Date of Hearing: March 29, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 1928 (McCarty) – As Amended March 10, 2022

SUBJECT: Hope California: Secured Residential Treatment Pilot Program.

SUMMARY: Authorizes the Counties of San Joaquin, Santa Clara, and Yolo to establish pilot programs to offer secured residential treatment for qualifying individuals suffering from substance use disorders (SUDs) who have been convicted of drug-motivated felony crimes. Specifically, **this bill**:

1) Permits the Counties of San Joaquin, Santa Clara, and Yolo to offer secured residential treatment pilot programs (STRP), known as "Hope California," for individuals suffering from SUDs who have been convicted of drug-motivated felony crimes, as specified.

2) Requires the STRPs to align with the resolutions adopted by the counties in recognition of the goal of ensuring that people with behavioral health conditions receive treatment out of custody wherever possible.

3) Authorizes the Counties of San Joaquin, Santa Clara, and Yolo to offer STRP to eligible individual's if the STRP meets all of the following conditions:

    a) The secured residential treatment facility (SRTF) is licensed by the Department of Health Care Services (DHCS) as an alcoholism or drug abuse recovery or treatment facility;

    b) The SRTF is a clinical setting managed and staffed by the county's health and human services agency (the county HHSA), with oversight provided by the county's probation department;

    c) The SRTF is not offered in a jail, prison, or other correctional setting;

    d) The SRTF is secured but does not include a lockdown setting;

    e) The individual, upon a judge pronouncing a sentence to be served in a county jail or state prison, to choose and consent to participate in the STRP in lieu of incarceration;

    f) The STRP is limited to one STRF site per county;

    g) DHCS monitors the SRTF to ensure the health, safety, and well-being of STRP participants;

    h) DHCS has authority to access the SRTF to investigate complaints by STRP participants and to ensure the SRTF complies with applicable statutes and regulations;

    i) The SRTF ensures that participants have visitation rights, including through the use of a telephone;

j) The county develops and staffs the STRP in partnership with relevant community-based organizations and drug treatment services providers to offer support services;

k) The support services include, but are not limited to, employment skill assessments, money management, technology education, tutoring, career planning, developing resumes and cover letters, and searching and applying for employment;

l) The county HHSA ensure that a risk, needs, and psychological assessment, utilizing the Multidimensional Assessment of the American Society of Addiction Medicine (ASAM), as part of the ASAM criteria, be performed for each individual identified as a candidate for the STRP;

m) The participant's treatment, in terms of length and intensity, within the STRP is based on the findings of the risk, needs, and psychological assessment and the recommendations of treatment providers;

n) The STRP adopts the Treatment Criteria of ASAM;

o) The STRP may take into consideration evolving best practices in the SUD treatment community;

p) The STRP has a comprehensive written curriculum that informs the operation of the STRP and outlines the treatment and intervention modalities;

q) The STRP provides an individualized medically assisted treatment (MAT) plan for each resident including, but not limited to, MAT options and counseling based on the recommendations of a SUD specialist;

r) A judge determines the length of the individual's treatment program after being informed by, and based on, the risk, needs, and psychological assessment and recommendations of treatment providers;

s) The participant continues outpatient treatment for a period of time and may also be referred to a "step-down residential treatment facility" after leaving the SRTF;

t) A judge determines the STRP will be carried out in lieu of a jail or prison sentence after making a finding that the defendant's decision to choose alternative treatment program is knowing, intelligent, and voluntary;

u) The STRP provides, for each participant successfully leaving the STRP, a comprehensive continuum of care plan that includes recommendations for outpatient care, counseling, housing recommendations, and other vital components of successful recovery;

v) To the extent permitted under federal and state law, treatment provided to a participant during the STRP is reimbursable under the Medi-Cal program, if the participant is a Medi-Cal beneficiary and the treatment is a covered benefit under the Medi-Cal program;

w) If treatment services provided to a participant during the STRP are not reimbursable under the Medi-Cal program or through the participant's personal health coverage, funds

allocated to the state from the 2021 Multistate Opioid Settlement Agreement, subject to an appropriation by the Legislature, may be used to reimburse those treatment services to the extent consistent with the terms of the Settlement Agreement and the Final Judgment;

x) An outcomes assessment is completed by an independent evaluator; and,

y) The county collects and monitors all of the following data for participants of the STRP:

i) The participant's demographic information, including age, gender, race, ethnicity, marital status, familial status, and employment status;

ii) The participant's criminal history;

iii) The participant's risk level, as determined by the risk, needs, and psychological assessment;

iv) The treatment provided to the participant during the STRP, and if the participant completed that treatment;

v) The participant's outcome at the time of program completion, six months after completion, and one year after completion, including subsequent arrests and convictions; and,

vi) The county reports all of the following information annually to the DHCS and to the Legislature, excluding any personally identifiable information of participants:

(1) The risk, needs, and psychological assessment tool used for the STRP;

(2) The curriculum used by each STRP;

(3) The number of participants with a STRP length other than one year and the alternative program lengths used;

(4) Individual data on the number of participants in the STRP;

(5) Individual data, as specified; and,

(6) A one- and three-year evaluation of the number of subsequent arrests and convictions of the participants.

4) States that eligible drug-motivated crimes include any felony crime except sex crimes, "serious" felonies, and "violent" felonies, as specified.

5) Requires the judge to offer the defendant voluntary participation in the STRP as an alternative to a jail or prison sentence that the judge would otherwise impose at the time of sentencing or pronouncement of judgment in which sentencing is imposed if the following conditions are met:

a) The defendant's crime was caused in whole or in part by the defendant's SUD;

b) The defendant's crime was a felony, except for specified sex crimes or serious or violent felonies; and,

c) The judge makes their determination based on the recommendation of the treatment providers who conducted the assessment, on a finding by the county HHSA that the defendant's participation in the STRP would be appropriate, and on the report on whether to offer the defendant placement in the SRTP, as specified.

6) States that the amount of time in the SRTF is determined by the recommendations of the treatment providers who conducted the assessment.

7) Requires that the amount of time, combined with any outpatient treatment or "step-down" residential treatment, does not exceed the term of imprisonment to which the defendant would otherwise be sentenced, not including any additional term of imprisonment for enhancements, for the drug-motivated crime.

8) Prohibits the court from placing the defendant on probation for the underlying offense.

9) Declares that the defendant is eligible to receive good conduct credits.

10) Declares that the individual shall be on supervision with the probation department during the period in which an individual is participating in the STRP.

11) Requires a report to be prepared with input from any of the interested parties – including the district attorney, the attorney for the participant, the probation department, the county, and any contracted drug treatment program provider – to assist the court in making the determination as to whether to offer the defendant placement in the SRTP.

12) Authorizes the treatment providers or STRP administrators to recommend to the court that the individual's participation be terminated and that the individual be transferred out of the SRTP if they determine that continued participation in the STRP would not be in the best interest of the individual.

13) Requires the court to order the participant to be transferred out of the secured residential treatment phase of the STRP prior to the end of the original order and to order the participant to complete the remainder of the original sentence imposed prior to their consent to enter the STRP if the treatment providers or STRP administrators make a recommendation under 12) above.

14) Authorizes a STRP participant to request that the court terminate their participation in the STRP and that the participant be transferred out of the SRTP to complete the remainder of their originally imposed sentence, after account for any credits.

15) Requires the court to order the participant released prior to the end of the original order if the treatment providers make a recommendation to the court that the participant no longer needs to be in the SRTP.

16) Requires the court to expunge and seal the conviction from the participant's record if the participant successfully completes the court-ordered drug treatment program.

17) Requires the court to expunge the conviction of any previous drug possession or drug use crimes on the participant's record if the participant successfully completes the SRTP.

18) Declares that a participant's completion of treatment must be defined and determined by the treatment providers and not by the court, district attorney's office, or the probation department.

19) Declares that the participant's successful completion of treatment does not require the participant to complete the duration of the treatment originally ordered by the court.

20) Requires the court to ensure that the rights of the victim under Marsy's Law (Proposition 9 of 2008, also known as the California Victim's Bill of Rights Act) are honored before expunging the conviction.

21) Sunsets the STRP on January 1, 2026.

22) Declares that a special statute is necessary and that a general statute cannot be made applicable because of the unique circumstances that the Counties of San Joaquin, Santa Clara, and Yolo have experienced with regard to difficulties in treating individuals who have been convicted of drug-motivated crimes as a result of their SUD.

23) Contains findings and declarations.

EXISTING LAW:

1) Grants DHCS the sole authority in state government to administer, license, certify, and regulate all SUD functions and programs.

2) Requires DHCS to license alcoholism or drug abuse recovery or treatment facilities (RTFs) that provide residential, non-medical SUD services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery, treatment, or detoxification services.

3) Requires DHCS to adopt ASAM treatment criteria as the minimum standard of care for licensed RTFs.

4) Prohibits any person, firm, partnership, association, corporation, or local governmental entity from operating, establishing, managing, conducting, or maintaining an RTF to provide recovery, treatment, or detoxification services within this state without first obtaining a current valid license issued by DHCS. Requires DHCS to conduct an investigation against any entity operating an unlicensed RTF and to assess a civil penalty of $2,000 per day the facility continues to operate without a license, as specified.

5) Grants DHCS the authority to implement a program certification procedure for alcohol and other drug (AOD) treatment recovery services and to develop standards and regulations for

the AOD treatment recovery services describing the minimal level of service quality required of the service providers to qualify for and obtain state certification.

6) Prohibits a DHCS licensed or certified program, and specified individuals associated with or employed by those programs, from giving or receiving remuneration or anything of value for the referral of a person who is seeking alcoholism or drug abuse recovery and treatment services, as specified (referred to as "patient brokering"). Permits DHCS to investigate allegations of violations and take action, such as revocation of licensure or certification, or assessment of penalties and other enforcement actions.

7) Grants DHCS the sole authority in state government to determine the qualifications, including the appropriate skills, education, training, and experience of personnel working within alcoholism or drug abuse recovery and treatment programs, including RTFs.

8) Prohibits Medi-Cal federal match dollars from providing funding for services delivered to individuals in custody.

9) States that pretrial diversion refers to the procedure of postponing prosecution of an offense filed as a misdemeanor either temporarily or permanently at any point in the judicial process from the point at which the accused is charged until adjudication.

10) Authorizes diversion programs for specified crimes (drug abuse; child abuse; contributing to the delinquency of another, writing bad checks and for specific types of offenders; veterans; and persons with mental disorders).

11) States that the purpose of mental health diversion is to promote the following:

    a) Increased diversion of individuals with mental disorders to mitigate the individuals' entry and reentry into the criminal justice system while protecting public safety;

    b) Allowing local discretion and flexibility for counties in the development and implementation of diversion for individuals with mental disorders across a continuum of care settings; and,

    c) Providing diversion that meets the unique mental health treatment and support needs of individuals with mental disorders.

12) Authorizes the court, after considering the positions of the defense and prosecution, to grant pretrial diversion to a defendant if the defendant meets specified criteria.

13) Provides that "pretrial diversion" for purposes of mental health diversion means the postponement of prosecution, either temporarily or permanently, at any point in the judicial process from the point at which the accused is charged until adjudication, to allow the defendant to undergo mental health treatment, subject to specified conditions.

14) Permits the counties of Alameda, Butte, Napa, Nevada, and Santa Clara to establish a pilot program to operate a deferred entry of judgment pilot program for certain eligible, young-adult defendants.

15) Provides that for time spent in the county jail, a term of four days will be deemed to have been served for every two days spent in actual custody.

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, SUD is a public health issue, not a public safety issue and needs to be treated as such. It is clear that treatment options are not working. We need to help people with their addictions through treatment instead of throwing them in jail. The author concludes by stating that this voluntary STRP will help those get the treatment they need, which will ultimately help reduce the recidivism rate.

2) **BACKGROUND.**

   a) **Licensed RTFs and certified programs.** RTFs licensed by DHCS, based on what is commonly referred to as the social model, provide recovery, treatment, or detoxification services. (The Department of Public Health licenses medical model RTFs, known as chemical dependency recovery hospitals.) The services provided by social model RTFs include group and individual counseling, educational sessions, and alcoholism or drug abuse recovery and treatment planning. Social model RTFs are allowed to provide clients first aid and emergency care, and since the passage of AB 848 (Stone) Chapter 744, Statutes of 2015, RTFs can apply to DHCS for an additional license to provide incidental medical services by a licensed physician and surgeon or other health care practitioner, as specified. SB 823 (Hill), Chapter 781, Statutes of 2018, requires DHCS to adopt ASAM treatment criteria as the minimum standard of care for licensed RTFs. DHCS also offers a voluntary facility certification to those programs that provide the following services: day treatment, outpatient, and nonresidential detoxification. The certification is granted to programs that exceed minimum levels of service quality and are in substantial compliance with state program certification standards. Certification is available to both residential and nonresidential programs. The majority of facilities licensed by DHCS are also certified. DHCS also certifies RTFs licensed by the Department of Social Services that provide SUD services to youth. As part of their licensing and certification functions, DHCS conducts reviews of licensed and certified programs every two years, or as necessary; checks for compliance with statute, regulations, and certification standards to ensure the health and safety of clients; investigates all complaints; and has the authority to suspend or revoke a program's license or certification for a violation of statute, regulations, and certification standards. It should be noted that DHCS does not currently license or certify locked or secured facilities and passage of this bill would require the development and adoption of new regulations to appropriately provide for those settings.

   b) **Involuntary/secured treatment for SUDs**. Despite widespread implementation of involuntary drug treatment worldwide, there appears to be little high-quality research available on its effectiveness. A comprehensive study was published in 2016, claiming to be the first of its kind, in the *Journal of Drug Policy*, "The Effectiveness of Compulsory Drug Treatment: A Systemic Review." That study concluded that evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms. The study also stated that given the potential for human rights abuses within compulsory treatment settings, non-compulsory treatment

modalities should be prioritized by policymakers seeking to reduce drug-related harms. It is worth noting that the study did not limit its assessment of compulsory drug treatment in detention centers, but also included compulsory treatment in inpatient and outpatient settings. Other research in "Offender Treatment: A Meta-Analysis of Effectiveness," published in *Criminal Justice and Behavior,* found that mandated treatment was ineffective, particularly when the treatment was located in custodial settings, whereas voluntary treatment produced significant treatment effects regardless of setting. Likewise, two more reports, "Improving In-prison Rehabilitation Programs" by the California Legislative Analyst's Office (LAO) and "Lifetime Benefits and Costs of Diverting Substance-Abusing Offenders from State Prison" in *Crime and Delinquency,* stress the importance of using evidence-based treatment modalities in community-based settings, rather than in prison, in order to effectively reduce recidivism. One important risk factor for criminal activity noted in the LAO report is antisocial relationships, such as the association with other criminal actors and isolation from noncriminal actors. While this bill is not specific about the operations of STRFs, the author notes that participants in SRTFs would not be allowed to come and go from the SRTFs as they please, such as in DHCS-licensed RTFs when residents leave the facility to attend school or work, or visit family.

c) ASAM criteria. Founded in 1954, ASAM is a professional medical society representing over 5,000 physicians, clinicians, and associated professionals in the field of addiction medicine. According to ASAM's website, the ASAM criteria, formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. Today, the criteria have become widely used for placement, continued stay, and transfer/discharge of patients with addiction and co-occurring conditions. ASAM's criteria are required in over 30 states. ASAM has established five main levels in a continuum of care for SUD treatment:

i) Level 0.5: Early intervention services;
ii) Level 1: Outpatient services;
iii) Level 2: Intensive outpatient/partial hospitalization services (Level 2 is subdivided into levels 2.1 and 2.5);
iv) Level 3: Residential/Inpatient services (Level 3 is subdivided into levels 3.1, 3.3, 3.5,and 3.7); and,
v) Level 4: Medically managed intensive inpatient services.

According to its website, ASAM encourages patients to work with their treatment providers to create an individualized treatment plan based on ASAM's assessment dimensions. The criteria views patients in their entirety, rather than by a single medical or psychological condition. This means it pays attention to the whole patient, including all of his or her life areas, as well as all risks, needs, strengths, and goals. Patients can become active participants in their own care; learn about, anticipate, and understand treatment options and protocols; and, use ASAM's six dimensions, or life areas, to better understand how risks and strengths, skills, and resources in one life area can affect another. ASAM also provides treatment providers a holistic approach for determining individualized and outcome-driven treatment plans for patients. Using the criteria as a guide, practitioners can assist a patient from assessment through treatment; work with the patient to determine goals; help rank and rate all the patient's risks, using ASAM's

multidimensional approach to determine where to focus treatment and services; and, determine intensity and frequency of services needed using ASAM's detailed guides to levels of care. It should be noted that the ASAM criteria, while widely hailed as the "gold standard" for addiction treatment does not include locked and/or coerced SUD treatment in that they have not been proven as an effective treatment model.

d) Overdose Rates and Negative Mental Health Outcomes for Incarcerated People: This bill proposes to offer some offenders the option to consent to participation in a SRTP instead of serving their sentences in jail or prison. Research (Mika'il DeVeaux, *The Trauma of the Incarceration Experience)* shows that incarceration can be traumatic. Incarcerated persons may suffer from "posttraumatic stress disorders, as well as other psychiatric disorders, such as panic attacks, depression and paranoia; subsequently, these prisoners find social adjustment and social integration upon release. "Moreover, incarcerated persons have an increased risk of overdose and death upon release.

According to a report by the Massachusetts Department of Public Health (MDPH) analyzing available data on opioid deaths in the state, "Those who have recently been released from Massachusetts prisons have a short-term risk of death from opioid overdose that is greater than 50 times the risk of the general public." (MDPH, *An Assessment of Opioid-Related Deaths in Massachusetts* (2013-2014) (Sept. 2016) at p. 9. Many of these deaths may be attributable to a loss of tolerance resulting from forced abstinence.

e) 2021 Multistate Opioid Settlement Agreement: This bill permits funds allocated to the state from the 2021 Multistate Opioid Settlement Agreement may be used to reimburse treatment services given to program participants if those services are not reimbursable under Medi-Cal or through personal health care coverage. Upward of $2 billion is expected to come to California communities and state government from the various opioid settlement agreements. A large coalition of the country's leading medical and mental health groups, public policy organization, and research centers worked together to develop specific recommendations for how best to spend funds received from the settlement. The resulting "Principles for the Use of Funds From the Opioid Litigation" (Johns Hopkins Bloomberg School of Public Health) recommended, among other things, spending money to bolster underfunded substance use and behavior health programs; funding initiatives that have been shown to work, such as harm reduction programs and communication campaigns to reduce stigma; investing in youth prevention; focusing on racial equity by elevating and expanding diversion programs and linking participants with community-based services; and developing a fair and transparent process for deciding where to spend settlement funds.

f) CARE COURT. On March 3, 2022, Governor Newsom announced the establishment of the Community Assistance, Recovery and Empowerment (CARE) Court, a new framework to get people with mental health and substance use disorders the support and care they need. According to the Administration's fact sheet, CARE Court is aimed at helping the thousands of Californians who are suffering from untreated mental health and substance use disorders leading to homelessness, incarceration or worse. CARE Court aims to connect a person in crisis with a court-ordered Care Plan for up to 12 months, with the possibility to extend for an additional 12 months. The framework provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent. This includes short-term stabilization

medications, wellness and recovery supports, and connection to social services and a housing plan. CARE Court is an upstream diversion to prevent more restrictive conservatorships or incarceration; this is based on evidence that demonstrates that many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings. With advances in treatment models, new longer acting antipsychotic treatments, and the right clinical team and housing plan, individuals who have historically suffered tremendously on the streets or during avoidable incarceration can be successfully stabilized and supported in the community. CARE Court is not for everyone experiencing homelessness or mental illness; rather it focuses on people with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capacity – before they enter the criminal justice system or become so impaired that they end up in a Lanterman-Petris-Short (LPS) Mental Health Conservatorship. Although homelessness has many faces in California, among the most tragic is the face of the sickest who suffer from treatable mental health conditions—this proposal aims connect these individuals to effective treatment and support, mapping a path to long-term recovery. CARE Court is estimated to help thousands of Californians on their journey to sustained wellness.

g) Proposition 36: The Substance Abuse and Crime Prevention Act (Prop36). Prop 36, was passed by 61% of California voters on November 7, 2000. This vote permanently changed state law to allow first- and second-time nonviolent, simple drug possession offenders the opportunity to receive substance abuse treatment instead of incarceration. Prop 36 went into effect on July 1, 2001, with $120 million for treatment services allocated annually for five years. Over 36,000 Californians entered treatment each year through Prop 36.

Not all defendants convicted of a non-violent drug possession offense were eligible for probation and treatment under Prop 36. Under Prop 36, qualified defendants who were charged with non-violent drug possession had to complete a licensed and/or certified drug treatment program. The following defendants were ineligible for the program:

i) Any defendant who had been incarcerated within the last five years for a serious or violent felony offense;
ii) Any defendant convicted in the same proceeding of a non-drug related misdemeanor or any felony;
iii) Any defendant who, during the commission of the offense, was in possession of a firearm;
iv) Any defendant who refused treatment; and,
v) Any defendant who had two separate drug related convictions, had participated in Prop 36 twice before, and who was found by the court by clear and convincing evidence to be unamenable to any and all forms of available drug treatment. In such cases the defendant was sentenced to 30 days in jail.

If the defendant failed to finish the program or violated any other term or condition of their probation, the probation could be revoked and the defendant could be ordered to serve an additional sentence – which may include time behind bars.

By July 2006, when initial funding for the program ran out, over 150,000 people benefited from Prop 36 treatment and California taxpayers saved about $1.3 billion.

Requests for expanded funding in 2006 were ignored, and again in 2007, Governor Schwarzenegger threatened to keep funding at 2000 levels, which amounted to a significant cut.

The University of California at Los Angeles, which was chosen to run the required evaluation of Prop 36, issued five annual reports on the implementation and impact of the program beginning in 2003. The latest report, released in April 2007, showed that Prop 36 treatment was severely under-funded, and that as a result treatment quality was affected. According to researchers at the time, the program needed at least $228.6 million annually to provide adequate treatment.

Governor Arnold Schwarzenegger was critical of Prop 36 because many in the program failed to complete treatment. About 34% of drug offenders completed treatment. Governor Schwarzenegger attempted to modify Prop 36 which would have given judges the power to sentence jail time for a brief period to drug offenders who relapsed. Prop 36 supporters objected to the changes and an Alameda County court ordered an injunction on the reforms. Although Prop. 36 continues to be law, the lack of funding stalled ongoing implementation.

h) Assembly Bill 1542 (McCarty) of 2021 and Governor's Veto Message. This bill is substantially similar to AB 1542 but expands the number of counties that can offer pilot programs to include the Counties of San Joaquin and Santa Clara, in addition to Yolo County. Unlike AB 1542, this bill would require: the judge to make a finding that the defendant's decision to enter treatment was "knowing, intelligent, and voluntary"; the county to develop and staff the program in partnership with relevant community-based organizations and drug treatment service providers; and, the program to provide an individualized treatment plan with MAT options and counseling based on the recommendations of a SUD specialist. This bill would also prohibit the facility from going into "lockdown."

AB 1542 would have allowed Yolo County to establish a SRTF pilot program where felony offenders could be sentenced and treated for SUDs rather than going to jail or prison. It would have, among other provisions, required the Yolo County HHSA to create a risk and needs assessment to evaluate potential STRP participants. The judge would have been required to offer eligible participants the option of attending the secured residential treatment program instead of jail or prison at the time of sentencing. The amount of time a participant would have spent in the SRTF would have been determined by the recommendations of the treatment provider who conducted the initial assessment. The participant would have been able to request transfer out of the STRP to complete the remainder of their originally imposed sentence; and, if the participant no longer needed to be in the STRP, the treatment center would have been able to recommend to the court that the participant should be released from the STRP prior to termination of the court's original order. After leaving the SRTF, the participant would have been required to participate in an outpatient treatment program. AB 1542 would have required an annual report to the Legislature and would sunset on January 1, 2025.

The Governor vetoed AB 1542 on October 8, 2021. In his veto message, the Governor said:

"I am returning Assembly Bill 1542 without my signature.

"AB 1542 would authorize the County of Yolo to offer a pilot program that would allow individuals struggling with SUDs, who have been convicted of qualifying drug-motivated crimes, to be placed in a SRTP.

"I understand the importance of developing programs that can divert individuals away from the criminal justice system, but coerced treatment for SUD is not the answer. While this pilot would give a person, the choice between incarceration and treatment, I am concerned that this is a false choice that effectively leads to forced treatment. I am especially concerned about the effects of such treatment, given that evidence has shown coerced treatment hinders participants' long-term recovery from their SUD. For these reasons, I am returning this bill."

3) **SUPPORT.** The Yolo County Board of Supervisor (Yolo County), sponsor of this bill, states that the intent of such a program would be to address gaps in the current criminal justice rehabilitation system that have resulted in those suffering from substance abuse cycling in and out of local jails without a clear pathway to treatment. In supporting this bill, Yolo County acknowledges the existing tools to address SUDs particularly among those who are frequently involved with our criminal justice system, are not sufficient to address this issue which has sadly become all too pervasive in our community and other communities across our state. Yolo County concludes by stating that it is clear we need more tools to address this intractable issue and we appreciate you advancing AB 1928 as a means for exploring such alternatives.

4) **OPPOSITION.** The County Behavioral Health Directors Association of California (CBHDA) in an oppose position, states that this bill expands upon AB 1542 from 2021 which was unanimously opposed by CBHDA and SUD stakeholders. This bill envisions a 'voluntary' STRP to direct individuals with SUDs into locked treatment in lieu of incarceration. However, locked, and coerced SUD treatment have not been proved as an effective treatment model by the national best-practice standards developed by ASAM. Further, this model raises the risk of overdose, and cannot be used to draw down federal funding through Medi-Cal, a key funding source for SUD treatment in California. While AB 1542 was limited to a pilot program in Yolo County, AB 1928 is expanded to include Yolo County, San Joaquin County, and Santa Clara County.

   The California Society of Addiction Medicine (CSAM) in an oppose position, states that involuntary SUD treatment is neither effective nor ethical. Forcing people into treatment against their will can damage the relationship between the treatment provider and the recipient. Individuals who have often experienced severe hardship can be further traumatized. In addition, judges are not trained to assess peoples' substance use needs and determine the appropriate length of treatment and level of care. Thus, it is inappropriate to allows judges to determine the length of treatment and requires that treatment be provided in a SRTF, even if not clinically appropriate. These provisions are opposite to the criteria developed by addiction professionals for determining the appropriate level and length of care, which specify that these be based on professional assessment and individual circumstances. Most individuals would likely be better served by services in the community. CSAM concludes by stating that resources that would support this bill would be better

invested in community services such as expanding access to voluntary SUD treatment and harm reduction services, permanent supportive housing, and access to other health and social services.

5) **OPPOSE UNLESS AMENDED.** The California Public Defender's Association (CPDA) in an oppose unless amended position, states that while they are appreciative of the amendments made by the author and empathetic with the author's good intentions, this bill is misguided, flies in the face of substantial evidence regarding the efficacy of community-based drug treatment and is a return to the failed policies of involuntary treatment, i.e., the California Rehabilitation Center in NORCO, which disproportionately harmed Black and brown communities. As an example, this is particularly worrisome in a pilot program for Yolo County given the demographics and arrest rates of blacks and other minorities. According to the Board of State and Community Corrections, blacks represent 2.4% of the population of Yolo County but comprise almost 12.5% of the arrests, almost five times their representation. CPDA concludes by stating that they must oppose this bill unless it is amended to provide: voluntary treatment for people held pretrial or post-conviction in county jail, as well as persons on probation; medications for addiction treatment, community outpatient or residential, based on the recommendation of SUD specialist; no locked setting separate from the county jail; and, upon appropriation by the Legislature, provide for continuum of care in appropriate housing.

6) **DOUBLE REFERRAL.** This bill has been double referred. It passed the Assembly Committee on Public Safety with a vote of 5-0 on March 15, 2022.

7) **RELATED LEGISLATION.**

   a) AB 1750 (Davies) requires probation departments to design and implement an approval process for education and treatment programs for probationers, and it would require education on the dangers of ingesting controlled substances. AB 1750 is pending in the Assembly Health Committee.

   b) AB 1670 (Bryan) creates within the California Health and Human Services Agency the Commission on Alternatives to Incarceration to research and develop policy recommendation on alternatives to incarceration. AB 1670 is pending hearing in Assembly Health Committee.

   c) SB 1338 (Umberg) establishes the CARE Court Program to connect a person struggling with untreated mental illness and SUDs with a court-ordered CARE plan. The bill would authorize a court to order an adult person who is suffering from a mental illness and a SUD and who lacks medical decision-making capacity to obtain treatment and services under a CARE plan that is managed by a CARE team, as specified. The bill would require each county to participate in providing services under the program. SB 1338 is pending referral in the Senate Rules Committee.

8) **PREVIOUS LEGISLATION.**

   a) AB 1542 (McCarty) of 2021 would have authorized the Yolo County to establish a pilot program to offer secured residential treatment for qualifying individuals suffering from SUDs who have been convicted of drug-motivated felony crimes. The Governor vetoed

AB 1542.

b) AB 2877 (McCarty) of 2020 would have required a person who commits a crime while under the influence of a specified controlled substance, or with the specific intent of directly or indirectly obtaining that controlled substance to participate in a drug treatment program as a condition of probation, if probation is imposed. AB 2877 was held in Assembly Public Safety Committee.

9) POLICY COMMENTS.

a) It is unclear how this bill is different from AB 1542 of 2021 that was vetoed by Governor Newsom and how it has addressed the concerns raised in the veto message as well as the significant and varied opposition. In responding to the Governor Newsom's veto, the author references a 2005 Treatment Improvement Protocol (TIP) from the Substance Abuse and Mental Health Services Administration that cites a 2000 study by Miller and Flaherty (Department of Psychiatry, Michigan State University, Lansing) which states that "treatment adherence and outcomes are the same among those coerced into treatment and those who entered treatment voluntarily. The TIP goes on to state that in terms of prison-based treatment programs, a 1996 study reported that these programs are often the only treatment opportunities for offenders and that two key issues regarding treatment to offenders are time spent in treatment and engagement in the process. Coerced treatment can force inmates to begin a treatment episode, but the program must be able to engage them in a meaningful rehabilitation process. The longer the inmate remains in treatment, the greater the likelihood for success, (Hubbard et al. 1988; Simpson 1984; Wexler 1988).

It is not clear how these studies address the veto message or the overwhelming body of more recent research demonstrating that coerced treatment is far more expensive than voluntary treatment, has no demonstrable benefit in terms of treatment outcomes when compared to voluntary treatment, makes individuals less trustful of SUD treatment, and therefore less likely to engage in SUD treatment or other medical services in the future.

b) This bill's creation of SRTFs would require a regulatory process for DHCS in order to develop appropriate licensure requirements for facilities that are not based on the social model or existing requirements. As only one example, RTFs may only provide first aid and minor medical attention unless also licensed for incidental medical services. They may not provide comprehensive medical care that may be required in a SRTF. Regulations would need to also be developed to ensure safety of participants and staff of the SRTF. DHCS would need to develop guidelines regarding potential use or threat of punishments, procedures to address complaints from participants, evaluate whether current certification standards for counselor are appropriate to meet the needs of incarcerated individuals, etc. DHCS would need to address what a "step-down" facility would look like in a secured environment and whether that is even possible. The author may wish to offer guidance on these matters and to adjust the timeline for implementation of this bill to factor in the regulatory process.

c) This bill requires the SRTF to be managed and staffed by the county's HHSA with oversight provided by the county's probation department." It is unclear what level of oversight would be required. Is this round the clock oversight of a SRTF, periodic site

visits by probation officers, or administrative functions only? The author may wish to clarify the responsibilities of both the staff of the county and the probation department.

REGISTERED SUPPORT / OPPOSITION:

Support

Santa Clara County District Attorney's Office
Yolo County Board of Supervisors

Opposition

A New Path
ACLU California Action
Bend the Arc: Jewish Action, Southern California
California Behavioral Health Planning Council
California Council of Community Behavioral Health Agencies
Cal Voices
California Association of Alcohol and Drug Program Executives, INC.
California Association of Social Rehabilitative Agencies
California Attorneys for Criminal Justice
California Coalition for Women Prisoners
California Consortium of Addiction Programs and Professionals
California Society of Addiction Medicine
Care First California
County Behavioral Health Directors Association
Dignity and Power Now
Disability Rights California
Drug Policy Alliance
Ella Baker Center for Human Rights
Encode Justice
Freedom 4 Youth
Harm Reduction Coalition
Healthright 360
Human Rights Watch
Initiate Justice
Justice LA
Justice2jobs Coalition
Kern County Criminal Justice Coalition
Project Amiga
San Bernardino Free Them All
San Francisco Pretrial Diversion Project
San Francisco Public Defender
The Gubbio Project
The Sidewalk Project
Transforming Justice Orange County
White People 4 Black Lives

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