Date of Hearing: May 13, 2026

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 1897 (Haney) – As Amended April 29, 2026

Policy Committee: Public Safety Vote: 9 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill requires the use of the Historical Clinical Risk Management-20, Version 3 (HCR-20 V3) structured violence-risk assessment — in addition to any other test or assessment the evaluating professionals deem appropriate — as part of the evaluation conducted before the certification of an incarcerated person to the Board of Parole Hearings (BPH) as an offender with a mental health disorder (OMHD), and changes the venue for a petition challenging an OMHD determination from the superior court of the county where the person is incarcerated or being treated to the superior court of the county of commitment to state prison.

FISCAL EFFECT:

1) Significant ongoing costs (General Fund) to the Department of State Hospitals (DSH) associated with the bill's mandated use of the HCR-20 V3 structured violence-risk assessment. DSH estimates costs ranging from tens of millions of dollars annually and approaching $100 million in the high range, primarily driven by anticipated population growth in the OMD patient population. DSH estimates the bill would result in the following cost components:

    a) HCR-20 V3 evaluation workload — $2.77 million annually. The HCR-20 V3 takes approximately four hours to complete. DSH conducted approximately 2,000 initial OMHD evaluations and 370 patient-appealed cases in 2025; DSH reports that adding the HCR-20 V3 to each evaluation would add approximately 15,000 workload hours annually, requiring seven additional psychologists. DSH reports an additional $140,000 annually to retain contractors to conduct annual OMHD evaluations for patients on outpatient status.

    b) Increased OMD patient population — tens of millions to $100 million annually. DSH estimates the bill would increase new OMHD commitments by up to 20% and reduce decertifications by up to 30%, increasing the OMHD patient population overall. At a daily treatment cost of $1,121 per patient and an average length of stay of 259 days (approximately $290,000 per patient), the cost of treating the increased population could range from tens of millions of dollars up to $100 million annually. DSH notes that it has limited available bed capacity to activate for this purpose. If the OMD patient population exceeds DSH's available beds, DSH would need to contract for additional jail-based or community-based bed capacity to treat other DSH-committed populations and free up DSH beds for OMDs.

2) Workload costs (Trial Court Trust Fund, General Fund) of an unknown amount to the trial courts. The venue change shifts petitions for hearing on OMD determinations from the superior court of the county where the prisoner is incarcerated or being treated to the superior court of the county of commitment to state prison. Net statewide workload is likely unchanged, but the change redistributes existing workload from courts in counties that house state prisons (such as Kern, Kings, Lassen, San Bernardino, San Luis Obispo, and Solano) to courts in counties of commitment. DSH reports that current OMHD-receiving courts are well-versed in OMHD law, while courts in most other counties are not, which may increase per-case workload during a transition period as commitment-county courts develop expertise. Although courts are not funded on the basis of workload, increased pressure on the Trial Court Trust Fund may create a demand for increased funding for courts from the General Fund. The state budget provides annual General Fund backfills to the Trial Court Trust Fund to offset revenue reductions, totaling approximately $117.3 million in 2025-26.

3) Costs in the low millions to the California Department of Corrections and Rehabilitation (CDCR) (General Fund). In order to comply with the bill's requirement for use of this particular assessment, CDCR and the California Correctional Health Care Services (CCHCS) would need to obtain evaluator access to the tool, purchase manuals and assessment materials, provide specialized training, and absorb any associated implementation or ongoing licensing costs where such access does not currently exist. CDCR reports that administration of the HCR-20 V3 would require four additional psychologist positions, resulting in staffing costs at $902,063 annually. Additional one-time and ongoing costs for training, manuals, assessment forms, staff backfill during training, supervisory review, and onboarding of new clinicians would further increase implementation costs. The ultimate fiscal impact will depend on final implementation requirements, evaluator availability, training capacity, and whether the HCR-20 V3 replaces or supplements existing evaluation practices.

The Legislative Analyst's Office recently warned of General Fund structural deficits of around $35 billion per year beginning in the 2027-28 fiscal year.

COMMENTS:

1) **Purpose**. According to the author:

> California's Mentally Disordered Offender laws are designed to ensure that individuals with severe mental illness who pose a danger to others receive appropriate treatment while protecting public safety. However, recent cases have exposed gaps in the law that allow dangerous individuals to be released due to inconsistent interpretations of the statutory standard used to determine risk. AB 1897 addresses this issue by … requiring use of a structured risk assessment tool to support more consistent and evidence-based decisions. By improving the reliability of these determinations while preserving due process protections, this bill strengthens California's ability to protect communities and ensure the fair administration of our criminal justice system.

2) **Background**. California law provides that a person leaving state prison who meets specified criteria — including a severe mental health disorder that contributed to the underlying crime, treatment for at least 90 days during the year prior to release, and a determination that

the person represents a substantial danger of physical harm to others — may be involuntarily committed to DSH for treatment as a condition of parole. This OMHD framework is administered by CDCR and DSH evaluators in coordination with BPH. An incarcerated person who disagrees with BPH's OMHD determination may currently file a petition in the superior court of the county where the person is incarcerated or being treated and may obtain a jury trial on the question.

This bill makes two changes. First, it requires the evaluating professionals to administer the HCR-20 V3 — a structured professional judgment instrument for assessing risk of violence, published by Simon Fraser University's Mental Health, Law, and Policy Institute — as part of every pre-parole OMHD evaluation, in addition to any other test or assessment the evaluating professionals deem appropriate. Second, it shifts the venue for a petition challenging an OMHD determination from the county where the person is incarcerated or being treated to the county of commitment to state prison. The Public Safety committee analysis notes that the impetus for the bill was the case of Bill Gene Hobbs, a person whose post-release behavior in San Francisco prompted media scrutiny of the OMHD framework and questions about whether existing evaluation tools adequately identify risk in cases where the person was committed and then released after a relatively short DSH commitment.

DSH has raised concerns that the HCR-20 V3, while widely used as a structured violence risk assessment tool, was not developed to evaluate the specific OMHD statutory question of whether a person, "by reason of a severe mental health disorder, represents a substantial danger of physical harm to others." DSH suggests that incorporating the HCR-20 V3 into OMHD evaluations could lead evaluators and courts to conflate general violence risk or recidivism with the narrower OMHD statutory standard, potentially resulting in OMHD designations for individuals whose risk profile resembles that of general criminal recidivists rather than reflecting an established link between a severe mental health disorder and dangerousness. DSH projects this dynamic would contribute to the increase in new OMHD commitments and the reduction in decertifications underlying its fiscal estimate.

3) **Related Legislation.** AB 1825 (Krell), of this legislative session, specifies factors that a chief CDCR psychiatrist must consider when determining whether an incarcerated person with a severe mental health disorder poses a substantial danger of physical harm to others. AB 1825 is pending in this committee.

   AB 1792 (DeMaio), of this legislative session, reduces the number of factors required for OMHD certification. The bill failed passage in Assembly Public Safety.

4) **Prior Legislation**. AB 2475 (Haney), Chapter 963, Statutes of 2024, extended the post-OMHD-reversal release stay from five to 30 working days to allow for orderly release.

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