SENATE OFFICE OF OVERSIGHT AND OUTCOMES

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State's erratic policing of drug and alcohol homes left clients vulnerable, report finds

SACRAMENTO— The California department in charge of licensing residential drug and alcohol programs failed to catch life-threatening shortcomings and, when it did, neglected to follow up to assure that the problems were fixed, according to a new report by the Senate Office of Oversight and Outcomes.

In several cases, people died after the Department of Alcohol and Drug Programs failed to pursue evidence of problems, reacted slowly, or refrained from using its full statutory power to suspend programs that posed an immediate danger, the report finds.

The report, "Rogue Rehabs: State Failed to Police Drug and Alcohol Homes, With Deadly Results," is available here.

The department has taken some steps in the past two years to identify and crack down on problem programs, a small minority of California's roughly 800 treatment homes. But with the department's licensing responsibilities slated to be handed over to another department on July 1, 2013, the Senate report calls for bills and regulations to prevent a return to a legacy of spotty enforcement.

The second part of the report reveals that many programs flout the state's prohibition against treatment homes providing medical care, and discusses the pros and cons of lifting that ban.

In one case examined in the report, four people died over two-and-a-half years at a Riverside County program called A Better Tomorrow. While deaths do not necessarily indicate that a program did anything wrong – many clients are weakened by their addictions – they can indicate underlying problems.

In the first death at A Better Tomorrow, the state found the program had done nothing wrong despite several unanswered questions and evidence that the program was providing medical care contrary to state law. The second death was not investigated for a year and a half. By then, two more deaths had occurred. The department eventually shut down the facility where four people died, but allowed A Better Tomorrow to continue running several other homes.

At Bay Recovery in San Diego, the department had ample evidence that the director was overmedicating clients and admitting people who were too sick to be there. The Medical

Board of California had said as much in an accusation against the director, Dr. Jerry Rand, after a 29-year-old woman at Bay Recovery drowned in a bathtub. The department conducted its own investigation, but didn't issue formal findings for 16 months and chose not to revoke the program's license. The department finally took action after a 28-year-old man died at Bay Recovery in June 2012. It found that the program failed to refer the man to a hospital even though he had been hallucinating and disoriented for several days.

The department chose not to immediately shut down The Living Center in Modesto after it found the program was admitting people who were too sick for the program to handle. Two months later, The Living Center repeated the practice when it accepted a man who was shaking, dizzy, unable to walk and showing signs of jaundice. He was eventually transferred to a hospital, where he died.

The report profiles the case of Brandon Jacques, a 20-year-old college student from a small town in Missouri who suffered from bulimia and alcoholism. He ended up at Morningside Recovery in Orange County, a program that for years had openly flouted the state's prohibition against medical care in treatment homes. In its routine reviews, the department failed to note the violation. Without telling Brandon's family, Morningside transferred the young man to another facility that also claimed to provide medical and psychiatric supervision contrary to state law. He died there while watching television. In a lawsuit, Brandon's family alleges that neither program was equipped to handle him and that Morningside failed to transfer him to a hospital right away when tests showed his electrolytes were out of balance from purging.

The department says that to comply with state law, clients of rehab homes – not the programs themselves - must pay doctors and other medical professionals. Yet the Senate office found 34 programs that made claims that appeared to violate this prohibition. "We have everything you can imagine – doctors, psychiatrists, addictionologists…That's all part of the fee," one program owner told the oversight office.

Program directors say they must twist themselves into knots to comply with state law while satisfying insurers and accrediting agencies that often require the involvement of medical professionals. One program director told the Senate office that a department analyst said he could comply with state law by having a doctor see clients in his car parked outside the rehab home. The report recommends the state lift the ban on medical care, but only if other laws and regulations are strengthened to make sure that it's done safely and in the best interests of clients.

The oversight office checked with nine other populous states and found that all but one of them allow medical care in rehab homes. All nine allow it in programs that do detox, with four of them requiring the involvement of doctors in those settings.

The non-partisan Senate Office of Oversight and Outcomes was created in 2008 by Senate President pro Tempore Darrell Steinberg (D-Sacramento) to bolster the Senate's ability to gauge government performance.

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