talking about five or six a week.

Assemblyman Oscarson:
How do you envision this will affect rural communities that do not have the resources some of the big urban areas have?

Judge William Voy:
If you look at the statute, it says if a program is available or has been established—meaning the resources. I just spoke with Dr. Green, the state Health Officer, about this. She asked me, "If I only have enough resources for 40 patients in this program at any given time, what do we do when you send me the 41st patient?" I said, "You tell me no." Normally as a judge I do not like to give the State that ability, but looking at section 13, subsection 2, paragraph (a) in the bill, that is what it is. We made a commitment. These are the same people who are taking up the bed days—those expensive $500-a-day beds. In order for us to demonstrate that this can work, we need to be a team—the courts, law enforcement, and mental health. I believe that in the long run this will save us money. I am committed to work within the existing resources that state mental health has. If they can only accommodate so much, then that is all they can accommodate at any given time. It is so

important to the court and to me that we give this a shot that I am willing to limit myself in that capacity.

Assemblyman Oscarson:
I am not opposed; I am just trying to figure out how this is going to work in some of the rural communities where those resources are stretched to the maximum. There are just a limited amount of places and resources we can utilize in some of those smaller areas.

Assemblyman Eisen:
This is actually an opportunity for rural areas in particular. The entire state is underserved in mental health services, but particularly when we are talking about the only option being inpatient hospitalization. If we have a patient who is in a rural area that does not have an inpatient facility, this bill would create an opportunity to have a program in place that could rely on professionals who are in the area or who can monitor the area. They could be in their own community and enrolled in one of these programs.

I would refer you to section 2 of the bill that defines what the program is. It is not exclusively medication-based. It may be counseling or it may be screening tests to monitor for presence of drugs if it is a patient who is a known drug abuser. These are things that could be done on a mandated basis in an outpatient setting where an inpatient facility does not exist. The only option now for many of our rural communities is to take that patient out of their community and put them in an inpatient facility somewhere else far from their family and home. It does not magically create providers in those areas. I recognize that is an issue, but hopefully, if we can be more efficient about the way we utilize our providers and the system, we will be able to take care of more patients overall.

Assemblyman Sprinkle:
In regard to when law enforcement is sent out to pick these individuals up, the way I read the amendment (Exhibit E), it reads, ". . . deliver the consumer to the appropriate location for an evaluation by an evaluation team from the Division as set forth in Sec. 10." Is this now eliminating the need for a medical evaluation and release first? The way I understand it, that typically is the process when someone is involuntarily committed. They first must go through a medical evaluation; but now you are having police officers doing what medical professionals usually do.

Assemblyman Eisen:
That is not what is being suggested here. That initial evaluation would still need to take place. The issue then becomes, where does that patient go? You and

I and Assemblyman Oscarson have seen patients who have been brought to a medical facility to have an initial screening, and then there is no place to send them. There is no inpatient bed available. In this bill, what we are hoping for is that some of those patients who are appropriate for this kind of assisted outpatient treatment, once they are medically cleared, could be sent from the hospital to an outpatient or community-based setting and not have to go to an inpatient mental health facility. It does not, however, obviate the need for that initial evaluation.

Chair Dondero Loop:
We have talked a lot about people who are already diagnosed, who already have issues, and who have been in and out. I would like some clarification on what happens with someone who has never been seen and never been arrested—that initial contact. What happens with that person? Could you take us through a scenario like that?

Judge William Voy:
When we encounter a patient who appears to be mentally ill and presents as a danger to himself or others, the Legal 2000 enables us to bring the person into a mental health facility for a clearance. The medical clearance the statute currently has is a leftover from when the statute was originally created back in the ancient days of mental health in Nevada. Because people would have seizures, people would think they were having some kind of mental health issue or some other medical complication like dehydration, which can cause someone to be psychotic. That provision was put into statute to make sure that someone was not appearing to be mentally ill due to some medical emergency. That is why the medical clearance has been in the statute. Take them to a doctor first. It is not for a physical; it is to rule out epileptic seizures, dehydration, or some other medical emergency causing them to appear to be mentally ill and acting the way they are acting.

That is done in the initial process. If they still meet commitment criteria, then within 72 hours, the petition is made to the family court division for the actual civil commitment. That hearing has to be held within five days from that date. At that point it comes to court at the Rawson-Neal. At that point, a determination is made whether or not the person meets commitment criteria. Two independent doctors, paid for by the county, review the patient and make their opinions known at the hearing. The person is represented by counsel at the hearing; the district attorney is also represented. Approximately 1,100 petitions are filed each week.

Chair Dondero Loop:
Are you saying 1,100 people? What is the total number of petitions filed, and could you break that number down for us, please?

Jon Norheim, Hearing Master, Eighth Judicial District Court:
The number of petitions filed each week has been running between 300 and 400. Those are people who have gone the entire 72 hours after the Legal 2000 and who have not been cleared such that they could be released within the 72 hours. Last week there were 425.

Chair Dondero Loop:
What percentage of those are people who need assistance through a program like this?

Jon Norheim:
A very small percentage. I do not envision this program having more than 200 people in it at any given time. Those are the hard-core people who revisit the system week after week. We have to do something to try to help them because the system currently is not helping them.

Chair Dondero Loop:
If we identify 400 people each week who may need some medical mental intervention, and if, out of that, we have a very small percentage, how are those people being identified? Are they picked up because they are high on drugs? Have they had too much alcohol? Has a wife called in saying her husband is nuts?

Jon Norheim:
That is how we get from 1,500 to 2,000 Legal 2000s a week down to only 300 to 400 court filings. During that 72-hour period, the goal is to weed out those individuals who are there because they were high on drugs, or there was a misunderstanding, or there was a medical problem. An enormous number of people come into the system through the Legal 2000s, but that gets considerably winnowed down to the 300 to 400 who have court petitions filed each week. By the time we have the hearing four or five days later, a number of those people are well on their way toward being stabilized. A lot of people enter the system because they try to kill themselves, have situational depression, or have mental health issues. That is not what we are talking about here. They still qualify to be Legal 2000 because they are a danger to themselves, but they are not the kind of people who we would be talking about putting into outpatient commitment programs. There is a significant number of those people. There are people who develop schizophrenia and do real well taking their medication. They only have to come into the hospital every year or

two for a tune-up. Those people would not qualify either. We are talking about the people who have had a long history of not taking their medication, decompensating, and doing bad things out in the community.

Chair Dondero Loop:
Are there additional questions from the Committee? [There was no response.] Will those in support please come forward?

Donna Marie Shibovich, representing the National Alliance on Mental Illness, Nevada Chapter:
[Ms. Shibovich read her testimony in support of the bill from prepared text (Exhibit F).]

Joe Tyler, representing the National Alliance on Mental Illness, Nevada Chapter:
A lot of times we lack insight, especially when we are not on our meds, so we do not understand that we need to take our meds. I have been taking my meds now for 30 years. They work and I realize that; but some people who are just starting out do not understand that. I work in the state system and am familiar with the observation unit that was just spoken about. I work the inpatient service. There is a mental health court; a veterans court; a drug and alcohol court. The more resources we can get and the more effective ways to get people in, as this one does, the better.

Christy Craig, Office of the Public Defender, Clark County:
I am an attorney at the Clark County Public Defender's Office. I work primarily with people about whom there are concerns regarding competency to stand trial. These are the people who would go through Judge Bell's competency court to determine whether they are competent to proceed. I will confine my testimony to those who have criminal issues.

Judge Voy referred to the "treatment-resistant loopers," people who commit a crime. They go to jail. Jail costs about $139 a day to hold someone who has mental issues. They go up to Lake's Crossing, which costs $500 to $550 a day for treatment. They are found to be incompetent without probability; the criminal charges are dismissed; and they are returned to Rawson-Neal. They are treated for a relatively short period of time. Despite being found incompetent without probability of attaining competency, they are able to refuse treatment. They are then released to the street, or to their home, or to their family. They frequently recommit crimes and loop back around again. It is a ridiculous and expensive way of treating the mentally ill. In the email I sent you, I included an example of someone who is in that process right now (Exhibit G).

I believe this bill is a very small first step in allowing longer treatment for those treatment-resistant loopers so we can avoid prison and we can avoid jail. It allows a judge to maintain control over some of the criminal cases for a longer period of time to ensure that they are getting treatment from the State and that they themselves are continuing the treatment. It provides some ability to maintain oversight that we do not currently have to try to avoid these looping problems. As a criminal defense attorney, I should not be in the position of hoping that my client commits a more serious crime—not too serious, but serious enough that he could potentially be housed at Lake's Crossing for a longer period of time. Lake's Crossing is a last-ditch, long-term treatment facility by way of statute for people who have committed A or B felonies who have been found to be incompetent without probability. Other than that, there is no middle ground other than prison or jail. This is a small first step, and I urge the passage of this bill.

Joe Tyler:
A lot of times I represent the families. I would go with my parents to inpatient treatment. I was hospitalized seven times. Many people need more force to go in. Sometimes authority comes and shows its face. I also do crisis intervention team training. We try to get the officers to be gentle, kind, and supportive of the needs of the person while they are transporting.

Dan Musgrove, representing West Care Nevada and The Valley Health System:
Some of these people end up in the emergency rooms because there is no other place besides jail or prison and they need medication. That has an impact on the care our constituents need that is medically-related or urgent. We do not want them clogging up our emergency rooms. We want them in the best place at the right time, so this bill is very important.

Eric Spratley, representing the Washoe County Sheriff's Office:
I am here to express our support for A.B. 287.

John Jones Jr., representing the Nevada District Attorney's Association:
We want to be on record as supporting A.B. 287.

Frank Reagan, Chair, Southern Nevada Adult Mental Health Coalition; Captain, Field Services Section, Las Vegas Metropolitan Police Department:
We are in full support of A.B. 287. I also am Captain of Metro's Field Services Section, which does the civil commitment orders. As well as being in full support, we believe this will have a minimal operational impact. We have worked tirelessly to make sure everyone's concerns were addressed.

Robert Lynn Horne, M.D., Private Citizen, Clark County:
[Dr. Horne presented a letter in support of A.B. 287 (Exhibit H).] Nevada County, California, implemented a similar law in 2007. In the first 30 months, they were able to save over $500,000. Assisted outpatient treatment significantly reduced hospitalization and incarceration rates in Seminole County, Florida, after that state passed the law in 2004 using the existing services and funding allocations.

Similar results can be achieved in Nevada with court-ordered, long-acting injectable medication. It is intramuscular (IM), not intravenous. Twelve patients in Las Vegas voluntarily began receiving a long-acting injectable medication after having 27 hospitalizations and 14 incarcerations in the previous three years. In the next six and a half years, only one patient was rehospitalized, and he had dropped out of the program after four years and moved out of state. I urge you to support this bill.

Deacon Tim O'Callaghan, Private Citizen, Las Vegas, Nevada:
I am speaking as the parent of a mentally ill child who has a borderline personality disorder. I am also speaking for families that often have to worry about their family members not taking their medications. That causes a great deal of anxiety to families. I support this bill.

As a pastoral associate, I deal with several schizophrenics. Often when they get off their medication, they feel as though they do not need their medication anymore. When that happens, I often have to get them back into the system. This would be very helpful in that aspect.

Chair Dondero Loop:
Are there questions from the Committee? [There was no response.] Is there anyone else in support? [There was no response.] Is there anyone in opposition?

Robert Bennett, Private Citizen, Carson City, Nevada:
[Mr. Bennett read his testimony in opposition from the bill from prepared text (Exhibit I).] Let me read from Levine's book on human trauma: "A compulsion can develop to repeat the circumstances of the original trauma. This can result in an individual placing himself, herself, or others, in harm's way due to an unconscious effort to achieve a better outcome of a traumatic circumstance." Going back between 20 and 30 years, the traumas I experienced got me placed into mental hospitals and jails on a number of occasions. It was not until I chose a better outcome that I stopped having those problems.

Twenty-one years ago the state of California enacted the Koran algorithm—a step-by-step series to eliminate various physical conditions that can manifest as psychological programs. The screening process we have in Nevada does not include this. They primarily look for illegal drug use, and that is about it. Basically, they neglect all these physical problems that can manifest as psychological problems. Some research has shown that between 41-75 percent of individuals having a mental health diagnosis actually have physical conditions that can be treated. These various other conditions should not be handed over to psychiatry to treat. They are much too reliant on drugs for everything. We really need to get to the heart of things and not just force people on drugs.

Jack Mayes, Executive Director, Nevada Disability Advocacy and Law Center:
We are here to express our opposition to A.B. 287. [Mr. Mayes read his testimony in opposition to A.B. 287 from prepared text (Exhibit J).]

Vanessa Spinozola, representing the American Civil Liberties Union of Nevada:
We are here in opposition to A.B. 287. I want to thank Assemblyman Stewart for putting together a coalition over the past few months and really talking through these issues. The warrant issue, the order issue, has definitely been improved, but we still are opposed based on the fact that, as Americans, we have a right to choose our course of medical treatment. We should not be forced by other people to take medication. We have laws on the books here that if you are a danger to yourself or others, you get a Legal 2000. This goes far beyond that and tries to put people in who simply do not want to take their medication. This right, as discussed, is protected by the *Constitution*.

I want to point out a few things. Kendra's Law could have the unintended consequences of scaring people away from treatment. The element of trust between a doctor and patient is one of the most important bonds that can be made in mental health treatment. If people begin to hear that they could get picked up if they are not participating, it could start to break that bond down.

It will also, as mentioned, lessen treatment options for those who voluntarily seek treatment because, in a system where treatment services are in short supply, there are already folks on waiting lists who want treatment and cannot get it at this time. I think it is a resource issue.

While Kendra's Law is on the books in 44 states, it is not actually implemented in all those states because of the cost issues associated. There will need to be experts called in court proceedings to verify that folks are actually dangers to themselves. There will be a cost associated with that. There are costs associated with law enforcement going out and picking people up if they are not

in compliance with their treatment programs. So I believe that fiscal note should be noted for this bill.

Chair Dondero Loop:
While I realize that there may or may not be a cost, this is a policy committee and not a finance committee. Are there any questions from the Committee? [There was no response.] We will continue with opposition testimony.

Coni Kalinowski, M.D.; Faculty Member, University of Nevada School of Medicine; Medical Director, Mojave Mental Health:
[Dr. Kalinowski read her testimony in opposition to A.B. 287 from prepared text (Exhibit K).]

Jason Schwartz, Director of Community Sports Services, Mohave Mental Health:
I am here to speak against A.B. 287. I would like to speak about funding demonstrably effective programming. If we are looking to spend mental health dollars, there are some programs that have demonstrated their effectiveness that are underfunded at this point. For instance, the mental health court that is dealing specifically with some of these people we are characterizing here is woefully underfunded. It is an extremely effective program as most outcome measures have demonstrated. We participate in the mental health court program and would be willing to expand the program if funding expanded.

We have severely inadequate funding for supportive housing programs. When you are talking about a person who is homeless, an involuntary commitment on an outpatient basis cannot possibly be very effective. We could be treating this problem with a carrot instead of a stick. Move into a group home; have support; have monitoring of your meds. Clients may still opt to not take their meds occasionally, but they are much more likely to take their meds when they are in a supported environment, when they are fed, and when they have housing instead of living on the streets. A significant proportion of our clients do not have sufficient housing options, and are, therefore, on the streets and unable to maintain their med regimens even if they wanted to.

Right now, we are seeing three-week to three-month delays in recertification of Medicaid eligibility. If you look at the employment flow chart on the Nevada website, there are dozens of unfilled positions at the Welfare Division. Even people in the severe and persistent mental health category with Supplemental Security Income, who have had Medicaid for 10 or 20 years are losing their Medicaid because the workers do not have time to complete the recertifications that are turned in a month early. These people cannot refill their meds.

These folks are cycling through the hospitals. We should be funding more positions at Welfare.

Mojave Mental Health has a day treatment program. In the last two years, only one person involved in the day treatment program was arrested. We have recently received a significant number of denials of prior authorization requests (PARs) for the people in that program. In the last three months, six people who have been denied PARs have been arrested. Keep people productively engaged and they will not be unproductively engaged.

Fund programs that assist these folks and provide positive reinforcement rather than negative reinforcement or something to be avoided, and we will have a much more effective program.

Certain agencies providing services to our clients go to involuntary termination when a client evidences treatment disinterest, which some are still calling noncompliance. Maybe we need to strengthen our policies providing involuntary termination of services as a last resort and not allow workers to engage in such behavior without oversight or supervision.

In section 4, subsection 2, A.B. 287 provides sanction or protection for state agents who have a client who is in this program, but no other entity appears to be protected. If a client is put into an involuntary outpatient status, I do not see any protection for any service provider, other than the state, in case that does not work and there is some kind of untoward behavior.

I urge the Committee to rethink this support they heard and provide support for more progressive programming that already exists that is severely underfunded.

Assemblywoman Pierce:
Mr. Schwartz, when you were talking about your day treatment program you said something about PARs. Is that an acronym?

Jason Schwartz:
Yes, PARs are prior authorization requests that are submitted to Medicaid through their fiscal intermediary, Hewlett Packard. Hewlett Packard is routinely denying PARs that in the past have never been denied. Even when they are appealed by medical professionals who know the clients, the PARs continue to be denied. The clients may have service but the provider will not get paid for it.

Chair Dondero Loop:
Are there additional questions from the Committee? [There was no response.] Is there any additional opposition? Is anyone neutral?

Tracey D. Green, M.D., Nevada State Health Officer, Health Division, Department of Health and Human Services; Medical Director, Division of Mental Health and Developmental Services, Department of Health and Human Services:
[Dr. Green read her testimony from prepared text (Exhibit L).] We have been working with the bill's sponsor and continue to plan on working with the sponsor to work through the amendment. We were given the amendment this morning. The amendment solves some of the issues the state has; however, there are two areas that continue to be of concern to us. The first was just mentioned—the liability given to state employees and those working for the state or state agents. The second is the lack of specificity for those clients being enrolled in the program. Given that the state Mental Health and Developmental Services Program is the largest deliverer of outpatient mental health services, we believe that, with the bill requirements to refer to an existing outpatient mental health program, that the implementation of this bill will require us to expand our current program. We call the program the PACT program, which is a Program for Assertive Community Treatment. Currently, this program provides the outpatient services and wraparound services for those intensive clients who would be enrolled in this program. These services include the services that were mentioned in some of the previous testimonies—the direct giving of medications, those IM medications as they are needed. In addition to community triage, the finding of housing, if necessary, the establishment of care, therapies, and any of those services that might be needed for the clients.

We have estimated that one PACT team would be required at least to provide for the increase in clients we would see from this bill. This bill would, if left in this format, require us to submit an unsolicited fiscal note. The fiscal note would be for one PACT team. The PACT team could provide services to 75 clients. That is what we use now and is a 12:1 ratio. That is 12 clients to 1 case worker with a part-time psychologist and a part-time psychiatrist. We also believe some of these services will be offset by the Affordable Care Act as some of these services are covered and will be covered under Medicaid within the Affordable Care Act.

Chair Dondero Loop:
Are there questions from the Committee?

Assemblyman Hogan:
Is involuntary involvement in the sort of treatment your teams would provide a possibility under that system, or is this only fully voluntary on the part of the person needing the services?

Tracey Green:
Yes, currently we work with the Lake's Crossing forensic system. At times a part of our treatment concerns the involuntary delivery of medications, as described. It is usually IM or by a shot in the arm. We may need to train if there was increased frequency of need for that type of service, but we are capable of providing that kind of service.

Assemblyman Hogan:
All of us here who are not expert in the field have heard some very serious and very sincere testimony from people with quite varied views on this. We certainly do not want to blunder into the wrong approach because someone was more persuasive than someone else. From your standpoint, is there an accepted or emerging consensus regarding the value, in appropriate circumstances, of requiring persons having these problems to submit to treatment involuntarily?

Tracey Green:
There is not a clear consensus. In my opinion, if the population is selected appropriately—in that these are frequent users of the system who have been involved in both the mental health system and the criminal justice system—then this becomes a tool in the tool kit and we have an opportunity to perhaps save a life. We have seen mentally ill clients who have been killed by law enforcement because of being off of medications. I think as a tool in the tool kit, this does provide us with another opportunity to serve clients.

Chair Dondero Loop:
Are there additional questions from the Committee? [There were none.] Does anyone else want to speak as neutral? [There was no response.] Mr. Stewart and Dr. Eisen, do you have any closing comments?

Assemblyman Stewart:
I appreciate your taking the time to hear this bill.

Assemblyman Eisen:
We have heard a number of folks testify today as to shortcomings in our mental health system in the state, and I do not disagree at all. This bill seeks only to provide an alternative pathway for treatment for patients who, under the current system, would have no other choice but inpatient, involuntary admission, or

sitting in a hospital emergency department or medical facility not receiving any mental health treatment at all. It is really a matter of opening up an opportunity for a different pathway—something that is less restrictive for the patients and, in fact, less expensive and more effective. While we recognize that there is not exactly a glut of providers currently in the outpatient setting, we are hoping that we will be able to redirect resources to that kind of service and be able to reach and help more patients than we can under the current system.

Chair Dondero Loop:
Does anyone else wish to testify? Then I will close the hearing on A.B. 287 and open the hearing on Assembly Bill 351.

Assembly Bill 351: Revises provisions governing the medical use of marijuana. (BDR 40-733)

Assemblyman William C. Horne, Clark County Assembly District No. 34:
Existing law allows for the regulated use of marijuana by a person who suffers from certain illnesses if they obtain a prescription and registry card from the Department of Health and Human Services (DHHS). These persons are exempt from prosecution for using such a substance. Assembly Bill 351 provides that such a person who is allowed by law to use marijuana in the state of Nevada may not be prosecuted for driving, operating, or being in control of a vehicle or vessel with a certain amount of marijuana in their bloodstream or urine as provided in the *Nevada Revised Statutes* (NRS): 10 nanograms of tetrahydrocannabinol (THC) per milliliter of urine; 2 nanograms per milliliter of blood; 15 nanograms of THC metabolite per milliliter of urine; 5 nanograms per milliliter of blood. This bill further provides that a person is not exempt from prosecution if they are driving under the influence of marijuana. In your exhibits, you will find the Drug and Human Performance Fact Sheet provided to the public by the National Highway Traffic Safety Administration (Exhibit M). According to their findings, "It is difficult to establish a relationship between a person's THC blood or plasma concentration and performance impairing effects. Concentrations of parent drug and metabolite are very dependent upon pattern of use as well as dose." This fact sheet demonstrates the difficulty associated with establishing causal relationship between marijuana use and impaired driving. Some marijuana users may be impaired with undetectable levels of THC in their system. Others may have high levels of THC in their system even though they have not used the substance in several hours or even days.

Since medical marijuana card holders are legally able to ingest marijuana, it is inevitable that they will have THC in their system, although they may not be impaired. Unless there is a change in state law, a patient could be found guilty of driving under the influence (DUI) simply because they have prescribed

medication in their blood. I want to make clear that it is still against the law to drive under the influence of marijuana regardless of whether you are a medical marijuana card holder. This bill simply holds medical marijuana to the same standard as any other potentially impairing prescription drug. This bill simply allows a person with a legal ability to obtain marijuana to not be prosecuted for the legal use of that substance. A similar example would be a patient prescribed anti-anxiety or pain medications. It is the responsibility of that patient to not drive impaired by those medications. It is also the obligation of the State to ensure that patients are not prosecuted because they have traces of that prescribed medication in their bloodstream or urine. To simplify, medical marijuana should not be treated any differently than any other prescribed medication, particularly those medications that are far more dangerous. Since traces of marijuana can stay in a user's system for more than five weeks, it is crucial that the state use a better determination to determine impairment.

The simple message in the bill is, if marijuana is going to be legally prescribed by a doctor to a patient, no differently than Lortab, oxycodone, OxyContin, Flexeril, or even over-the-counter drugs such as Benadryl, why would we treat marijuana differently than these other prescribed or over-the-counter drugs? It is unfair. This bill does not take away the ability for law enforcement and the district attorneys' offices to prosecute someone driving while impaired under this drug—just as with any other drug. Just because it is prescribed does not mean you cannot be prosecuted for driving under the influence, but with marijuana there are per se levels that are not applied to the other drugs—drugs that are far more dangerous than marijuana. No one can tell you why it is treated differently. I can make a guess that we still live under the societal beliefs we grew up with that marijuana was a bad drug. It had negative connotations to it. As we have evolved into the twenty-first century and as more states are legalizing it both for medical use and for recreational use, it is time for us to change our laws accordingly. Marijuana is no different than any other prescribed drug and should be treated just like those other prescribed drugs.

Chair Dondero Loop:
Would this only pertain if we pass a medical marijuana law? Would this only pertain to Nevada doctors who distribute Nevada cards, or would it apply to a card from any jurisdiction such as Washington State?

Assemblyman Horne:
I think it is going to apply if you are prescribed in Nevada or you have a card from any other state. That would be applicable just like your driver's license and prescription drugs are accepted elsewhere. If you had any other type of drug, you can show you have been prescribed that particular medication by a

treating physician. That should not be any different in our state. If you have been prescribed it legally, it should be treated the same.

Assemblyman Hambrick:
Under today's technology, you mentioned certain chemicals can stay in the blood system. Is there any way for a police officer who makes a righteous stop to be able to determine, if they do a sobriety or blood test, how long that legal amount we are talking about has been in that individual's system? Was it 4 hours or 75 hours? With today's technology, is there any way to determine how long?

Assemblyman Horne:
The levels of THC in one's system can vary depending upon the degree of use. You may have some patients who use it far more throughout a day than other patients. Also, that prolonged period of time allows both the THC and the metabolite, which is the byproduct of THC, to remain in your system. That would make it difficult to say whether or not you are necessarily impaired. You can have an average, but everyone is different. For instance, there are functioning alcoholics—they may blow a 0.2 on a breathalyzer—but if you did the indicia, they are functioning alcoholics. They drink so much their bodies have adapted to that alcohol. There have been studies and arguments made that when they do not drink, they are actually more impaired than when they are drinking because they do not have alcohol in their systems.

Nothing in this bill prevents a police officer showing up at the scene of an accident from doing all the standard field sobriety things to determine whether this person might be impaired. If you are, regardless of whether you have this card or not, you should be prosecuted for that.

Assemblywoman Fiore:
Is there a blood test that our officers can apply versus the one in current use to tell the different levels of THC? I believe the tests given today are on THC, so if you smoked marijuana about 30 days ago or ate a cookie containing marijuana, it would still be in your system. Is there another blood test that could actually determine someone's real levels? Can we implement that?

Assemblyman Horne:
I am not familiar with the specific blood test you are talking about that more narrowly focuses on the window of time from when the substance was ingested.

Assemblyman Sprinkle:
Let us say that a person was pulled over for speeding. The police officer does a field sobriety test and believes it comes back positive enough to take that person into custody. Once these tests are performed, if those levels are lower than the accepted level, where does that leave that situation? Is this similar to alcohol if their EtOH levels are lower than 0.08°, will they just be released? How does that work?

Assemblyman Horne:
I would say it would work just like an alcohol-related instance. Individuals have been stopped and failed the field sobriety tests. Then they were tested upon arrest and the results said they were below the limits. That happens. In that regard, I would say those charges would be dropped or reduced to a different standard such as reckless driving.

Chair Dondero Loop:
Are there additional questions from the Committee? [There were none.] I will call those in support of the bill forward.

Steve Yeager, Office of the Public Defender, Clark County:
We are in support of A.B. 351. I wanted to make a couple of comments I hope will clarify in the Committee's mind exactly what the application of this bill would be. Right now, when people accused of DUI are prosecuted, there are two theories under which they can be prosecuted. One is the per se theory, and this is what we hear in the law. For alcohol, it is 0.08. If your blood alcohol level is 0.08 or greater, the prosecutor does not have to prove that you are intoxicated. That is presumed. If you are below 0.08, a prosecution can still happen but the prosecutor then has to prove beyond a reasonable doubt at trial that you were, in fact, intoxicated.

What we are talking about here in this bill is that in the statute as it exists currently, there are levels for marijuana and for marijuana metabolite. Those are baseline levels similar to the 0.08 that we have with alcohol. Right now, if you were arrested and they do a blood draw and you come in over those levels, you are presumed to be intoxicated similar to a DUI. This bill says if you have a medical marijuana card, that particular provision does not apply to you as a medical marijuana card holder. In reality you can still be prosecuted, but the prosecutor would have to prove intoxication. This bill does not change how a prosecution would look against someone who does not have a medical marijuana card. In the law, those levels would continue to exist because those individuals would be illegal users of the substance versus legal users of the substance.

A question I thought the Committee might have is what other drugs do we have in the statute in terms of baseline levels where one is presumed to be intoxicated? Other than alcohol, those are typically the Schedule I controlled substances; for instance, there is a level prescribed for amphetamine, for methamphetamine, cocaine, heroin, LSD, and PCP. Those are obviously all illegal substances. We do not currently have anything in our laws that relate to substances that can be legally prescribed such as OxyContin, Xanax. Those types of prosecutions can still happen under the law, but intoxication has to be proved. How would a prosecutor prove that? The ways one would normally assume—the facts of the incident and their observations upon the scene. They certainly can do a blood draw and talk about what levels of drugs are in someone's system, but that would not, in and of itself, prove intoxication.

The way I look at this law, it is a very nice complement to the laws that currently exist about medical marijuana and the fact that the *Nevada Constitution* allows for approved individuals to use medical marijuana. This is just a protection for those individuals and says we need to take into account that they are lawful users, that they might have some tolerance built up, and that they cannot be guilty of a per se DUI offense.

Currently, there is a lot of debate about what level exactly does mean intoxication for THC or marijuana metabolite or the cannabinoids. There is a lot of differing science on this. I looked to see what was out there, and I will tell you that the universe is complicated in terms of what test best covers these substances. In researching it, I found a very interesting video on CNN. I would urge the Committee members to go on CNN and search "Driving Marijuana." In a jurisdiction, not in Nevada, they had legal users of medical marijuana go through the process of smoking and then driving. The users were with driving instructors and police officers were monitoring how they were doing. Interestingly enough, some of those individuals at five or seven times the legal level proscribed in statute, had no problems driving whatsoever. The officers said that they would not have pulled that person over. They seemed to be doing just fine. Obviously, the more marijuana ingested, the worse the driving got, but that was a pretty instructional video in terms of just how difficult it is to come up with levels in the law.

Assemblyman Hambrick:
I appreciate the background. There are one or two people in this building who believe that, because I have never had experience with marijuana, I should not be sitting in judgment on some of these bills. Regarding the tolerance, and I will use Assemblyman Horne as an example because our body frames are different, Mr. Horne works out regularly; I do not. Then we would take a third person, slight of frame who is very athletic. The metabolisms of the three of us would

differ. I am 67. My metabolism is at a certain rate. Mr. Horne is a very youthful 45 and the third person is an athlete 21 or 22 years old and a marathon runner. How can we as a society properly proscribe what would be safe for someone to get behind the wheel and not be impaired? I am more concerned about the judgment factor and the physiological problems such as reaction time; a 21-year-old shifting from the accelerator to the brake compared to my time from accelerator to brake. It might be infinitesimal in timing, but in reality it could be an eternity. The police officer has to get all these things and put them together. What do we tell the police officer? Using the three examples, how do we tell a police officer what would be proper? Looking at this legislation, it appears to me you want to get a get-home-free card in some of these instances. I am in favor of medical marijuana for legitimate reasons such as chemotherapy and a number of things, although ingrown toenails are not among them. But we have to protect the drivers out there, the pedestrians, the people at the bus stops in Clark County. What do we tell the police officers and the prosecutors? How do we address these issues?

Steve Yeager:
You are right. When it comes to any substance, it is going to depend on the individual, their characteristics, their metabolism, their weight, their tolerance, and male versus female. This bill does not change how it currently works for illegal users of marijuana. They are still going to be prosecuted the same way they have always been prosecuted. We have levels that have been set by statute. If you are above that level, you are per se intoxicated. This bill is going to only apply to those who are only legal users of the substance.

You raise a good question: How do we tell in the individual cases? In terms of guidance, we can look at what we do now for legally prescribed substances such as Xanax or OxyContin. There are individuals who are taking those drugs lawfully prescribed, and who are choosing to drive. In an ideal world, they would have that discussion with their doctor about what dosage is appropriate. They would know not to drive when they had too much, but you and I know that does not necessarily happen. There are individuals on prescription drugs who should not be driving but who are driving. What does law enforcement do in those circumstances? I do not speak for them, but they look at it like any other driving incident. If someone is pulled over or gets in an accident, they go out to the scene. They are able to evaluate that person, speak to that person, and get a sense of whether something is not right. They have at their disposal drug recognition experts who are certified experts who can come out to the scene; talk to the individual and get a sense about their individual circumstance, what drugs they are on and what their tolerance is. Ultimately, if they feel it is appropriate and they think there is probable cause that the person was impaired,

whether legally prescribed or not, that case can be referred to the district attorney's office and a prosecution can commence.

This bill does not give anyone a get-out-of-jail-free card. If you are driving under the influence of marijuana, whether legally prescribed or not, you can still be prosecuted. It just makes it perhaps a little more difficult for the prosecutor to prove the intoxication when we are talking about a legally prescribed substance, because there would be no level in the law. It is a difficult issue; but ultimately, the arresting officer will make those kinds of determinations at the scene, hopefully in conjunction with a drug recognition expert, and then along the line the right thing will be done throughout the prosecution.

Assemblyman Oscarson:
What kind of training do your officers have to determine that? Would they require additional training that would cost you additional money to provide?

Steve Yeager:
I am with the public defender's office, so I do not speak for the police department. I do know that there are certified drug recognition experts who are already trained and go to the scene; however, I cannot give you an idea how many of those individuals there are or how many more they would need if this bill were to be passed. I do know that currently that is often the process when there are prescribed drugs involved.

Chris Frey, Washoe County Public Defender's Office:
I am speaking in support of A.B. 351. Mr. Yeager did an excellent job of summarizing the intent of the bill and giving you a sense of how it would apply in certain situations. I endorse what he said and urge passage of A.B. 351.

Chair Dondero Loop:
Is there anyone else in support? [There was no response.] We will go to opposition.

Brett Kandt, Special Deputy Attorney General, Office of the Attorney General; representing the Nevada Prosecution Advisory Council:
I am speaking on behalf of Attorney General Catherine Cortez Masto and the Nevada Prosecution Advisory Council. My testimony is based on the police proposal here. I will leave the technical aspects to law enforcement officials and prosecutors in the trenches to speak to.

A car operated by an impaired driver is a lethal weapon. It does not matter if that driver is impaired by alcohol or marijuana or OxyContin, or heroin or codeine or cocaine or any other controlled substance or prescription drug. The

purpose of our per se laws is public safety. It certainly does not make the public safer if a driver impaired by marijuana has a medical marijuana card. I checked with my counterparts in other states that have enacted either medical marijuana laws or have actually gone so far as to legalize marijuana for recreational purposes. To date, I have not determined that a single one of those states has enacted or is considering enacting what this bill proposes. In some of the states that enacted medical marijuana laws, they expressly provided in the law that medical marijuana use was still prohibited to the extent that it endangered the health or safety of another person, or it was specifically prohibited for use when operating a motor vehicle. Connecticut is an example of that. In Michigan, an individual who had a medical marijuana card was charged and convicted of a DUI. That individual unsuccessfully challenged that conviction arguing that his right to utilize marijuana pursuant to his medical marijuana card should exempt him from prosecution for DUI. That individual lost that court challenge; it was upheld by the Michigan Court of Appeals. In so doing, the Michigan Court of Appeals in part recognized that there is a compelling government interest in preventing impaired driving and in protecting the public from impaired drivers. There is a sound public policy reason why the other states that have authorized the use of medical marijuana or authorized the use of marijuana for recreational purposes have not gone in this direction. They recognize that a car operated by an impaired driver is a lethal weapon.

Chuck Callaway, representing the Las Vegas Metropolitan Police Department:
We are here today in opposition to A.B. 351. The police officer on the street who encounters an impaired driver does not take a blood sample in the field under normal circumstances, so a booking or an arrest of a driver for being impaired is part of the totality of the circumstances. Circumstances include whether or not that person fails a field sobriety test; whether that person fails a horizontal gaze and nystagmus test; their actions; bloodshot eyes; their physical characteristics—all those things come into play. The metabolite in their system is a component of that. To say that someone cannot be prosecuted if they have a medical marijuana card, but if they are using marijuana illegally they can be prosecuted, to me is almost as ludicrous as saying if you have a prescription for Lortab and you drive with Lortab in your system, you are not subject to the same penalties as if you do not have a prescription and drive with Lortab in your system.

I ask that the Committee consider that we have had a number of cases in Las Vegas where people have been involved in fatal accidents. There was an accident at a bus stop last year and another accident several years back involving kids on the roadway who were struck by a vehicle. In all those accidents, marijuana was a contributing factor. I cannot sit here before you and

tell you that was the only substance in those folks' blood, but it was definitely a contributing factor.

As the public defender said, there may be people who can smoke a certain amount of marijuana and appear to be fine, but I know from personal experience in law enforcement that there are people who can drink a substantial amount of alcohol and appear to be fine and maybe even pass some of the field sobriety tests, but when you get them to the Clark County Detention Center and they take a breathalyzer test, they are way beyond the legal limit. I ask the Committee to consider that and the fact that we oppose this bill.

John Jones Jr., representing the Nevada District Attorneys' Association:
With me from Las Vegas is Brian Rutledge who is head of the vehicular crimes unit in the Clark County District Attorneys' Office. I would like to defer to him.

Brian Rutledge, Chief Deputy District Attorney; Head, Vehicular Crimes Unit, Office of the District Attorney, Clark County:
I would like to note that of the last five major DUI cases my unit has dealt with—serious felony cases with multiple people injured and killed—in four of those cases, marijuana was either the main or a contributing factor to those incidents. Alcohol was only a contributing factor in four of them, so marijuana is just as prevalent as alcohol in the felony cases. What is interesting though is that marijuana is a very small, single-digit percent of the misdemeanor cases. Marijuana was the main factor in the case where an individual drove through a bus stop killing four and severely injuring two more. Recently, someone crashed into The Egg and I restaurant injuring ten people. Marijuana was a factor in that accident along with a prescription drug. In a case I prosecuted a month ago in which a man killed a 15-year-old boy, marijuana and alcohol were involved. Large quantities of marijuana and some alcohol were involved with one we just had a few weeks ago where a Hummer ran into a Ford Escort and killed a man. In only one of the five accidents was there alcohol and no marijuana on board.

I heard you want to treat this like other prescription drugs, but if you look at the schedule of substances where we have a per se limitation, many of those substances are things that can be prescribed or can be part of medicine. We have a per se limit for morphine and amphetamines—both of which can be prescribed. More importantly, there are dozens of medicines, mostly the liquid medicines, that alcohol is an ingredient of. If you drink a lot of prescription cough syrup and get over 0.08, you cannot show your prescription and say that the 0.08 does not apply to you. We would be carving out a special exception just for marijuana.

I heard from the public defender that this will only apply to people with medical marijuana cards. You could still use the per se limits for people who do not have medical marijuana cards. That is what the bill says, but the very first time we charge someone, those same attorneys would file an equal protection claim, and almost certainly win it, that we cannot have a different per se limit based upon whether or not you have a prescription. That is why there is no different per se limit for any of the other substances where we have per se limits. You cannot differentiate between the people. You cannot say, yes, you were both impaired the same amount, but he had a prescription to be impaired and to drive impaired; therefore he gets off and you get prosecuted. There is no way that would hold up in court. It would definitely be an equal protection violation.

The fiscal note for this bill claims that there would be no effect on local government. That is not true either.

Chair Dondero Loop:
This is a policy committee; we do not deal with fiscal notes. While that may be relevant to your job, please confine yourself to the policy discussion.

Brian Rutledge:
Where it was stated that we could continue to prosecute without the per se violations, we could try to prosecute under those. It will be more difficult; it will be more expensive. That would be the same with alcohol, and I do not hear anyone considering getting rid of the 0.08 limit. Carving out a special exception for a drug that has actually been causing significant problems with felony DUI cases, I do not believe would be good public policy at all.

Chair Dondero Loop:
Using the privilege of the Chair, I am going to ask a couple of questions for clarification. Let us say I have a prescription for Vicodin, I am taking it, and I have been stopped by a police officer. I show the policeman that I have a prescription and explain I did not realize I was impaired. What happens? Would this bill allow the same legal implications that would be applied to any other impaired driver?

Brian Rutledge:
It would depend on your level of impairment. Whether you have a prescription or whether you legally have the substance is not part of the DUI laws. It is looking to impairment. With alcohol, the level is 0.08 whether or not you legally obtained the alcohol. If you are 21 years old and you legally bought the alcohol, it is 0.08. If you are 19 years old, it is 0.08. It does not change for the impairment. That is why this would be such a big difference.

Chair Dondero Loop:
Is there anything in this bill that states that medical marijuana would be exempt?

Brian Rutledge:
This bill says if you have a medical marijuana card, we no longer can prosecute you for being in violation under the per se limits. It would be the equivalent of saying if you had a techniques in alcohol management (TAM) card, you could not be prosecuted for being over 0.08. You could still be prosecuted under the general theory of being impaired by alcohol, but 0.08 would not be admissible in court. We could not use that evidence against you; you would not be convicted for being over the legal limit. That is what this would do for marijuana. This bill removes the legal limits from people with medical marijuana cards. Once this is implemented, most likely after the first court case, it would remove the legal limits for everybody else.

Chair Dondero Loop:
So that is dissimilar from me having a prescription for Vicodin. Whether I have a medical marijuana card or a prescription for Vicodin, if I am under the influence, I could be arrested and charged under both scenarios?

Brian Rutledge:
If you are impaired under any substance and it is unsafe for you to drive, you can be charged whether or not you have a prescription. If you are under the influence of Vicodin to such an extent that you are an impaired driver, and you do not have a prescription, there is a separate charge—possession of dangerous drugs without a prescription—that we would charge you with. The prescription means you legally have the substance. Let us say you have a prescription for Vicodin that says take one every eight hours and do not drive or operate heavy vehicles. If someone takes six or eight Vicodins, which is what often happens, that is when they end up getting impaired. That also is a big difference between medical marijuana and all the other prescriptions. If you get a prescription for Vicodin, the dosage will be listed on the bottle. If you get a medical marijuana card, it does not give any dosages.

Assemblyman Oscarson:
Do you have specific officers on the street who evaluate drug issues? How many do you have and do you foresee this creating a need for additional folks on the street?

Chuck Callaway:
In our academy, all officers are trained on standard DUI investigation. They learn how to conduct a field sobriety test and what signs to look for to determine if someone is impaired. That covers the whole gamut from a person's physical appearance—bloodshot eyes, white in the corner of the mouth, how they are acting, et cetera. Beyond that, our traffic officers are often trained in other techniques such as horizontal gaze and nystagmus during which they look at your eyes and have them follow a pen. Based on how your eye twitches, they can determine whether you are under the influence of either alcohol or, sometimes, drugs.

The difficult part is that, often when it comes to drugs, there may not be the odor on the breath you smell with alcohol. Their impairment may be of a different type. In fact, with some drugs that speed your system up such as cocaine, the person may be very hyperactive as opposed to the person who has drunk a lot of alcohol and has slowed down and is very lethargic. The officers are trained to take all that into consideration.

I do not necessarily think what is in this law would require us to have to put more officers on the street to do more in-depth testing. This ties into the Chair's question. Currently, the person would take a field sobriety test and fail it. The person would have the physical indicators—not know where they were, the time of day, would answer questions such as, "Have you smoked marijuana or have you used any drugs?" If the response was, "Yes, I did," they would be arrested. When they arrived at the jail and their blood was taken, based on what is in this law, if they had a medical marijuana card, we would not be able to use the results of that blood test. That is the way I read this bill. Whereas if the person was driving under the influence of marijuana or any other substance illegally, you could use the results of their blood test. It carves out those folks who have the medical marijuana permit, if that makes sense.

Assemblywoman Spiegel:
This is getting muddy for me. Let us say someone is prescribed medical marijuana and smoked it today. The individual does not drive today, but two days later, that individual is driving and is pulled over for some reason. The person has not consumed marijuana for approximately two days, but there is still some residual in the blood stream. It is my understanding that, with this bill, if that person has a medical marijuana card, he would not be penalized for having residual marijuana in his system. If this bill is not passed; he would be. Am I reading this correctly?

Brian Rutledge:
Marijuana comes out of the blood stream very quickly. You are only talking a matter of hours. In Las Vegas where we only do blood tests, it will be out of a person's system in three to eight hours.

Chuck Callaway:
From a law enforcement perspective in the case you described, if the person smoked marijuana yesterday, got in his car today, was driving and got pulled over for running a red light; if the person was not showing any signs of impairment, the officer would have no reason to investigate further. However, if the person's speech was slurred or his eyes were bloodshot and the officer asked specific questions, like where he is coming from or where he is going, he could not answer and if the officer felt the individual was impaired, he would then perform a field sobriety test. If the individual failed that field sobriety test, he would be arrested for suspicion of being under the influence of a controlled substance, or DUI. He would be transported to the jail where his blood would be taken and then, yes, in the scenario you described, the blood test should show the residual marijuana in his system. If he smoked it yesterday and was not impaired, it should never get to that level because the officer would see no signs of impairment when the person was stopped.

Assemblywoman Spiegel:
Last summer there were a couple of instances in Henderson where someone had an issue because he was driving while having diabetes. It concerned many of my constituents. You could have an instance where someone who is a medical marijuana patient might not have smoked today but been driving as a diabetic and had other issues, which would make a bill like this necessary.

Assemblyman Sprinkle:
If I understand the bill correctly, if we were to pass this and a person has a medical marijuana card, if their levels come back above a certain level, that person is still going to be prosecuted for that. It is only if it comes back under, is that correct, or did I misunderstand this bill?

Chuck Callaway:
It is my understanding of the bill, and maybe I read it wrong, but if they possess the medical marijuana card, they could not be prosecuted solely on the metabolites in their system. I would assume that the district attorney's office could still pursue charges based on their failure of the field sobriety test, their failure of a gaze and nystagmus; however, without that blood test to show definitively that they had marijuana in their system, a good DUI defense attorney would be able to beat most of those cases pretty easily.

Assemblyman Sprinkle:
Mr. Kandt, in your opinion, or in fact, are all people who have THC in their systems impaired?

Brett Kandt:
No, that is not the point I was trying to make. The point I was trying to make is that the illegal per se laws were enacted for public safety. Based upon the quantities established in the illegal per se law for the different types of substances, there is a strong presumption, based upon scientific evidence, that the driver is impaired.

Assemblyman Hogan:
Most people believe that the federal drug enforcement officers are even more strict than many local or state officials. I do not know if that is true or not, but it is assumed by many and caused me to wonder. With respect to the per se violations, the level at which that is placed in local jurisdictions in Nevada, is it commonplace to adopt a per se limit that corresponds to the limit that the federal drug enforcement personnel use, or do we tend to arrive at a per se limit based on other local decision making?

Brian Rutledge:
To my knowledge, the federal government has not set a limit on anything other than alcohol while driving.

Assemblywoman Fiore:
When we went to Arizona to visit the marijuana dispensary and spoke to those experts, they told us that some ingredient in marijuana stays in your system for 30-plus days. As I read the bill, I read it as Assemblyman Sprinkle read it and not this way. I think what this bill is trying to get to is making sure we do not prosecute people who have marijuana in their system because they might not be impaired because of the blood test. The gentleman in Las Vegas is saying it is out of your system; however, I would have to disagree because of what the experts are telling me.

Brian Rutledge:
It is out of your blood; they are absolutely correct, but traces of the metabolite can be in your urine for up to 35 or 40 days. We only do blood tests on these. It comes out of your blood much more quickly. That is why we do the blood tests; because we are looking for impairment. That is only the metabolite, not the THC level. This would do two things that are quite different. One is that it would eliminate the level for the actual active ingredient of THC which in both the blood and urine gets eliminated very quickly. It is peaking as you are smoking. The second thing it does is eliminate the metabolite from blood,

which also clears very quickly. If you just wanted to address the concern about trace amounts left in the urine, they can be there for 30 days. If you wanted to even eliminate the metabolite in the urine from the statute, I would not oppose that. I have never used it; and I do not think that is important for public safety. The levels you find in the blood are important for prosecution of these cases for public safety, and it would not cause the problems you are concerned with.

Assemblywoman Fiore:
What is it you do, again? Are you a doctor?

Brian Rutledge:
No, I am the head of our vehicular crimes unit.

Assemblywoman Fiore:
I would like to hear testimony from a doctor who draws the blood with evidence of what you are saying, because I am getting conflicting information.

Brian Rutledge:
Yes, we can get you the information from our lab. The last time I talked to our lab about how fast it clears from your system, the numbers for blood were three to eight hours; urine was 2 to 45 days. We could get you testimony from the lab personnel who actually test the blood and would know these numbers.

Assemblyman Sprinkle:
I feel I just heard two conflicting things from the comments Mr. Kandt just gave me, but then I hear from Las Vegas that they only test the blood because they are checking for impairment. It leaves the blood that quickly, so they do not need to check further than the six or eight hours after it leaves the blood. I am hearing conflicting things here as to whether or not if someone has THC in their system, but it may be days or weeks or months later, are they still impaired? I am not quite sure.

Chuck Callaway:
I will try to answer from a law enforcement perspective. Before we even get to the blood test, the officer is going to have to have some physical signs of impairment which give him probable cause to make an arrest. If the person shows no signs of impairment, we are not going to load him in a car and take him down for a blood test. Assuming they failed a field sobriety test, they failed a gaze and a nystagmus, their physical condition, all those things lead that officer to believe that they are under the influence, we place them under arrest and transport them to the jail. If we believe they are under the influence of alcohol, and oftentimes we find that drivers mix substances—they may have smoked marijuana and then drank a beer. If the officer believes they are under

the influence of alcohol, typically they will do a breathalyzer test. If they are showing signs of impairment and they pass the breathalyzer test, the officer would assume they are probably under the influence of something other than alcohol. Then a blood test may be taken, or in some cases, if the citizen chooses, they can give a blood test rather than do a breathalyzer test. Some people, for whatever reason, would rather give blood than breathe into the machine. That blood test will be sent to the lab. The lab will test it to see if that person has a controlled substance in their system. We may not know at the time if it is marijuana or what it is. It may come back that they have cocaine in their system; it may come back methamphetamine; it may come back marijuana. Once that blood is tested, the results of that blood test are part of an overall package regarding the totality of the probable cause that led to the arrest. I do not want the Committee to have the false assumption that we are relying solely on a blood test that maybe shows that the person had marijuana in their system because they smoked marijuana two weeks ago. If the person does not show any characteristics of being impaired, it would never get to the point where we would take a blood test.

Assemblyman Eisen:
The last statement you made was that, in the absence of demonstrated impairment, then someone would not be tested. If there is no impairment, why are we concerned with what the level is? If there is impairment, why are we concerned with what the level is? I am not a marijuana specialist, but if the relationship between a blood level of marijuana and the clinical impairment that it creates is minimal, if any, the ability to predict how impaired someone might have been, based on their blood level, is very poor.

It goes back to what you just said. If they did not demonstrate an impairment, then you would not get a level. If they do demonstrate an impairment, you do not have to have a level because you have already shown that they are impaired.

You mentioned the nystagmus a couple of times and I want to be certain we are talking about the same thing here. It is my understanding that marijuana does not cause nystagmus. There are a number of drugs that do, and a number of medical conditions do, but marijuana specifically does not.

Chuck Callaway:
To your last statement, I believe that is true, but the officer in the field would normally conduct a nystagmus if he feels the person is under the influence of something other than alcohol. It may be to determine methamphetamine or cocaine or something else, but it would be part of the overall test that was done.

I am not trying to muddy this bill up more, but there is one situation where I can see that someone may be tested without showing signs of impairment. I believe last session, a bill was passed that requires anyone involved in an accident where a fatality occurs to submit to a blood test. I stand corrected; that bill did not pass, but if you are involved in an accident and someone died, you may be asked by the traffic officer. However, that officer would have to believe you were impaired in order to request that you submit to a blood test.

Brian Rutledge:
Yes, it is absolutely true that you would need to have evidence of impairment, probable cause of impairment, before the officer could ask for a blood test. In every case, you are going to have evidence that this person is impaired, so we do not have the issue of someone who smoked days ago who is not impaired anymore.

To answer the question, what does this affect? What this affects is how difficult it is to prove someone guilty beyond a reasonable doubt, which is what all the per se limits are. The more serious the case, the harder that is going to be without a per se limit. If someone is extremely impaired but also managed to hurt themselves as well as all the other people they crashed into, which is often the case, there are not going to be field sobriety tests. There is not going to be a walk-and-turn test or something like that because the person is not going to be able to do it. If you eliminate the per se limits, you make it difficult, if not impossible, to convict many of the people who are the most impaired and who are causing the greatest amount of damage and danger on the marijuana cases.

Assemblyman Eisen:
In that case, in light of the poor correlation between level and actual impairment, is that really the basis on which we want to be convicting people? If there is a demonstration that they were impaired in their driving, that is one issue. If we do not have evidence of that and we know that the correlation between a blood level and impairment is not strong, is that a basis on which to make that conviction? All we are talking about here are those people who already have a legal right to utilize this substance and to have it in their systems at some level.

Brian Rutledge:
As was stated earlier, if you are an alcoholic you can have a pretty high blood alcohol level—more than someone else's. We do not make specific exceptions for them however. We do not say that alcoholics can drink up to a different level than can nonalcoholics. There is an immense amount of evidence that marijuana impairs driving and that the more you consume, the higher the level.

There is a lot of argument as to what exactly that level should be, but this bill completely throws it out, and we are not going to consider the levels at all.

As to the second point that this is only for people with medical marijuana cards, I do not believe that will hold up in court. Once we eliminate it for people with medical marijuana cards, you have eliminated it for everyone. If that is what you want to do because you do not think it is reliable enough, then that is a policy decision you could make. I think that would be a bad policy. Again, the idea that we are only eliminating this for people with medical marijuana cards will not hold up in court in my opinion.

Chair Dondero Loop:
Are there any questions from the Committee? [There were none.] Is there anyone else in opposition?

Eric Spratley, representing the Washoe County Sheriff's Office:
I am here to express opposition to A.B. 351 in its entirety. The issues in A.B. 351 also extend to commercial vehicle drivers. There is an extreme difference between a Kia and Kenworth, so please, take that into consideration. The commercial vehicle code does not allow drivers to operate their commercial vehicles anywhere in the United States concurrently with the use of any Schedule I controlled substance, and marijuana is still classified as a Schedule I controlled substance under the federal Controlled Substances Act.

The Washoe County Sheriff's Office does support the *Nevada Constitution* and the voice of the citizens regarding medical marijuana. It also supports the *U.S. Constitution* and those federal laws currently in force, so we are at a crossroads in this legislative session regarding marijuana and medical marijuana. It is still recognized federally as a Schedule I and, therefore, is staying in our NRS as such and in the list of per se substances. This legislative body has recognized the wishes of the voters in their prior change to our *Nevada Constitution*, and you are moving legislation forward regarding medical marijuana. However, this is not the time for this pioneering legislation into the uncharted territories of our roadways.

Chair Dondero Loop:
Are there any questions from the Committee? [There was no response.] Seeing no more people who want to speak in opposition, we will go to those who want to speak in the neutral position. [There was no response.] Would you like to make any closing comments, Assemblyman Horne?

Assemblyman Horne:
Eighteen states, plus the District of Columbia, have effective medical marijuana laws on their books. Under ten of these laws, an individual is guilty of driving under the influence of marijuana if the state proves, through a totality of the circumstances, that the driver was impaired. These laws do not single out marijuana impairment from other forms of impairment. The same standard applies to OxyContin, Benadryl, and all other drugs. Alaska, New Mexico, Colorado, Hawaii, Maine, New Jersey, California, Oregon, Vermont, and Washington, D.C. all have laws with the above criteria.

I reiterate that nothing in this bill prevents the prosecution of anyone, whether that person was prescribed medical marijuana or was using medical marijuana illegally. This bill only addresses those persons who have been prescribed medical marijuana to not be subject to prosecution simply because of the fact of the per se laws and that a doctor has prescribed it for them.

A couple times, Mr. Callaway stated that when going onto a scene, there have to be those things in the field sobriety test or in the nystagmus test that are going to cause an arrest. They are not going to get to the point where there is going to be a blood draw. One scenario he missed was an admission. Let us say a patient has a car accident at an intersection. The police arrive and ask the parties whether they have been drinking. The person voluntarily says, "No, but I am a medical marijuana user per my doctor's prescription." To some officers, that might be enough to arrest, take down, and have the blood drawn, et cetera. If this person is impaired, they should determine if that is the case. That determination on this patient should not be that "this is your limit, 2 nanograms; therefore, you are impaired." We treat them as patients. The reason they have that is because they are patients. Different patients are using different quantities. Some will have THC in their blood longer than a couple of hours. Some studies show that it could be upwards of a week to have it in your system.

Mr. Rutledge kept pointing out all the horrible accidents that occur with alcohol, marijuana, and other drugs. I do not deny that these accidents occur. The one thing I did not hear was that all these accidents were being caused by medical marijuana users. He talked about how marijuana and other substances were in their systems. I think it is important to note that when we are talking about patients, we do not want to penalize that patient just because a doctor has prescribed medical marijuana for them. Many people today went out of their way to say, "I am no expert on marijuana; I did not partake; I did not inhale," because of the stigma that goes along with marijuana. Some of these patients never had marijuana until they developed a chronic illness or disease. Finally, after multiple attempts at pain relief and gaining an appetite, they went to

marijuana and found some relief. The people of Nevada found it proper to change the *Constitution* and, under certain circumstances, to allow medical marijuana to be prescribed. In addition, I am asking that, under certain circumstances, we are not going to hold a per se for these patients. The other people are still going to be applied with this per se, but not patients. Patients are not going to be burdened with this. The prosecutors are still going to be able to prosecute them for impairment.

I will end with this statement, and we can provide the studies this came from: "Heavy marijuana user's blood can contain detectable amounts of THC even after periods of abstention. In one controlled study, 6 of 25 participants tested positive for active THC levels a full seven days after abstention, with the highest concentrations detected—3 nanograms a milliliter of whole blood." I state that again, because we have different types of patients, we are going to have situations in which persons who are using this have detectable amounts for longer periods of time and it should not be a per se that they are impaired. We are only providing that for these types of patients. We are treating them just as we would treat any other patient on any other narcotic or prescribed drug.

Chair Dondero Loop:
Is there anyone else wishing to testify on A.B. 351?

Jim Holmes, representing the Northern Nevada DUI Taskforce:
The issue here is impairment. My group has spoken to over 60,000 DUI offenders over the years. Southern Nevada is addressing approximately twice that many, so we are talking about potentially 300,000 impaired drivers. I am not concerned about what happens when you get to a court of law. I am talking about potential killers on the streets—the issue here being impairment and putting someone behind the wheel who is a potential killer. If they cannot control that automobile, that is what you have. If you pass this law, you are going to put more potential killers on the street.

Chair Dondero Loop:
Is there any additional public comment? Seeing none, I will close the hearing on A.B. 351, and we will move to our work session. I would like our policy analyst to take us through the bills.

Kirsten Bugenig, Committee Policy Analyst:
The first bill we will hear on work session is Assembly Bill 144.

Assembly Bill 144: Revises certain provisions pertaining to anatomical gifts. (BDR 40-141)

[Mrs. Bugenig read a description of the bill and presented a proposed amendment submitted by the bill's sponsor (Exhibit N).]

The sponsor's attached mock-up is to address the Committee's concerns regarding parental consent.

Chair Dondero Loop:
Is there a motion?

> ASSEMBLYMAN SPRINKLE MOVED TO AMEND AND DO PASS ASSEMBLY BILL 144.
>
> ASSEMBLYWOMAN SPIEGEL SECONDED THE MOTION.

Is there any discussion?

Assemblyman Sprinkle:
I did have concerns about this bill in the past; however, this amendment has addressed those concerns. That is why I made the motion.

> THE MOTION PASSED. (ASSEMBLYMAN HICKEY WAS ABSENT FOR THE VOTE.)

Chair Dondero Loop:
Assemblyman Carrillo, I assume you would like to make the floor statement.

Now, we will move to Assembly Bill 183.

Assembly Bill 183: Allows a person who is 16 years of age to donate blood with the consent of his or her parent or guardian. (BDR 40-1015)

Kirsten Bugenig, Committee Policy Analyst:
[Mrs. Bugenig read a description of the bill from her work session document (Exhibit O).]

This is Assemblyman Duncan's bill. It was brought forth because 41 other states have the practice of allowing 16-year-olds to donate blood with the consent of their parent or guardian. The intent is to increase Nevada's blood supply by encouraging high-school-age individuals to donate. There were no proposed amendments for this bill.

Chair Dondero Loop:
Is there a motion?

> ASSEMBLYMAN HAMBRICK MOVED TO DO PASS ASSEMBLY BILL 183.
>
> ASSEMBLYMAN MARTIN SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMAN HICKEY WAS ABSENT FOR THE VOTE.)

Assemblyman Duncan will do the floor statement.

Next is Assembly Bill 200.

Assembly Bill 200: Revises provisions relating to food establishments. (BDR 40-129)

Kirsten Bugenig, Committee Policy Analyst:
[Mrs. Bugenig read a description of the bill and proposed amendments from her work session document (Exhibit P).]

Chair Dondero Loop:
Is there a motion?

> ASSEMBLYMAN OSCARSON MOVED TO AMEND AND DO PASS ASSEMBLY BILL 200.
>
> ASSEMBLYWOMAN SPIEGEL SECONDED THE MOTION.

Is there any discussion?

Assemblyman Eisen:
I believe there was still some question about the frequency of these events. I spoke with a cosponsor earlier, and he might have something to add.

Assemblyman Cresent Hardy, Clark County Assembly District No. 19:
Yes, both Washoe and Clark Counties had concerns with the number of events. They do not want this confused with having a restaurant-type standard, so we requested the ability to have 24 events a year. I believe they are fine with that, so we will have to add some language to make that change. Also, we are still having challenges with section 4. The county has agreed to move the bill as is,

and we will work on that section in the Senate to clarify those issues that are of concern.

Assemblyman Eisen:
I want to clarify the version of the bill we are voting on.

Chair Dondero Loop:
The motion was to amend and do pass to accept all the amendments stated in the work session document including the frequency issue.

Assemblywoman Pierce:
I still do not have a level of comfort with this bill, so I will vote no.

Chair Dondero Loop:
Mr. Oscarson, could you please clarify your motion?

Assemblyman Oscarson:
My motion is to amend and do pass with the amendment, including the number of events Mr. Hardy just stated.

Chair Dondero Loop:
To include the sponsor's amendments plus the Southern Nevada Health Department amendments?

Assemblyman Oscarson:
That is correct.

Chair Dondero Loop:
The amendments include everything that is listed on the work session document (Exhibit P) plus the twice-a-month stipulation. Is that correct, Mr. Hardy?

Assemblyman Hardy:
That would be fine.

Chair Dondero Loop:
Does that clarification give the Committee a level of comfort? Is there any other discussion? [There was no response.]

> THE MOTION PASSED. (ASSEMBLYWOMAN PIERCE VOTED NO. ASSEMBLYMAN HICKEY WAS ABSENT FOR THE VOTE.)

Assemblyman Hardy will be doing the floor statement.

Next is Assembly Bill 221.

Assembly Bill 221: Requires the Director of the Department of Health and Human Services to consider measures to revise the manner in which payments are reviewed and made to providers under Medicaid and the Children's Health Insurance Program. (BDR S-232)

Kirsten Bugenig, Committee Policy Analyst:
[Mrs. Bugenig read a description of the bill and proposed amendments from her work session document (Exhibit Q).]

This bill provides an opportunity to advance the current Medicaid fraud prevention by gathering information to implement a prepayment system in preparation for the Medicaid expansion.

Chair Dondero Loop:
Is there a motion?

> ASSEMBLYMAN SPRINKLE MOVED TO AMEND AND DO PASS ASSEMBLY BILL 221.
>
> ASSEMBLYMAN HAMBRICK SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMAN HICKEY WAS ABSENT FOR THE VOTE.)

Assemblyman Eisen will do the floor statement.

We will move on to Assembly Bill 255.

Assembly Bill 255: Provides for an audit concerning the use by the Department of Health and Human Services of certain assessments paid by counties to the Department. (BDR S-191)

Kirsten Bugenig, Committee Policy Analyst:
[Mrs. Bugenig read a description of the bill from her work session document (Exhibit R).]

Chair Dondero Loop:
Is there a motion?

ASSEMBLYMAN HAMBRICK MOVED TO DO PASS ASSEMBLY BILL 255.

ASSEMBLYMAN MARTIN SECONDED THE MOTION.

Is there any discussion?

Assemblyman Hambrick:
The document we have in front of us (Exhibit R) says that a final written report is due by January 31, 2015; but the bill read that the audit report was due by January 31, 2014.

Kirsten Bugenig:
The bill says that the report is due by January 31, 2015. That is the correct date, because there are no amendments to the bill.

THE MOTION PASSED. (ASSEMBLYWOMAN BENITEZ-THOMPSON VOTED NO. ASSEMBLYMAN HICKEY WAS ABSENT FOR THE VOTE.)

Chair Dondero Loop:
We will ask Assemblyman Livermore to make the floor statement and Assemblyman Hambrick will be his backup.

Our last bill is Assembly Bill 344.

Assembly Bill 344: Provides for the use of Physician Orders for Life-Sustaining Treatment in this State. (BDR 40-682)

Kirsten Bugenig, Committee Policy Analyst:
[Mrs. Bugenig read a description of the bill from her work session document (Exhibit S).]

Chair Dondero Loop:
Is there a motion?

ASSEMBLYMAN SPRINKLE MOVED TO DO PASS ASSEMBLY BILL 344.

ASSEMBLYMAN EISEN SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMAN HICKEY WAS ABSENT FOR THE VOTE.)

We will ask Assemblyman Bobzien to carry the floor statement and Assemblyman Sprinkle will be backup.

Is there any public comment? [There was no response.] This meeting is adjourned [at 3:50 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Marilyn Dondero Loop, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: April 8, 2013 **Time of Meeting: 12:45 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 287	C	Assemblyman Lynn D. Stewart	Letter: Dr. Lesley Dickson
A.B. 287	D	Kristina Ragosta	Written testimony in support
A.B. 287	E	Assemblyman Lynn D. Stewart	Proposed amendment
A.B. 287	F	Donna Marie Shibovich, rep. Nat'l Alliance on Mental Illness, NV Chapter	Written testimony in support
A.B. 287	G	Christy Craig, Office of the Public Defender, Clark County	Email
A.B. 287	H	Robert Lynn Horne, M.D.	Letter in support
A.B. 287	I	Robert Bennett, Private Citizen, Carson City, Nevada	Testimony in opposition
A.B. 287	J	Jack Mayes, Ex. Dir., NV Dis. Advocacy & Law Center	Testimony in opposition
A.B. 287	K	Coni Kalinowski, M.D.,	Testimony in opposition
A.B. 287	L	Tracey D. Green, M.D.	Testimony in opposition
A.B. 351	M	Assemblyman William Horne	Drug & Human Performance Fact Sheet
A.B. 144	N	Kirsten Bugenig	Bill description and proposed amendment
A.B. 183	O	Kirsten Bugenig	Bill description
A.B. 200	P	Kirsten Bugenig	Bill description and proposed amendments
A.B. 221	Q	Kirsten Bugenig	Bill description and proposed amendments

A.B. 255	R	Kirsten Bugenig	Bill description
A.B. 344	S	Kirsten Bugenig	Bill description