Office of Senate Floor Analyses
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THIRD READING

Bill No: AB 1356
Author: Dixon (R)
Amended: 8/29/25 in Senate
Vote: 21

SENATE HEALTH COMMITTEE: 11-0, 6/25/25
AYES: Menjivar, Valladares, Durazo, Gonzalez, Grove, Limón, Padilla, Richardson, Rubio, Weber Pierson, Wiener

SENATE APPROPRIATIONS COMMITTEE: 7-0, 8/29/25
AYES: Caballero, Seyarto, Cabaldon, Dahle, Grayson, Richardson, Wahab

ASSEMBLY FLOOR: 70-0, 5/29/25 - See last page for vote

SUBJECT: Alcohol and other drug programs

SOURCE: Author

DIGEST: This bill requires licensed adult alcohol or other drug recovery or treatment facilities to submit to the Department of Health Care Services (DHCS), relevant information about a resident's death.

ANALYSIS:

Existing law:

1) Grants sole authority in the state to DHCS to license adult residential alcohol or other drug recovery or treatment facilities (RTFs). [Health & Safety Code (HSC) §11834.01]

2) Requires DHCS's death investigation policy to be designed to ensure that a RTF resident's death is addressed and investigated in a timely manner, including timeframes for submitting to DHCS telephonic and written reports containing all specified relevant information concerning the incident. [HSC §11830.01]

This bill requires a RTF to submit to DHCS, within 30 days of a resident's death, as well as of receiving a notice of any deficiencies DHCS identifies in the course of its investigation into the death, any relevant information that was not known at the time of the initial incident.

Comments

According to the author of this bill:

> This bill requires a RTF to provide a subsequent report to DHCS within 60 days of a resident's death at the facility, with updated information on the events surrounding the resident's death and on the facility's follow-up action plan to prevent future incidents occurring, if DHCS identifies any deficiencies in the response to a death. This bill provides a practical solution to strengthen DHCS's death investigation policy, provides the necessary information to properly regulate and oversee RTFs, and improve the safety of residents receiving treatment within those facilities.

Background

RTFs. Licensure is required when at least one of the following services is provided: detoxification; group sessions; individual sessions; educational sessions; or, alcoholism or other drug abuse recovery or treatment planning. As part of their licensing function, DHCS conducts reviews of RTFs every two years, or as necessary. DHCS's Substance Use Disorder (SUD) Compliance Division checks for compliance with statutes and regulations to ensure the health and safety of RTF residents and investigates all complaints related to RTFs, including deaths, complaints against staff, and allegations of operating without a license. DHCS has the authority to suspend or revoke a license for conduct in the operation of an RTF that is contrary to the health, morals, welfare, or safety of either the RTF residents or to the people of the State of California.

DHCS death investigations. According to a October 2024 California State Auditor (CSA) report titled Drug and Alcohol Treatment Facilities (or "RTF report"), complaints about the roughly 1,000 licensed RTFs to DHCS may arise from various sources, including RTF residents, neighbors, staff members, or government agencies. According to internal guidelines, DHCS prioritizes death investigations over investigations into all other types of complaints. When DHCS initially receives complaints, they are logged, assigned a complaint number, and designated as a high-, medium-, or low-level priority. The RTF report stated DHCS aims to

assign death investigations to a staff member on the day it receives the report. In the course of a death investigation, DHCS directs its staff to perform a complete review of the facility where the death occurred to determine whether the resident's death was related to deficiencies in the RTF's operation. As an example, a "Class A" deficiency is any presenting an imminent danger to a resident of the RTF, which DHCS considers to mean the more likely consequence is a resident's death; physical injury that would render a part of the body functionally useless or temporarily or permanently reduced in capacity; or, inhibit any function of the body to such a degree as to shorten life or to reduce physical or mental capacity. If any deficiencies are identified and substantiated, RTFs may be subject to a corrective action plan or verification of correction, as well as civil penalties for failure to respond timely to a Notice of Deficiency. Deficiencies can also result in action to suspend or revoke the RTF's license.

DHCS's current death investigation processes were implemented by AB 2374 (Mansoor, Chapter 815, Statutes of 2014), which requires a RTF resident's death to be addressed and investigated in a timely manner, including timeframes for submitting to DHCS telephonic and written reports. The impetus for AB 2374 were two reports issued by the then Senate Office of Oversight and Outcomes (SOOO):

a) *Rogue Rehabs: State Failed to Police Drug and Alcohol Homes, with Deadly Results.* Issued September 2012, SOOO identified a pattern over the previous decade of the Department of Alcohol and Drug Programs (ADP, which was absorbed by DHCS in July 2013) failing to identify potentially dangerous problems and, when it did, neglecting to follow up and assure that the problems were corrected. This report cited several incidents where ADP's enforcement and investigation activities following resident deaths at RTFs were inconsistent. At one facility where four patient deaths occurred over a span of two and a half years, SOOO reported that ADP was slow to respond. One death was only investigated a year and a half after the fact, upon ADP learning of another death in the same facility. By the time ADP suspended the facility's license, the home had been foreclosed. At other facilities, SOOO reported that patients who needed medical care were admitted to an RTF with the expectation they would receive medical care and ended up dying at the RTF. The report states that ADP indicated it was being more aggressive in halting practices that could lead to injury or death, and was revoking and suspending licenses more frequently. ADP also stated it had implemented new policies intended to focus limited resources on cases that pose the greatest risk to the public. The report recommended that ADP's

improved death investigation policy be used as a template for statutory death investigation requirements, if the policy was found to be effective.

b) *Suspect Treatment: State's lack of scrutiny allows unscreened sex offenders and unethical counselors to treat addicts.* Issued May 2013, SOOO reported that for three decades the state and the SUD treatment industry had been unable to agree on a framework to give the state authority to credential counselors. The report concluded that California's public-private hybrid system precluded criminal background checks and left gaps that could be exploited by counselors who move between seven counselor certifying organizations that register and certify them. While the report acknowledged that many counselors draw from their own struggles with SUD to excel at jobs with not much pay, some come to the profession with serious criminal backgrounds, which the report stated raises questions about their fitness to treat clients, who are often at the most vulnerable time of their lives.

While deaths may occur at DHCS-licensed RTFs, current day media reporting about deaths at "drug treatment facilities" often conflate RTFs with sober living homes/recovery residences (SLH/RRs), which are not required to be licensed by DHCS because they are not authorized to provide treatment services and merely are cooperative living arrangements for those who choose to live with others who are in recovery from a substance use disorder. However, many SLH/RRs have often been found to be unlawfully providing treatment services, or advertise as a RTF without being properly licensed, in which case DHCS has authority to take action against these entities.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: No

According to the Senate Appropriations Committee:

Unknown ongoing General Fund costs, potentially in the tens of thousands to low hundreds of thousands, for the DHCS for state administration.

SUPPORT: (Verified 8/29/25)

Advocated for Responsible Treatment
Capo Cares
County of Orange
One individual

OPPOSITION: (Verified 8/29/25)

None received

ARGUMENTS IN SUPPORT: Supporters of this bill state that DHCS's death investigation policy requires that a resident's death is addressed and investigated promptly, including a written report from the facility within seven days of the incident that includes a description of the follow-up action that is planned to prevent a future death. However, there is no statutory requirement for these facilities to provide any subsequent reports in the aftermath of the incident. Therefore, this bill requires a subsequent report to be submitted to DHCS within 60 days of the initial incident that describes the follow-up action plan.

ASSEMBLY FLOOR: 70-0, 5/29/25
AYES: Addis, Aguiar-Curry, Ahrens, Alanis, Arambula, Ávila Farías, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Calderon, Caloza, Carrillo, Castillo, Connolly, Davies, DeMaio, Dixon, Elhawary, Ellis, Flora, Fong, Gabriel, Gallagher, Garcia, Gipson, Jeff Gonzalez, Mark González, Hadwick, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Kalra, Krell, Lackey, Lowenthal, Macedo, McKinnor, Muratsuchi, Ortega, Pacheco, Papan, Patel, Patterson, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Celeste Rodriguez, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo, Schultz, Sharp-Collins, Stefani, Ta, Valencia, Wallis, Wicks, Wilson, Zbur, Rivas
NO VOTE RECORDED: Alvarez, Bryan, Chen, Lee, Nguyen, Solache, Soria, Tangipa, Ward

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