

Rogue Rehabs:

State failed to police drug and alcohol homes, with deadly results

This report was prepared for the California Senate Rules Committee

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Executive Summary

Over the past decade, the California department in charge of regulating residential drug and alcohol programs consistently failed to catch life-threatening problems and, when it did, neglected to follow up to assure that dangerous practices stopped, an investigation by the Senate Office of Oversight and Outcomes found.

The first half of our report reveals troubling gaps in the Department of Alcohol and Drug Program's regulation of residential programs: failure to pursue evidence of problems, slow responses to deaths and other serious incidents, and reluctance to use the full spectrum of its statutory powers to shut down programs that pose a danger to the public.

In the second part, we examine widespread flouting of the state's ban on medical care at residential drug and alcohol programs and the advisability of changing state law to better reflect current treatment practices.

In the past two years, the department has become more aggressive in policing wayward programs. The new approach, in fact, has exposed some of the lapses of the recent past. But with the department scheduled to be eliminated and its duties assigned to another state operation - and recent reforms not enshrined in law or regulation - a legacy of inadequate enforcement could take hold again. And our investigation found that some programs continue to flout the law and engage in dangerous practices.

The department's handling of four deaths at a program called A Better Tomorrow in Riverside County highlights breakdowns in the state's oversight. After the first death, in 2008, state analysts concluded the program had done nothing wrong. But they never determined how the 68-year-old woman obtained an anti-depressant implicated in her death. The department ignored evidence that she had seen a doctor affiliated with the program, a violation of state law that limits the homes to "non-medical" treatment. And it never addressed whether the program should have admitted the woman, who suffered from hypertension, had experienced several strokes, and had taken so many pain killers when

she was brought in by her family that she was unable to walk on her own. Programs are prohibited from taking clients so sick that they need a higher level of care.

When a second death occurred in 2009, the department failed to investigate for a year and a half. It did so only after learning of another death at the same facility.

In its examination of the fourth death, the department found that the program had failed to obtain an oxygen tank for the client, who suffered from chronic obstructive pulmonary disease and emphysema and had recently been hospitalized with pneumonia. Staff gave the Arizona man medications from an “extra supply” without a prescription, and then failed to check on him throughout the night he died, contrary to the program’s own guidelines. They were asleep, the state’s investigation found.

The department finally took action against A Better Tomorrow by revoking the license of the facility where the four deaths occurred. But by then, the home had already shut its doors because of a foreclosure. A Better Tomorrow continues to run several homes. Two former employees told our office that, even after being sanctioned by the state, the program continued to accept clients too sick for it to handle. The program denies those allegations.

Our investigation of the department’s oversight focused on a handful of serious cases. The overwhelming majority of residential drug and alcohol programs treat clients without incident. Even when deaths occur, the program may not be at fault. Many of those seeking help face complicated health issues. Nothing in this report should be construed as discouraging those who need it from seeking safe, effective treatment. Yet, because addicts and alcoholics are often sick and vulnerable, the few programs that go astray can put their clients at grave risk, making it crucial that the department identify and focus its enforcement on those outliers. Over the past decade, that record has been spotty at best:

- At Bay Recovery in San Diego, the Medical Board of California sought to revoke the license of the program’s operator, Dr. Jerry Rand, after a 29-year-old woman drowned in a bathtub. The medical board found that Rand engaged in “extreme polypharmacy” – prescribing multiple medications with little consideration of possible interactions. The board alleged that Rand failed to monitor the woman, who was too sick to be there in the first place. In its own investigation, the Department of Drug and Alcohol Programs also found an array of problems, but didn’t issue its formal findings until 16 months later. Bay Recovery

remained open despite a long list of Medical Board allegations pending against Rand. In June 2012, another client – a 28-year-old man - died at one of Bay Recovery’s facilities. The state finally suspended the program’s licenses after finding that Bay Recovery had failed to refer the young man to a hospital even though he had been hallucinating and disoriented for several days.

- At First House Detox in Orange County, the department cited the program in 2008 for not checking often enough on clients going through withdrawal. Three months later, a client died, and the state found that despite the earlier citation the program hadn’t checked on him as frequently as its procedures required. In 2011, another client died. Logs showed that workers had checked on him four times without realizing he was dead. The department finally decided to revoke First House’s licenses, but refrained from suspending the program right away. A few days later, another client died. The young man’s family alleges in a lawsuit that First House was not equipped to deal with his bulimia.
- In 2010, the department found that The Living Center in Modesto was admitting clients too sick for it to handle. A former staff member told a state analyst that one person had been kept at the program and not sent to a hospital because The Living Center wanted his money. The state let The Living Center stay open while it sought to revoke its license. Two months later, the program admitted another client in need of a higher level of care. The worker in charge of admissions was a marketer with no clinical background, a staff member told a state investigator. The client, whose eyes and skin were yellow, was shaking, dizzy and unable to walk. He was eventually sent to a hospital, where he died.

The second part of this report documents widespread flouting of the state’s prohibition against residential programs providing medical care, exposing a striking mismatch between the department’s regulation and the industry’s prevalent practices.

The department interprets state law to say that medical professionals who operate in residential treatment settings must maintain a separate relationship with clients and not receive payments from the program.

Yet in a survey of websites, press releases and non-profit tax returns, we found 34 programs that made claims that appeared to violate state laws or regulations barring medical care.

Typical was one in Orange County whose website promises “medical supervision” for detox clients. “We have everything you can imagine – doctors, psychiatrists, addictionologists, counselors... That’s all part of the fee,” the owner told our office when we called the intake number.

Those in the industry say the current system, rife with contradictions, is not good for clients. Program directors say they must twist themselves into knots to comply with the state law while also satisfying insurers and accrediting agencies that often require the involvement of medical professionals. One program director said he was told by the state to have the doctor park his car outside and have the clients visit him there.

Critics say the department’s strict interpretation of an antiquated state law prevents programs from providing state-of-the-art care to help clients get through withdrawal and go on to successful treatment. Much of the industry has left behind the Alcoholics Anonymous “social model” in favor of “comfortable” detoxification with the assistance of medicines and doctors.

Because of the department’s interpretation of state law, critics say, workers without medical training may admit people who need a higher level of care or fail to refer them if their conditions deteriorate. The state’s enforcement has been inconsistent and confusing, leading programs to change practices depending on current department leadership, administrators say.

Three bills in the past three years would have allowed some level of medical care. All three failed. Our investigation found that several issues must be resolved before the state’s prohibition on medical care is lifted. The state may have to strengthen other laws and regulations to make sure that medical care is safe and effective, for instance, and address the question of whether the involvement of doctors would violate a law prohibiting the corporate practice of medicine.

Many other states have long since resolved such issues. Nine other large states contacted by our office allow medical care in residential detox or treatment. Several not only allow doctors to oversee detox, but require it.

We make several recommendations, designed to assure that the transition of residential program licensing to a different department does not result in a return to a legacy of haphazard oversight. These include legislation to standardize death investigations and follow-ups of serious shortcomings and greater communication with medical professional licensing boards. We recommend lifting the ban on medical care as long as it is accompanied with more extensive oversight.

Case Study: Missouri college student's fatal encounter with California rehab

Brandon Jacques was a likable kid from small-town Missouri with a fondness for hunting deer and duck, trail-riding on his motorcycle, and working out. But he had a problem: Towards the end of high school, he developed an eating disorder. That led to a dependence on alcohol.

His attempts to beat his twin afflictions led him in 2011 to a drug and alcohol home in California that also claimed to treat mental illness. In Orange County, 1,600 miles away from his family, the 20-year-old college student would die.

What Brandon and his family didn't know was that he was entering a residential program that, like many in California, flouted the state's prohibition against providing medical care and was not regulated as a medical facility. Though the program, Morningside Recovery, had openly stated on its website for years that it provided medical care, the state Department of Alcohol and Drug Programs failed to take note. When Brandon got sicker, Morningside transferred him to a detox facility that also claimed to provide medical and psychiatric oversight contrary to state law. He died there.

"He was my best friend," Ted Jacques, Brandon's father, said in an interview with our office. "Wherever I went, he went with me."

The two liked to hunt and fish together, and spend time riding motorcycles on the family's 160-acre farm, 30 miles north-east of their home in Kearney, Missouri. Brandon worked out constantly. He designed work-out routines for friends. He and his father, a contractor, both felt the pull of the Western mountains. They'd been looking at properties in Colorado.

Brandon was a "health nut" who never drank or took drugs, his father said. But in high school, he developed bulimia. He started drinking so that he wouldn't eat as much, Ted Jacques said. He went to a small private university in Missouri, but his problems went with him. His parents told him he needed to deal with his bulimia and alcoholism and move on with his life. Brandon was willing. Early one morning, Ted Jacques said, his son showed him the website he'd found of a treatment program in Arizona. The next morning they were on a plane. Dropping off Brandon "was one of the hardest things I've ever had to do in my life," Ted Jacques said.

Brandon sounded like he was doing well at the Arizona program, but after a month or so, the program recommended that he go to Morningside Recovery to deal with his eating disorder. Morningside ran several rehab facilities in Orange County, including one treatment home in Newport Beach and two in Costa Mesa licensed by the state Department of Alcohol and Drug Programs.

For years, Morningside openly flouted the department's prohibition against providing medical care. Its website said that detox was done "under the supervision of a doctor," with medications to al-



leviate withdrawal. Its medical staff would give each resident a psychiatric evaluation. It listed a psychiatrist, Theodore G. Williams, on its staff page and said he had served as medical director for several years. The website also stated that the program would admit clients with just a mental health diagnosis rather than a “dual diagnosis” of mental illness and substance abuse.

All of these claims ran counter to state law. But in routine compliance reviews in 2008 and 2009, and an initial review of a new location in 2011, state analysts failed to note that the program was providing medical care.

Ted Jacques read some of those same claims and concluded that Morningside could handle someone like his son.

“They’re advertising that they’re everything to everyone,” he said. “They make it sound like they are a hospital with 24-hour-a-day nursing care.”

The program assured him that Brandon was doing fine, he said. A few days later, though, he heard from Brandon’s therapist that the young man would not be allowed to use a phone because he and some other clients had gotten into trouble – Brandon had tested positive for alcohol.

A couple days later, on a Friday afternoon, Jacques said, his wife got a call from a program staff member to say that Morningside was recommending that Brandon be transferred to an eating disorders hospital. When Jacques got home a while later, he called Brandon’s therapist to ask why, if Morningside treated eating disorders, his son needed to be moved again. He said he just wanted Brandon to be in the best place possible, and would fly out from Missouri to take him there. Jacques recalls that the therapist emailed him a link to the eating disorders hospital and told him to consider it - nothing would happen until the next week anyway. Jacques tried to call the hospital but couldn’t reach the woman he’d been given as a contact.

The next day, Morningside called to say that Brandon had died. He and a friend had been watching a movie on TV. Brandon rolled over on the floor and did 30 push-ups, then went into cardiac arrest.

In a lawsuit, the Jacques family alleges that the program failed to respond to lab work that showed Brandon’s electrolytes were out of balance from purging. Instead of transferring him right away to a hospital that could treat him, the lawsuit says, Morningside, without the family’s knowledge, sent him to First House, a detox facility in Orange County. Like Morningside, First House claimed to provide medical and psychiatric supervision and evaluation, contrary to state law. The department later shut down First House after the program repeatedly failed to check on detox clients often or thoroughly enough. Two of them died. The department found a long list of other violations as well.

In court filings, Morningside counters that it had informed the Jacques family that Brandon’s electrolytes were out of balance and that he should be transferred to the eating disorders hospital.

Four months after Brandon’s death, an investigation by the department found an array of problems at Morningside. The program had been providing medical services contrary to state law. As evidence, the department cited claims that had been on Morningside’s website for years. Among the other problems were irregularities in the handling of medications, use of unlicensed sober living houses for treatment, and the admission of a mentally ill client who was not addicted to drugs or alcohol.

Seven months after Brandon died, the state shut down Morningside’s three treatment homes. An administrative law judge will decide whether the licenses should be revoked permanently. Morningside representatives did not return calls seeking comment.

Background

The California Department of Alcohol and Drug Programs was created by the Legislature in 1979 to serve as the agency responsible for a statewide system of alcohol and drug care.

In 1984, the department took over licensing of alcohol programs from the Department of Social Services. The industry pushed for the change, arguing that clients were not as dependent as those housed in other types of facilities licensed by Social Services and therefore not in need of the same level of oversight. Five years later, the Legislature transferred the licensing of facilities that did both alcohol and drug treatment from Social Services to Alcohol and Drug Programs.

Another type of facility, the chemical dependency recovery hospital, is licensed by the Department of Public Health. Examples include the Betty Ford Center and a handful of other facilities that must meet requirements akin to other types of hospitals licensed by Public Health.

In the early days of drug and alcohol treatment, most programs stressed self-help and support from peers also going through treatment, and were wary of the involvement of medical professionals, according to “Considerations for Reorganization: California’s Departments of Mental Health and Alcohol and Drug Programs,” a 2011 report prepared for the department by researchers at UCLA.

Over time, as experts came to recognize substance abuse as a brain disorder and new medicines were developed to help people through detox, medical professionals became part of the mix at many treatment programs.

State law, however, permits residential programs to provide only “non-medical” treatment. The department interprets this to mean that programs must not pay medical professionals directly, either through a salary or a contract. Instead, the department says, each client must pay medical professionals directly.

The department’s licensing of residential programs focuses on health and

safety rather than the content of the treatment programs. Once every two years, a department analyst visits the program to assure that it's complying with regulations. The state checks whether staff members have passed tuberculosis tests, for instance, that residents have completed health questionnaires, at least one staff member is certified in First Aid and CPR, and residents are getting enough food.

Any "Class A" deficiencies discovered in the survey are considered to be an imminent risk to residents and must be corrected right away. The department has the power to suspend a license immediately pending a revocation hearing.

In addition to biannual compliance reviews, the department investigates complaints and deaths and may suspend and revoke licenses. The department may also impose fines, but does not keep track of the total collected.

Residential programs may voluntarily seek certification by the department. Programs that are certified must demonstrate compliance with a long list of standards such as personnel practices, recreational activities and individual and group sessions. Insurers and clients may favor programs that have obtained certification.

As of March 31, 2012, the department licensed 805 residential facilities. Of these, 506 were also certified. About 30 percent of residential programs – 240 – also provide detoxification. Two-thirds of the programs licensed by the department are non-profits. In the 2010-11 fiscal year, 21,649 clients were admitted to residential detox. Those in residential treatment apart from detox for less than 30 days totalled 1,769. Another 32,526 were in treatment for 30 days or more.

Treatment homes range in size from six-bed facilities in residential neighborhoods to centers that accommodate more than 100 beds. Some serve those with little money and rely on public funding. Others, including a cluster of facilities in Malibu, cater to the very rich, charging tens of thousands of dollars a month and offering amenities such as yoga, acupuncture, fine cuisine and equestrian therapy.

The department's budget for the 2012-13 fiscal year is \$322 million. Of its 231.5 positions, 15 do routine compliance reviews of residential, non-residential and Drug Medi-Cal clinics. Another eight analysts investigate complaints, including those about counselors, as well as deaths and tips about unlicensed facilities.

A trailer bill approved as part of the 2012-13 budget calls on the

department to be eliminated on July 1, 2013. Its functions will be transferred to other state departments. The bill calls on the Health and Human Services Agency to meet with stakeholders over the next year to come up with a reorganization plan.

The acting director of the department is Michael S. Cunningham. He was appointed in January 2011.

Methodology

The Senate Office of Oversight and Outcomes examined investigative and routine inspection files for programs where deaths occurred or the Department of Alcohol and Drug Programs found serious violations of laws and regulations.

The department redacted information from these files, including dates. Officials argued that the date of a death could be used to identify a client's identity, which the department is bound by law to protect, even after death. But the department also redacted many other dates from investigative files, including the dates analysts filed their reports.

Despite these limitations, we constructed timelines to ascertain when the state first became aware of or had evidence of problems and when it took enforcement actions. For some programs, we reviewed other sources of information such as coroner's reports, or interviewed former workers or clients, to get a fuller picture of incidents and routine practices.

We examined the websites of residential programs licensed by the department to find evidence that the program was offering medical care in apparent violation of state law. If the program was a non-profit, we reviewed tax returns to see if the program was making payments to medical professionals. In some cases, we called programs' intake numbers to ask about their services and payment arrangements as a potential client would.

When websites appeared to offer medical services, we used an Internet tool called The Wayback Machine, <http://archive.org/web/web.php>, to obtain snapshots of the website over recent years and determine how long the potentially illegal claims had been made. The Department of Alcohol and Drug Programs provided us with its routine reviews of several programs.

We called other states to learn about their laws and regulations regarding medical care in residential drug and alcohol programs. We interviewed industry representatives and others in California about the wisdom and implications of lifting the prohibition on programs providing medical care.

The department provided our office written answers to questions. In other cases, officials met with us to discuss our findings, but asked that they not be directly quoted in the report because their comments had not been approved.

Part I

The Department of Alcohol and Drug Programs, despite recent improvements, is dealing with a long-term legacy of overlooking dangerous problems in residential programs

Over the past decade, the Department of Alcohol and Drug Programs has shown a pattern of failing to identify potentially dangerous problems and, when it does, neglecting to follow up to assure that they have been corrected.

The department says it is now being more aggressive in halting practices that could lead to injury or death. The record shows that it is indeed revoking and suspending licenses more frequently. And the department has implemented new policies intended to focus limited resources on cases that pose the greatest risk to the public. This new approach, however, may be a function of the current leadership and subject to change, especially when the department's duties are shifted to another state operation in July 2013. In addition, our office found recent cases in which programs continued to break the rules even after they had been sanctioned by the department.

The department's handling of deaths at a program called A Better Tomorrow in Riverside County illustrates some of the most troubling gaps in its oversight. Four deaths occurred over two-and-a-half years. The case highlights the department's seeming inability to rein in a program that was admitting clients with medical conditions it was not prepared to handle.

In the first death in 2008, the department initially found that A Better Tomorrow had done nothing wrong, despite the fact that the female client, who had a complicated medical history including strokes, was

unable to walk and appeared to be intoxicated when she was admitted. This should have raised questions about whether she was too unstable to enter the program. She was taken to see someone referred to in a coroner's report as "the facility's psychiatrist" and in the department's own report as a doctor affiliated with the program despite the state's prohibition against medical care in residential settings.

The second death, in 2009, was not investigated for a year and a half. During that time, two more deaths occurred.

The department appears to have missed several opportunities to stop the program from admitting clients who needed a higher level of care. Even after the department took action, dangerous practices continued, according to two former employees.

First death: unanswered questions

On March 23, 2008, Roberta McMinn, a 68-year-old Hemet resident, died at an A Better Tomorrow facility on Irongate Lane in Murrieta. She had been admitted three days earlier, apparently under the influence of



ROBERTA MCMINN

painkillers and unable to walk on her own. She suffered from asthma, hypertension and had experienced several strokes. She had been in the hospital a week before for a prescription drug overdose, according to a coroner's report. The morning after she was admitted, McMinn was lucid but angry that she had been "committed" to the program by her family against her will, according to the coroner's report. Staff took her to "the facility's psychiatrist for evaluation," the report stated. A staff member said in an interview with a department investigator that McMinn had seen Dr. Noreen Bumby, a doctor of osteopathy affiliated with the program. It's unclear from the record whether the facility's psychiatrist referred to in the coroner's report was Bumby or someone else.

On the day she died, McMinn was found pale and vomiting in her bed. A worker at the Irongate house called another A Better Tomorrow office for help and changed her shirt, according to interviews with staff members. When the second worker arrived, the two cleaned her up again. They noticed that her skin was turning blue and white, and called 911. The worker from the program's office told investigators he knew CPR, but the state's report does not state that he or anyone else from the program

Cases reviewed in this report

Name of program: A Better Tomorrow

Location: Several in Riverside County

What happened: Four people died in about two-and-half years.

Gaps in department's response: Failed to pursue evidence of violations or answer unresolved questions in first death in 2008. Did not investigate the second death for a year and a half. After fourth death, revoked the license of one facility where deaths occurred – but the home had already shut down. Two former workers told our office the same problems are occurring at another facility. The program denies those allegations. An osteopathic doctor affiliated with the program faced discipline for appearing drunk and disheveled and acting erratically, but there is no evidence the department knew or acted on that information. Failed to act on evidence from its own analysts that the program was providing medical care.

Name of program: Bay Recovery

Location: Three homes in San Diego

What happened: Medical Board of California filed an accusation against the operator, Dr. Jerry Rand, alleging serious improprieties, many of which occurred at the treatment homes. Board alleged that Rand engaged in “extreme polypharmacy” with one client who drowned in a bathtub.

Gaps in department's response: Department did investigation after drowning but, for reasons it did not explain, did not issue a formal finding of deficiencies until 16 months later. Department's investigation did not address Medical Board allegation that Rand accepted clients he was not equipped to handle. Department allowed the program to continue until June, 2012 when another client died. That client was hallucinating and disoriented for several days, according to the department's accusation, but the program failed to refer him to a higher level of care.

Name of program: First House Detox

Location: Orange County

What happened: Program was repeatedly found to have done inadequate checks on clients going through detox. One client – who had not been checked often enough – died. Two years later, another died. In this case, the staff checked but failed to note he had stopped breathing. A third client, a young man suffering from bulimia, died two days after an analyst cited the program for deficiencies that posed an immediate danger. That client's family alleges that the program was not equipped to handle him.

Gaps in department's response: The department could not say how it assured that the program had corrected the problem of inadequate checks. After finding serious violations, the department declined to use its power to immediately suspend the program pending a revocation hearing. Two days later, another client died. The department failed to note evidence on the program's website over several years that it was providing medical care, contrary to state law.

Name of program: Creative Care

Location: Malibu

What happened: Program offered medical care, contrary to state law, for ten years. In 2010, after a 24 year old client died of pneumonia, the department found that the program had been prescribing him medicines and ordered it to stop. In February 2012, the department found that the program was continuing to provide medical care.

Gaps in department's response: The department did cite the program for providing medical care in 2004. But both before and after, the department either missed or failed to act on evidence that the program was violating the medical care ban. The evidence could be found in lawsuits, the program's website, and the department's own reviews of the program.

Name of program: The Living Center

Location: Modesto

What happened: The program repeatedly admitted clients it was not equipped to handle, including a bipolar man who had been hospitalized three days before when he threatened to harm himself and others. A month after the department cited the program for a host of deficiencies, it admitted a client who was dizzy, weak and unable to walk. An investigation found that the intake person was a marketer with no clinical experience. The client later died at a hospital. Also, the program's website openly stated for years that it provided medical care, contrary to state law.

Gaps in department's response: The department did not suspend the program after it found a long list of violations allowing it to stay open pending a revocation hearing. In that time, another client died under similar circumstances. Routine inspections failed to note that the program was openly advertising and providing medical care.

Name of program: Morningside Recovery

Location: Orange County

What happened: The program's website stated openly for years that it provided medical care and that it could treat clients with mental illness as a primary diagnosis. In 2011, the program admitted a young man with bulimia, who later died. A lawsuit by the client's family alleges the program's medical staff mishandled the case, and that the program was not equipped to treat mental illnesses such as eating disorders.

Gaps in department's response: The department failed to note until after the young man's death that the program was openly advertising medical care and treatment of mental illness on its website.

Name of program: Sober Shores

Location: Riverside County

What happened: Program's website over several years was open in advertising medical care, contrary to state law.

Gaps in department's response: In 2007, a department analyst opined that the program's close relationship with a doctor was acceptable. Four years later, after the death of a client, an investigation found that the program was illegally providing medical care.

attempted to revive McMinn. It's unclear from the documents how long McMinn had been vomiting and ill before someone called for an ambulance.

Her death was attributed to heart disease and intoxication with an anti-depressant called amitriptyline. But the department's investigation found that she had not taken more than the prescribed amount from the amitriptyline bottle she brought with her to A Better Tomorrow.

That left many questions unresolved. Where did she get enough of the anti-depressant to cause intoxication that contributed to her death? The autopsy also revealed prescription sedatives and sleeping medications in her blood at the time she died. Any drugs that had been in her system when she was admitted would likely have dissipated by the time she died, suggesting she took the drugs while at A Better Tomorrow. Where did those drugs come from? Programs are required to keep detailed logs of client medications – time and amount taken, for instance, and prescribing doctor. But the report of the department's investigation makes no mention of medication logs.

The department concluded that A Better Tomorrow had done nothing wrong. It issued no deficiencies regarding the death. Yet there appeared to be grounds for further investigation. The department has sanctioned programs for admitting clients who, like McMinn, suffered from complex medical conditions, or came in intoxicated and unable to walk on their own. It apparently did not follow up on the coroner's reference to McMinn being taken to "the facility's psychiatrist" or a worker's statement that she had seen Dr. Bumby – both indications that the program was providing medical care, contrary to state law. Not only that – in her written statement, the program's house manager stated that detox procedures called for staff to take blood pressure readings, which the department considers impermissible medical care.

The coroner's report also flatly states that McMinn was admitted against her will. In California, only those who have been declared a danger to themselves or others may be committed to a facility without their permission.

The department did cite the program for other problems it found during the investigation. One of them was that unlabeled sample medications had been found in a resident's medication bag, contrary to state regulations. Yet, the record does not indicate that the department considered any possible connections between the failure to properly control medications and McMinn's case.

Second death: no investigation for a year and a half

Less than a year after McMinn's death, on February 21, 2009, a second client died at the Irongate home. When he was admitted, the client reported a complicated medical history that included shakes, swelling, shortness of breath, choking, vomiting, diabetes, high blood pressure and liver disease. He had not seen a doctor in a year. There was no evidence that the staff at A Better Tomorrow arranged for the man to have a medical assessment. The same day he was admitted, he was found on the floor, apparently having a seizure, blood oozing from his mouth.

The client's widow notified the Department of Alcohol and Drug Programs of the death the same day. But the department did not investigate for a year and a half, after two more deaths had occurred at the same facility.

In its written response the department gave this explanation: "There were some different management directions as to who would conduct death investigations which caused a delay in responding to the second death... ADP staff now has clear and unwavering direction to properly conduct death investigations in a timely, efficient and effective manner."

The new policy requires a department investigator to convene a planning meeting within 10 days and set timeframes for the death inquiry. An analyst must start the investigation no more than five days after the meeting, according to the policy, which was put in place in November 2011.

On October 7, 2009, less than eight months after the second death at a Better Tomorrow and before the department had investigated that death, it did a routine review of the house on Irongate Lane and found no problems.

One month later, another Irongate client died after he was taken to a hospital. The department did not investigate this death for at least a year – again, only after a fourth death had occurred.

The department accused the program of mischaracterizing the death in its mandatory report to the state. The death report stated that the client had been weak but able to function on his own when he arrived at the program, the state's accusation said. Yet the program's own records reflected that he was incontinent, jaundiced and very weak. Although he told the program that he had suffered from liver disease, the staff did not do a medical assessment, the state's investigation later found.

Fourth death: program failed to provide oxygen tank

On July 25, 2010, Gary Benefield flew to California from his home in Arizona for treatment at A Better Tomorrow. He died the next day – his 53rd birthday.

Benefield, who was married with step-children, helped run a coal-operated power plant in Springerville, Arizona, in the White Mountains near the New Mexico border. He was coughing and wheezing when he arrived, according to the department's later investigation, which also found the following: His oxygen tank had been emptied at the airport because of flight regulations. Benefield suffered from chronic obstructive pulmonary disease, emphysema and had recently been hospitalized for pneumonia. Despite all this, the program failed to get him an oxygen tank. It also gave him an anti-depressant and an anti-anxiety drug without a prescription and before he had seen Dr. Bumby, listed on the program's website as "an outside medical consultant." It got the drugs from an "extra supply" it kept on hand. Staff members failed to check on Benefield after 12:30 a.m., contrary to its own guidelines, because they were asleep.

On Nov. 29, 2010, the department suspended the license of the Irongate home. But the action had no effect on the program, because the home had already been closed as the result of a foreclosure. Clients had been moved to other A Better Tomorrow facilities in the area. As of the publication of this report, the department had not taken action against the program's other homes.

In other programs where serious deficiencies were identified, the department has closed down all of its facilities. We asked the department to explain why that didn't happen in the case of A Better Tomorrow.

"Where ADP finds a pattern of wrongdoing across all facilities licensed by one entity, the Department takes action against all the facilities," the department wrote. "When an investigation determines serious issues at one program, ADP staff conducts subsequent investigations at the remaining facilities to determine if additional action is warranted."

Workers say problems continued

Two former workers at A Better Tomorrow told our office that similar problems continued at another of the program's homes even after the state's sanction.

Helene Leonard said she was hired at A Better Tomorrow the same month the department revoked the license of the Irongate facility, and left

ten months later. She said in an interview that workers were instructed to report clients in respiratory distress or suffering other medical crises to A Better Tomorrow's main office instead of dialing 911.

The main office "pushed people" who appeared too sick to be in the program, said Leonard, a vocational nurse for 10 years before having her license revoked over a drug incident.

In February or March 2011, Leonard said, A Better Tomorrow admitted a woman to its facility on Cottonwood Street in Winchester who suffered from chronic obstructive pulmonary disease, heart disease and diabetes. She was withdrawing from methadone, a complicated and potentially perilous detox. The woman was admitted several months after the department revoked the license of the Irongate facility, and around the same time it issued a report on the incidents there.

Leonard said the program promised the woman that she would get an adjustable bed, so that she could elevate her feet to deal with edema, a complication from COPD. In fact, she got a normal twin bed.

"They lied up and down about what they could do for this woman," Leonard said.

Leonard said she and one of the program's licensed vocational nurses, Raelyn Bobinger, complained to management that the woman's medical problems were too much for the program to handle.

"I told Rae, 'I can't believe they admitted her. She's not appropriate for this facility,'" Leonard said.

Bobinger, who left A Better Tomorrow in June 2011, confirmed Leonard's account.

"She scared me," Bobinger said of the client. "She wasn't fit for the program." For one thing, the client's diabetes was uncontrolled. Considering her serious medical problems, Bobinger said, taking her off methadone was risky.

She said she told management that the woman was a liability and should be referred elsewhere. The client, in fact, had to be taken to the hospital for several days. Bobinger said she received a reprimand after she told the hospital case manager that the client should not be returned to A Better Tomorrow because the program couldn't handle her.

Leonard, who is part of a class action lawsuit against the program over

back wages, said there were other such cases. In March or April of 2011, a woman with an eating disorder was picked up at a hotel room where she had been binging on cocaine and alcohol. She was brought to the program's house on Cottonwood Street. Leonard described her as delusional and "out of it." The woman, in her 40s, weighed 84 pounds. The woman had been there a couple of days when she took a turn for the worse. Leonard said she was hallucinating and so lethargic that she was nodding off into her dinner. During a break in a class she was taking, Leonard said, she called to see how the woman was doing and was told by the nurse on duty that she couldn't get a blood pressure reading. The nurse told Leonard she had called her supervisor, who had told her to wait 15 minutes before taking the blood pressure again.

Leonard told her to call 911 right away. The woman ended up being admitted to the intensive care unit for three days.

"I know she would have died," Leonard said.

In a written statement, A Better Tomorrow described the two women as disgruntled former employees who have made baseless accusations.

The company said it could not respond in detail to the accusations because Leonard and Bobinger did not disclose the clients' names. (Doing so to our office would have violated laws protecting client confidentiality.) In general, however, A Better Tomorrow said company policy requires workers to call 911 immediately when a client is in respiratory distress or facing any other medical crisis.

If clients arrive after being released from a hospital, the program assumes that clients are well enough to participate in rehab or go home. Other clients are screened through local health care facilities. But the program does not hesitate to refer clients to a higher level of care if that's needed, the statement said. A Better Tomorrow is the largest referral agency in San Diego County to a medical detox facility and a psychiatric treatment center, the statement said.

The program said state regulations are contradictory. The state holds programs responsible for deaths and injuries, yet will not allow them to provide comprehensive medical care. Their only option, the statement said, is to call 911.

Our office informed the department about the allegations made by the two former A Better Tomorrow workers and asked the workers to contact the department.

Cases involving programs with multiple facilities can be complicated by the fact that they may use a variety of names and corporate entities, as A Better Tomorrow does. The department recently deployed a new computer system that tracks facilities to their corporate owners, making it easier for the state to identify locations that are all run by the same company.

There is yet another issue raised by the investigations of A Better Tomorrow: none of the department's investigative records indicate that analysts were aware that Bumby, the doctor of osteopathy affiliated with the program, was facing troubles of her own.

Around the time of the first death at the program, in 2008, Bumby was behaving erratically in her private practice, according to an accusation filed later by the Osteopathic Medical Board of California. She often appeared to be drunk and disheveled, failed to get necessary information from patients, refused to refill medications, and allowed an assistant who was not a doctor to make decisions, the accusation stated.

Two months after the third death, the Osteopathic Board filed its accusation against Bumby for her erratic conduct in her private practice. The board later put her license on probation for five years and required her to seek substance abuse treatment.

If the department knew about Bumby's problems or considered whether they played a role in the care provided by A Better Tomorrow, it is not reflected in the records provided to our office.

San Diego doctor continues to run facilities despite Medical Board accusations

In the case of Bay Recovery in San Diego, the department allowed the program to stay open despite the fact that the director, a doctor, faced serious accusations and license revocation by the Medical Board of California. The Medical Board alleged that Dr. Jerry Rand had engaged in extreme polypharmacy – prescribing multiple medications with little regard to possible interactions – in his treatment a 29-year-old client who drowned in a bathtub.

That client and one other never should have been admitted to Bay Recovery, the Medical Board alleged, because they were too sick. Records provided to our office do not indicate the department ever addressed this allegation.

Then – on June 6, 2012 – another client died. The department finally

suspended Bay Recovery's licenses, finding that the program had failed to refer the 28-year-old man to a higher level of care despite the fact he had been hallucinating and disoriented for several days.

Bay Recovery ran three treatment homes at the time of the June 2012 death. Rand was barred from practicing for a time in the 1980s because of substance abuse problems. He was accused of treating patients while clearly impaired. He regained his license, but in 2002, the Medical Board of California put him on probation for seven years for what it deemed incompetent treatment of patients several years earlier.

In 2009, Rand again ran into trouble with the Medical Board. In an accusation filed then amended over the next two years, the board alleged the following:

Rand was grossly negligent in his treatment of the 29-year-old woman who drowned in a bathtub. He failed to properly detoxify her, instead engaging in "extreme polypharmacy" and overmedication. He failed to closely monitor her to prevent overdose and death. And he improperly accepted her into his residential treatment program when she was medically and psychologically unstable.

Rand was accused of overmedicating three other clients. In one case, he prescribed a 37-year-old woman opiates and sedatives in doses exceeding legitimate medical requirements. This client also never should have been admitted, the Medical Board stated, because she was medically and psychologically unstable.

Rand also prescribed himself controlled substances, the Medical Board alleged, by having one of his workers call in the prescription under the name of another Bay Recovery doctor without that doctor's knowledge. He failed to assure that Bay Recovery's homes had proper first aid supplies and someone on hand who knew CPR. While current law makes it very difficult for the Medical Board to suspend a physician's license when a case is pending, the Department of Alcohol and Drug Programs is under no such constraints in taking action against a program run by a doctor.

State investigates, but program remains open

The department did an investigation in October 2008, several months after the drowning. It found that 39 medications had not been properly labeled, as well as various other problems with the control of medications. The program failed to notify the state of the drowning in the time required by law, the investigation found, and did not list it in its own log of unusual incidents. It also cited the program for allowing clients, rather

than staff, to perform cardiopulmonary resuscitation on the drowning victim.

In a routine compliance review in 2009, a department analyst discovered while looking through residents' files that staff at Bay Recovery was doing blood pressure and pulse checks and that Rand was writing orders and prescribing medicines, contrary to state law.

For reasons that the department did not explain to our office, it did not issue a formal finding of deficiencies found in the October 2008 investigation until January 21, 2010, 16 months later. A week after that, just as Bay Recovery was planning to transfer ownership to a newly formed corporation, the department entered into an agreement with the program. It stated that, despite the change of ownership, the department reserved the right to take action against Bay Recovery if it failed to correct deficiencies.

In an interview, Rand said he could not recall the department "doing anything formal" in response to the drowning. He said that the woman who died had hoarded drugs and overdosed 12 times before. "Why would someone suddenly want to blame me?" he asked.

He suggested the accusation by the Medical Board was motivated by his own history of substance abuse two decades ago or by his appearances on television, including "Intervention," a reality show featuring people with substance abuse disorders.

"Maybe I'm too visible," he said.

The case offers a stark example of lack of coordination between two state entities, and the department's failure to stop dangerous practices. The Medical Board alleged that in 2008 Rand was accepting clients who were too sick to be there. But for four years, the record does not indicate that the department conducted its own investigation of that charge. Only after the 28-year-old man's death in June 2012 did the department conclude that the program had engaged in similar misconduct by failing to refer the client to a higher level of care despite the fact that he had been disoriented and hallucinating for several days. The cause of the man's death was unknown at the time this report went to press. Rand declined to discuss it.

Three weeks later, Bay Recovery's homes and offices, as well as Rand's personal residence, were raided by the U.S. Drug Enforcement Agency, the Medical Board of California and the Department of Alcohol and Drug Programs.

The department told our office it is discussing taking a broader interpretation of its own powers to protect the public in such situations.

The department also failed to crack down on the program for providing medical care. The Medical Board allegation clearly states that Rand was providing medical care at his residential treatment program, despite the requirement that such programs be “non-medical.” The department reached the same conclusion in a 2009 compliance review.

Yet before the state suspended the programs in July 2012, Bay Recovery’s website was still offering medical services.

Rand told our office that he separated his roles as physician and operator of the program. If he provided medical care to clients of his homes, he said, he saw them as outpatients. But when we called the program’s 1-800 hotline, a representative told our office that the monthly fee for residential treatment included “seeing Dr. Rand, a really good doctor here.” Several other physicians also are listed on the program’s staff.

State identified dangerous practice, but it continued

In the case of First House Detox in Orange County, a life-threatening problem persisted even after the state identified it and demanded that it be corrected. The program repeatedly failed to do frequent or thorough enough checks on clients going through detox. Two of them died. The case demonstrates the department’s spotty record of following up once it has identified a potentially life-threatening problem.

In 2008, a routine bi-annual review at one of First House’s facilities in Costa Mesa found that the program was not physically checking on detox clients every 30 minutes for the first 12 hours, as required by the department’s certification standards and the program’s own protocols.

The department notified First House that the deficiency had to be corrected. Two months after the inspection, the department sent the program a letter stating that, based on documentation First House had submitted, the deficiency, along with several others identified in the inspection, had been “cleared.”

In such cases, problems are often corrected by the program submitting a corrective action plan. The department is authorized by regulation to do follow-up visits of programs where problems have been identified to make sure they continue to comply with standards. But “given a lack of resources, ADP does not revisit every program to ensure that a deficiency is corrected,” according to the department’s responses to our questions.

Recently, when the department reaches settlement agreements with programs, it may require them to cover the costs of regular follow-up visits.

Three months after the state told First House it had successfully “cleared” the deficiency of inadequate checks, a client died in another of the program’s facilities after leaving the facility twice when he relapsed. The department’s investigation found that, despite the program’s protocol to check detox patients every half hour, it had failed to monitor the man for 45 minutes. Sometime during that time, he died. The cause of death was later found to be “acute polydrug intoxication” caused by a combination of alcohol, antidepressants, anti-psychotics and sedatives. The department’s investigation did not address the question of where the drugs came from. Two years later, after another death, the state found irregularities with the program’s handling of medications, including giving clients drugs they had not been prescribed.

The department found that the failure to check often enough was a “Class A” deficiency – an imminent danger to residents – and had to be fixed immediately. The department provided us no records indicating what steps the program took to comply.

Routine reviews of all three of First House’s facilities in 2009 and 2010 found no problems related to checks on detox clients.

Program’s staff failed to realize a client had died

In 2011, at the same First House facility where a resident had died two years earlier, another detox patient died. In this case, the state’s investigation found that the client had been checked every 30 minutes. But the staff apparently had not observed the client closely enough to make sure that he was breathing, because they did at least four checks without realizing that he had died. It was only when another client alerted them that the death was discovered.

Three months after that second death, in a follow-up investigation, the state found that the program again fell short of state certification standards and its protocol by failing to check two detox clients every 30 minutes. Clients told a department analyst that the checks only occurred every two hours or so.

That represented the fourth time in three years that the department found First House had failed to adequately monitor clients.

Eventually, after finding a host of serious violations, the department

sought to shut down First House. But it failed to act immediately, as permitted by law. In the five months between the second death and the department's suspension of the program's license, a third client died.

A department analyst visited the program to investigate the second death on March 29, 2011, 43 days after it occurred. On that visit, she found evidence of several serious violations. The program was handing out medications that had been prescribed to different clients. Prescription labels had been removed from some medication bottles. The analyst did interviews that revealed the program was paying physicians to treat clients. She observed an extra bed, which suggested that the program was over capacity the night the client died.

After her inspection, she issued two Class A deficiencies, which by law must be fixed immediately because of an imminent danger to residents. They were for failing to store and destroy medications as required.

The department is authorized to immediately suspend a program's license "to protect residents from...substantial threats to residents' health and safety." But, in this case, it chose to allow the program to keep operating pending revocation proceedings.

Two days after the analyst's inspection, First House admitted Brandon Jacques, a 20-year-old man from Missouri who suffered from alcoholism and bulimia. According to a lawsuit later filed by Jacques' family, before being admitted to First House, he had been treated at another program, Morningside Recovery. There, he continued to binge and purge, according to the lawsuit, and should have been referred to a hospital. Instead, Morningside sent him to First House. On April 2, four days after the state's inspection, he had a heart attack while watching television and died.

On July 13, 2011, the department suspended First House's licenses. Two months later, it revoked them permanently. The department found that the program had improperly admitted the client who died in February, prior to Jacques' death, instead of getting him emergency treatment. The staff failed to do a face-to-face assessment of his condition, and did not complete a screening form. The department determined that First House was providing medical care, falsifying medication records, letting in more clients than allowed, and using uncertified counselors.

The department is now investigating the death of Brandon Jacques.

Program kept providing medical care even after state found out

At Creative Care in Malibu, the Department of Alcohol and Drug Programs discovered in 2004 that the program was providing medical care and demanded that it stop. Yet the program continued to do so for six more years until the department, after the 2010 death of a 24-year-old client who had been getting prescription drugs from Creative Care, threatened to take the program's license. Even after the program signed an agreement to no longer provide medical care, it continued on as before, according to an investigation in early 2012.

The program admitted in court that it was providing medical care contrary to state law even before the state's 2004 action.

In 2002, the parents of Pamela Tusiani sued Creative Care after she died while getting treatment from the program. She had eaten cheese pizza while taking an anti-depressant known to interact dangerously with dairy products.

One point of contention in the lawsuit was whether Creative Care was a health care provider. Creative Care argued that it was, and therefore came under the protections of the state's Medical Injury Compensation Reform Act, which limits the size of awards in lawsuits against health care providers. As evidence that it fit the definition of a health care provider, Creative Care said it employed professionals, including two doctors, who provided treatment to the program's clients. One of the doctors prescribed the anti-depressant that Tusiani was taking when she died.

The program's own assertions at the time should have alerted the state that Creative Care was violating state rules. We could not determine if the department investigated Tusiani's death or took any actions in response because it does not retain records from 2001, when she died.

There was another indication that Creative Care was providing medical care: The program stated it plainly on its website.

From at least 2001 to 2003, the program's website offered "Medical Detoxification."

"When detoxification is required, it can be done at Creative Care, depending on the physical condition of the patient," the website stated.

The program's drug protocol, dated February 11, 2002, clearly states that

Dr. Burton Chertock, the medical director, examines clients within the first week.

In 2004, for reasons that are unclear in a memo obtained by our office, the department issued a notice of deficiency to the program for providing medical services as part of treatment. But on the same day, Creative Care provided written documentation that the deficiency had been corrected. The memo does not say how the program demonstrated to the department that it had changed a practice central to its program in one day, or what the state did to assure that Creative Care didn't just return to its earlier improper practice.

That, in fact, is what appears to have happened.

From 2006 until 2009, the website included this information about Dr. Chertock, who is described as the program's medical director since 1997: "Upon admission, the client meets with Dr. Chertock for psychiatric evaluation and assessment to determine the need for any appropriate medications."

The website repeatedly referred to a "professional team" that included doctors and psychiatric nurses. In 2011 and into 2012, it stated that "Detoxification is done here at Creative Care under the supervision of a doctor and a nurse who specialize in this process."

Department's own analyst was aware of staff doctor

In a 2006 investigation of an unrelated matter, the department itself made mention in passing to "the program's doctor." But there is no evidence in the file that the analyst saw Creative Care's employment of a doctor as improper, even though the department had cited the program for providing medical care two years earlier.

In 2010, a 24-year-old Creative Care client died of what turned out to be pneumonia. According to the department's investigation, the program failed to identify the pneumonia despite having a medical director and a staff nurse. The department also found that Creative Care had been prescribing medications to the man. Several months later, it filed an accusation against the program, seeking revocation of its license. In July 2011, the department and Creative Care reached an agreement in which the program promised not to provide medical services, prescribe drugs, arrange for office space for doctors or nurses, or advertise services that it was not allowed to offer.

But four months after that agreement had been signed, Creative Care's

website still stated that Dr. Chertock was on staff, and that clients would see doctors up to three times a week.

In February 2012, a department investigation found that Creative Care was violating the agreement not to provide medical care. Dr. Chertock was seeing patients as part of the treatment program and prescribing drugs. The investigators discovered that one client had been given prescription drugs before seeing a doctor, and found sample medications with no prescription label in a medicine bag.

The oversight office asked the department why Creative Care was able to continue offering medical services for a decade despite repeated warnings.

“ADP has, in the last two years, been extremely aggressive in establishing consistency in the application of statute and regulations,” the department stated in its written response. “When previous problems have been identified with newly established information, ADP has taken appropriate and warranted action against providers.”

Department failed to use its power to suspend program

The department at times has failed to act as aggressively against problem programs as permitted by law, sometimes with dire consequences.

At The Living Center in Modesto, the department found that the program had been admitting clients that it was not equipped to treat. But rather than suspending the program immediately, the department allowed it to continue operating while it sought revocation of its license. Two months later, the program admitted another client who the state later found was clearly in need of medical care beyond what the program could provide. The client eventually was transferred to a hospital, where he died.

A state regulation says that the department may suspend a license immediately, before a license revocation hearing, “when such action is necessary to protect residents of the facility from physical or mental abuse...or any other substantial threat to the residents’ health and safety.”

On Feb. 16, 2010, The Living Center admitted a bipolar client who had been hospitalized three days before when he threatened to harm himself and others. Once in the program, the client continued to talk about violence and suicide and acted erratically, pounding on a desk and applauding at inappropriate times during counseling sessions. A counselor finally called 911 when the client started breaking things and

threatened to kill the counselor, according to the state's investigation. The program later readmitted him, but discharged him for harassing female clients. The state said in its accusation against the program that The Living Center should have referred the client to a medical or psychiatric facility.

On April 1, 2010, the program admitted an adolescent who recently had tried three times to commit suicide. Although the adolescent was using marijuana, his mother wanted him to be treated for his mental illness and was not aware, until told by a department investigator, that counselors at The Living Center could only handle drug and alcohol cases.

Three weeks later, the program admitted a client who had been found by a county psychiatric facility to be a danger to himself and others and gravely disabled. The client had tried to burn himself. A former staff member from the Living Center told a department investigator that the client had not been referred to a higher level of care because the program wanted the money. He was only discharged when other clients complained and threatened to leave.

In March 2011, the department cited The Living Center for failing to refer these clients to hospitals or other facilities that could better care for them, as well as a host of other deficiencies. Three months later, the department filed a formal "Accusation for Revocation of License," listing nine different allegations as the basis for a license revocation. The accusation said that the program took more adolescent clients than allowed, admitted a client under the age limit of 14, employed people who had failed a required criminal background check, neglected to make mandatory reports to the department of incidents in which clients were injured or became ill and were taken to the hospital, and provided medical services.

They were listed as Class A deficiencies, meaning they posed an imminent risk to clients and needed to be addressed right away.

But the department did not use its authority to immediately suspend the license, and the program continued to operate.

A little more than a month later, the program admitted a client who was withdrawing from alcohol. His eyes and skin were yellow; he was shaking and experiencing a racing heartbeat. On his third day at the program, the client was weak, dizzy and unable to walk. The Living Center transferred him to a hospital, where he died.

The department's later investigation found that the worker who admitted

the client had no clinical training and was unqualified to assess his medical condition. Another staff member described him as a “marketing finance intake person.” The intake worker himself said he would not recognize symptoms that required medical attention because he wasn’t a doctor. The worker told the state’s investigator “that unless a client fell down during time of admission he would not see a need for medical attention.”

Eventually, the department did suspend the program’s license pending revocation proceedings. The program has since been evicted and is out of business, the department said.

State forbids medical care, but misses evidence

Many of the problems that occur in programs overseen by the Department of Alcohol and Drug Programs center on the provision of medical care, which is prohibited by state law. Clients may be improperly medicated. In other cases, programs that advertise medical supervision do not provide adequate oversight of clients who should be receiving a higher level of care.

The department has the ability to identify programs that are offering medical care before resulting problems get out of hand. Analysts were advised to look at the programs’ websites as part of their routine reviews every two years – since March 2011, the department has required them to. And they can look through clients’ files for evidence that they have been receiving medical care from the program.

Our investigation found that the department has often missed these signs.

One – Camp Recovery in Scotts Valley – stated on its website since 2000 that it had a doctor on staff, performed psychiatric evaluations and prescribed medicines. It took nine years for the state to crack down.

Likewise, the website of The Living Center, a 28-bed facility in Modesto mentioned earlier, declared since at least 2006 that it was providing medical care.

Yet reviews by the Department of Alcohol and Drug Programs in 2007, 2008 and 2009 failed to note that fact. Only in 2011, in a thorough investigation of multiple allegations, did the department note the website language.

In the case of A Better Tomorrow, whose other problems were detailed earlier, the department’s own analysts noted the presence of doctors but

failed to rein in the illegal medical care. In 2007, an analyst mentioned the presence of a physician but failed to address why he was working there. In 2008, an investigator wrote that an unnamed staff member had prescribed medications to a client, but did not characterize it as a breach of state law.

In its investigation of the fourth death, the department found a manual that stated that “The Medical Director will prescribe such medications as needed for safe detoxification,” but again failed to cite this as evidence of illegal medical care.

“This may have been an oversight during the application review process,” the department wrote in its response. “ADP has implemented a quality review process (within the last 12 months) to ensure” that such red flags are detected.

Similarly, the website of First House in Orange County made clear statements as long ago as 2006 that it was providing medical care. Yet routine compliance reviews in 2008, '09 and '10 did not cite the program for providing medical care.

Only in 2011, after the death of a second client, did the department interview staff and clients who informed them that the program paid doctors to provide medical care. That violation was one of many the department cited in finally revoking First House’s license.

Analyst declared medical care was OK

A variation on this theme occurred in the case of Sober Shores, a residential rehab program in Riverside County.

In 2007, an analyst uncovered evidence that there was a close relationship between the program and a doctor. Although the doctor did not come to the site, he saw clients and gave them prescriptions. The analyst told the program that the arrangement complied with state law.

Then, in 2011, the state investigated a death at Sober Shores. Among several other serious findings, the investigation determined that the program was providing medical care. The detox manager admitted that the program was paying doctors, rather than the clients forming separate relationships with them. As further evidence, the state cited language from the Sober Shores website that had been there for at least four years but had not been noted during two routine reviews.

Late in 2011, the state suspended Sober Shores' license, and revoked it a few weeks afterwards.

The department could not explain how the state first approved Sober Shores' medical care and later found it illegal. "The division leadership present in 2007 is no longer with the department," it wrote. "We cannot speculate about decisions made, direction given and actions taken during that time period."

In March 2011, analysts were instructed by the department to check websites as part of their routine, two-year compliance reviews. They can also review client files to see if clients have been receiving care from doctors.

Part II

The state’s prohibition against providing medical care is widely ignored

Our investigation found 34 programs that made claims that appeared to violate state laws or regulations. The survey was not comprehensive – the 34 programs were found in a sample of a few hundred out of 805 licensed by the department. It also was impossible to determine with certainty that the programs were violating rules because our office does not have access to client files and other internal documents.

Our survey revealed a mismatch. On one side is a department that interprets its mission as overseeing non-medical care in residential homes. On the other is an industry offering services that include medications and care by doctors and other medical professionals. The state’s insistence on only “non-medical” care is so widely flouted as to seriously undermine the legal framework that governs residential drug and alcohol programs.

In some cases, the websites and other advertisements may overstate the involvement of medical professionals. But this points out another peril: Clients can arrive at residential treatment programs expecting more medical oversight than they get. Some of the most serious cases investigated by the Department of Alcohol and Drug Programs in recent years involve clients with complicated medical histories being admitted to programs not equipped to handle them, despite what they promised on their websites.

We did find many programs that adhered to the “social model” of treatment that the state envisioned when it set up that legal framework, centered on counseling and group meetings in the tradition of Alcoholics Anonymous.

But in many ways, the industry has abandoned that model in favor of “comfortable” detoxification with the assistance of medicines and doctors. Programs told our office that the state’s regulatory framework is outdated

and does not reflect new standards that rely on medicines in conjunction with counseling to free people from the grip of drug addiction and alcoholism.

One reason programs may find it hard to adhere to the rules is that the Department of Alcohol and Drug Programs does little to clarify what it means by “non-medical.” The department has never officially defined the term, and so is reluctant to go into detail about what it means, as that could constitute “underground rulemaking” – regulations without statutory authority.

Our office was able to flesh out the definition only by examining disciplinary actions against programs to glean what practices the department considers suspect.

These were some of the prohibited practices cited in investigations. But it is not a definitive list, because each case depends on the context and unique circumstances, making it hard to define a general rule:

- Clients do not set up separate relationships with medical professionals. The program, rather than the client, pays the doctor, registered nurse, physician’s assistant or other professional.
- The medical staff provides prescription medicines.
- A doctor is on staff as medical director.
- A staff physician is on site to provide medical evaluations.
- Medical services, such as blood work and the taking of vital signs, are provided.
- A doctor paid by the program orders detox protocols.
- Programs list separate fees for detox.
- The program provides office space for doctors.
- The program accepts clients who need medically supervised detox.

We looked for evidence of prohibited practices on websites and, in some cases, news releases and news stories. If the program was a non-profit, we examined Form 990 tax returns. For some of the programs that seemed to be offering care that went beyond “non-medical,” we called the intake

number and asked about their services. We do not name the programs because they were picked at random – others offering the same exact services could easily have been found.

Programs offer medical detox, supervision

Typical was the website of one Bay Area residential program that offers “medical supervision” and “a skilled medical team,” including a medical doctor, a psychiatrist, a nurse practitioner and 24-hour nursing. Clients are offered a comprehensive physical examination and medical assessment.

The program was investigated at some point in 2007 or 2008 – we could not pinpoint the exact timing because the department redacted dates in the documents it provided to us – after someone complained that it was doing medical detox. The department determined that the complaint was unfounded, because the program’s admission agreements state that clients pay fees directly to their treating physicians.

Yet, when our office called the program, an “adviser” stated unequivocally that clients pay their fees to the program, not to the doctors and other medical professionals. She said that the program had “medical staff on board,” and that the doctors are “on location.” The monthly fee, she said, included two psychiatric sessions per week.

Another example was a program in Orange County that promises “medical supervision” for clients going through detox. The owner told our office that the monthly fee covers detox and the doctors who oversee it.

“We have everything you can imagine,” he said, “doctors, psychiatrists, addictionologists, counselors... That’s all part of the fee.”

It also includes a physical, a blood test, a psychiatric evaluation and possibly even neuro-feedback to see if the client’s brain has been damaged.

“My doctor is here all the time,” with an office only two blocks away, he said.

In a third example, the website of one San Bernardino County facility lists its prices for detox, with the doctor’s fees and all medication included. Clients are given blood tests reviewed by “our physician.”

In its routine reviews of the program, in 2008, 2009, and 2010, the Department of Alcohol and Drug Programs has not cited the program

for providing medical services. As of March 2011, state analysts who do routine compliance reviews are supposed to examine a program's website to see if it makes prohibited claims about providing medical care. But another routine review in November 2011, eight months after the new policy was put in place, made no mention of the website's references to detox medications and doctor's fees and lab work.

The problems at this program may go beyond providing medical care. In an interview with our office, a recent client reported that he was medicated with "comatosing" drugs that were not prescribed to him and had their labels torn off. Another client who was coming off heroin was in bed for three days, he said, and seemed to be in distress.

Program said it would take client with severe mental illness

Our survey revealed another potential violation of state rules: Treatment homes willing to take clients with severe mental illnesses that could preclude them from benefiting from treatment or require a higher level of care.

We asked the representative of an Orange County program if it would admit a bipolar client. She said that such a client would be "no problem" and that 95 percent of clients are "dual diagnosis," meaning they suffer from a mental illness in addition to addiction. While admitting bipolar clients is not in and of itself a violation of state regulations, programs are required to screen such clients to make sure they're suitable for residential treatment.

Another Orange County program said it would admit a schizophrenic client, but that if the client was unstable, it would charge an extra fee to cover the costs of a psychologist. Other programs overseen by the Department of Alcohol and Drug Programs have been cited for admitting clients who were psychiatrically unstable.

On the other hand, a Malibu program said it would not accept a client with schizophrenia, but instead would refer such a person to a higher level of care.

Some said they're aware of state law

Some programs showed a knowledge of and apparent adherence to state regulations.

The Malibu program that said it would not admit a schizophrenic states

on its website that clients get a “medically supervised” detox under an expert team of professionals. The “staff” page lists two doctors.

But a representative told us that the doctors have separate relationships with clients. The program accepts the doctors’ fees on their behalf. The doctors are not on staff, the representative said, because it’s considered illegal.

Two other programs we reviewed made similar disclaimers. These programs appear to be complying with the law. But they raise a question: If independent doctors are affiliated with a program and only connect with patients because they are clients, is segregating their fees any different than the program contracting directly with the doctor?

In still other cases, there appears to be confusion about where the state draws the line between non-medical and medical.

The director of a Los Angeles program that offers detox under the care of a medical professional told our office that the state “does not allow doctors to practice in a residential setting.” Instead, clients of this program are taken to a doctor’s office, where they get prescriptions and may go for follow-up care.

Yet, the director said that clients do not pay the doctors separately. “We take care of all of that,” he said.

The Department of Alcohol and Drug Programs says it lacks the personnel to look for programs that are openly flouting the prohibition against medical care. Our survey makes it clear that such practices are widespread – possibly even the norm.

Critics say state law is outdated, but questions must be answered before the state lifts its ban on medical care

Almost everyone involved in the current system of regulating residential drug and alcohol programs agrees that it doesn't work and is not good for clients. Many programs flout the law or engage in elaborate schemes to technically comply. Those that hew to the department's interpretation of the law find they must jump through hoops to provide the kind of medically assisted care they say has become the industry standard. The state's enforcement is spotty and at times contradictory. Programs say they're forced to change their behavior depending on the views of the current leadership at the Department of Alcohol and Drug programs, and even the individual analyst who comes to survey their facilities once every two years.

Perhaps the best indicator of the failure of the current system is the degree to which the law prohibiting medical care in residential settings is ignored.

"The reality is that nearly every facility that has insurance reimbursement is required to have health care," said Ed Dilkes, attorney for CRC Health Group, one of the sponsors of a 2011 bill that would have allowed medical care. The bill died this year.

"If you just look on-line for rehab in California, the programs that pop up are the big for-profits," said David Peters, an adviser to the California Association of Addiction Recovery Resources. "They all name a physician as their medical director."

"The advertising of some of these places is mind-boggling, it's so blatant," said Al Senella, who runs Tarzana Treatment Centers in Los Angeles and is the president of the California

The Senate Office of Oversight and Outcomes interviewed experts and advocates in the residential treatment industry to get their accounts of current practices and opinions on what could be done to improve services for clients. They included:

- James Bailey, executive director of The Camp Recovery Services in Scotts Valley
- Jack Bernstein, president and chief executive officer of Cri-Help, a non-profit treatment program in Los Angeles.
- Ed Dilkes, attorney for CRC Health Group, one of the sponsors of a 2011 bill that would have allowed medical care. The bill died this year
- Robert Harris, a legislative policy adviser to the California Society of Addiction Medicine
- Helyne Meshar, a lobbyist for the California Association of Alcohol and Drug Program Executives
- David Peters, an adviser to the California Association of Addiction Recovery Resources
- Dr. David Sack, chief executive officer of Promises Treatment Centers in Malibu and West Los Angeles
- Al Senella, who runs Tarzana Treatment Centers in Los Angeles and is the president of the California Association of Alcohol and Drug Program Executives
- Dr. Mike Stone, president and clinical director of Cornerstone Southern California

Association of Alcohol and Drug Program Executives.

“I don’t think there’s a program of any quality that wouldn’t be found to be providing medical services,” said Jack Bernstein, president and chief executive officer of Cri-Help, a non-profit treatment program in Los Angeles.

Law based on outdated model, critics say

Critics of the current situation say laws and regulations reflect a bygone era when addicts and alcoholics were expected to tough it out through detox without the aid of medications that can ease withdrawal symptoms.

When the law was written, diseases that inordinately affect drug users such as Hepatitis C and HIV/AIDS were unknown, said Dr. David Sack, chief executive officer of Promises Treatment Centers in Malibu and West Los Angeles. Also, experts at the time did not recognize the prevalence among addicts of co-occurring mental illnesses that would not go away once they stopped using. Residential treatment programs are dealing with clients who have more complicated medical and psychiatric histories than envisioned.

There’s another reason clients may be sicker, said Dr. Mike Stone, president and clinical director of Cornerstone Southern California. Changes in health care over the years make it less likely that addicts will find a bed in a hospital. Instead, he said, they end up in treatment homes.

“The world has changed in 30 years,” Stone said.

Even given that the laws were written in a different time, critics say, the Department of Alcohol and Drug Programs is going too far in defining the term “non-medical” to mean no medical intervention whatsoever. In the early days of state licensing of treatment programs, the term was understood to mean care that did not take place in a hospital, said Robert Harris, a legislative policy adviser to the California Society of Addiction Medicine.

One of the disadvantages of the state’s interpretation is that clients who are already feeling unwell from detox and its aftermath must be taken to another location to see a doctor, critics say.

“Individuals who are ill and need to see a doctor have to have their treatment interrupted” even for something minor like a cold or slight fever, said Helyne Meshar, a lobbyist for the California Association of Alcohol and Drug Program Executives. It may mean waiting in a clinic

or emergency room for hours and the loss of a day of treatment, she said. It may involve taking clients to doctors whose reputations are unknown to the program. In addition, Stone points out, visits to emergency rooms and urgent care clinics are very expensive.

If residential programs took the state at its word and provided no medical detox, clients who needed it would be forced to go through withdrawal in a hospital, said James Bailey, executive director of The Camp Recovery Services in Scotts Valley. And patients who detox in a hospital unconnected to residential treatment are far less likely to go through the long and arduous recovery process, he said.

Meshar pointed out another pitfall – Medi-Cal will not accept billing from two different services for the same patient in the same day. So if a drug and alcohol client is taken to a clinic, either the clinic or the program might not get paid.

Critics point out what they see as the absurdities of the current system. The state, for instance, requires workers in treatment homes to be tested for TB. But because no medical care can be provided on-site, the workers can't be tested there, even if the program has a nurse on staff. So the program must contract with an outside party to do the TB tests. The same is true for medical clearances that clients must get before entering treatment. The state bars them from being done on-site, so the clients must go elsewhere.

The current system is rife with contradictions, Senella said. On the one hand, the state says that clients can go to an independent doctor and get the medications they need to go through detoxification at the program. But if the client needs those drugs, Senella said, it's by definition a "medical detox." Even so, staff members at programs that adhere to the state's insistence on only non-medical detox are not qualified to monitor the complications that can arise, he said.

"The only thing at their disposal is they can call 911," Senella said.

Lay people without medical training are more likely to make mistakes in the screening of potential clients, Stone said. Some of the cases of client deaths reviewed by our office involved programs admitting clients whose maladies were beyond their capabilities.

Under the current rules, the state draws the line at a program paying a doctor to provide medical care. Instead, the department says, a client must make his or her own financial arrangement directly with a doctor.

This presents another problem, Stone said. If a client runs out of money, even the most well-intentioned physician likely will stop providing care. But a doctor who is being paid by the program will continue to provide services.

Letting the program contract with a doctor also allows the program to fix its costs and make them predictable, Stone said.

Even as state prohibits medical care, insurers may require it

Drug and alcohol programs find themselves in a bind: While the state prohibits medical care, counties that contract with the program or insurers may encourage it, even require it.

Insurers consider medical treatment of alcohol and drug clients to be the standard of care, and reimburse a certain amount per month to cover the cost of a doctor, those in the industry say.

“Some of what they require probably puts us in violation of state regulations,” Bernstein said.

Camp Recovery’s contracts with insurers require clients to be seen by physicians, said Bailey, the executive director. The cost of medical services is rolled into the overall amount that the insurers reimburse for treatment. It would be impossible to break it out, and bill only for the non-medical portions, Bailey said.

A nationwide organization that accredits many California treatment centers – the Commission on Accreditation of Rehabilitation Facilities – likewise requires programs to have a medical director and nurses, he said.

The state’s stance can force operators to twist themselves into knots to comply with regulations, satisfy insurers and accrediting agencies and get clients the help they need. Bernstein recalled that an analyst from the Department of Alcohol and Drug Programs suggested he could adhere to state regulations by having a doctor park a car on the street outside the facility. Clients could see the physician in the car, the analyst said. Bernstein doubted that the agencies that refer clients to his program or the insurers that pay for their stays would have been happy with that arrangement.

There is a more subtle cost to the current state of affairs, critics say – the state’s rules force program operators to become sneaky.

“It forces people to do all this weird and wonderful stuff,” Stone said.

Some caution against overemphasis on medical solutions

Not all of those regulated by the Department of Alcohol and Drug Programs think that the system is badly broken or that medically assisted detox should become the norm.

Non-medical counseling is the heart and soul of treatment, said Peters, the adviser to the California Association of Addiction Recovery Resources.

The association’s “general philosophy is that this is not a medical situation,” Peters said.

Programs for years have taken clients to nearby doctors with little problem, he said.

But even the association supported a recent bill, AB 972, that would have allowed psychiatrists to do counseling and physicians to prescribe medications, perform physicals on incoming clients, and administer public health shots. The association’s main concern was that such services not become mandatory, he said.

Many in the industry agree that the department’s shifting interpretations of the standards and its lack of clear direction have resulted in widespread confusion.

Stone, the founder of Cornerstone of Southern California, said from the time the state starting licensing drug and alcohol homes in the late 1970s until about ten years ago, no one interpreted the law to prohibit medical care. That changed, he said, when the department became concerned that it might be held liable if it allowed medical care to occur in facilities.

“They decided to clamp down on any place that had any medical involvement at all,” he said.

Those who have been in the business for decades say the evidence of medical care had long been plentiful and in plain sight. What did state analysts think was happening at a program, for instance, when they came across examining tables? Harris, the adviser to the California Society of Addiction Medicine, recalls working in a Sacramento program years ago that incorporated medical detox into its treatment.

“It’s not like it’s something new,” he said.

Camp Recovery: confusing advice from the state

Confusion over the state's shifting definitions can be seen in its interactions with The Camp Recovery Center in Scotts Valley.

Since at least 2000, the program openly advertised on its website that it provided medical care and had a doctor on staff. In its routine bi-annual reviews, the state either failed to note that medical care was being offered or deemed it acceptable.

That changed in 2009, when the department cited the program for providing medical services. An investigation found that The Camp's doctor, although not a direct employee, was paid by the program through a contract, an arrangement at odds with the state's understanding of the law.

The program moved the office where the doctor saw clients to another location. Bailey, the executive director, said that during a routine inspection about a year later, the department found no problems. Then, in August 2011, a department investigator responding to a complaint interviewed clients and found, again, that the program was illegally providing medical care.

Bailey said that he and a lawyer for the program met with department officials in February 2012 to ask how to bring The Camp into compliance. The department showed them a plan from another program in which the physician was on contract and met clients at a location off-site. Bailey said he pointed out that his program was already doing that. The state finally approved, he said, when The Camp added a new procedure giving clients a choice between getting care from their own doctors or agreeing to use the program's physician. The Camp continued to pay its doctor through a contract, Bailey said.

But Bailey's description of what the department told him is at odds with what the department told our office – that clients must pay their physicians independently. The department says it has consistently told providers of this requirement.

In addition, Bailey said department analysts who do routine inspections have praised The Camp for its 24-hour nursing staff. The department told our office that nurses are legally prohibited from providing medical care at the programs it licenses.

Bailey said he regularly fields calls from other programs, including those owned by the same company, CRC Health Group, that have heard

contradictory information about what the state does and does not allow.

“There isn’t a single recovery center that I know that isn’t providing medical care,” he said. “All ADP is doing is making people dance around.”

State cited program for medical care, but never followed up

Jack Bernstein of Cri-Help in Los Angeles said that his program was fined by the state several years ago for providing medical care. He hired an attorney and the fines were forgiven, he said. Since then, he’s heard nothing from the department about the case.

He continues to do business the same way. Cri-Help has a doctor on contract for the program’s detox center, and a doctor and psychiatrist on contract for the residential part.

California is unusual among populous states in prohibiting medical care in residential drug and alcohol programs. Our office contacted nine other states and found that all but one of them allowed physicians and other medical professionals to work in such settings. Several, in fact, required the involvement of doctors in programs doing detoxification. Some employ medical professionals as surveyors, and said that while they would not second guess doctors who are overseen by their own licensing boards, they would cite a program if medical care was implicated in a bad outcome for a client.

	Illinois	Indiana	Massachusetts	New York	North Carolina	Ohio	Pennsylvania	Texas	Washington
Allows medical care in residential rehab?	Y	Y	N**	Y	Y	Y	Y	Y	Y
Requires medical professionals in detox?	N*	Y	Y	N	Y	Y	N***	N	N

* Medical directors required in residential programs
 ** Rehab homes refer clients to local doctors; nurses are available at homes
 *** Most programs employ nurses

“The idea that you can’t do a psychiatric assessment is really absurd,” he said.

Stone said the interpretation of the regulations keeps changing, depending on the director of the Department of Alcohol and Drug Programs, the legal counsel, and even the individual analyst who reviews his program. Some are guided by what he called “common sense,” recognizing that some degree of medical care may be necessary, especially in the early stages of treatment. Others are “sticklers” about the prohibition on medical care.

It doesn’t help, Harris said, that there’s been a high rate of turnover in the department since Proposition 36, which called for treatment instead of prison for some non-violent offenders, lost its funding.

The turnover has resulted in a loss of continuity, consistency and institutional memory, he said.

Attempts to overturn ban have failed

Three bills in the past three years would have changed California law to allow residential drug and alcohol programs to provide at least some medical services. All three died.

That leaves lawmakers, the administration, the industry and its clients facing a situation that many have described as untenable.

Several unresolved issues have blocked the approval of a bill that would open the door to medical care in residential settings. Among them:

- Does the state need to strengthen its laws and regulations to assure that medical care in residential programs is safe and effective?
- Do independent accrediting bodies like the Commission on Accreditation of Rehabilitation Facilities have a role to play in overseeing medical care?
- Considering that the Department of Alcohol and Drug Programs has been targeted for elimination on July 1, 2013, what department would be best suited to take over licensing of residential homes if they are permitted to provide medical care?
- Would allowing doctors to work for private companies run afoul of state law prohibitions against the corporate practice of medicine?

The three earlier attempts to pass legislation included Assembly Bill 1055 (Chesbro) in 2009, Assembly Bill 2221 (Beall) in 2010 and Assembly Bill 972 (Butler and Beall) in 2011. All three would have permitted some level of medical care at residential programs licensed by the Department of Alcohol and Drug Programs. The two more recent ones would have required programs that offer medical services to be accredited by nationally recognized organizations such as the Commission on Accreditation of Rehabilitation Facilities. AB 2221 limited medical services to those within the scope of an addiction medicine specialist. AB 972 specified the types of services that could be provided, including physicals, psychiatric evaluations, the prescriptions of medications for detox and other health conditions, blood work and public health inoculations.

The Department of Public Health opposed AB 2221. Its position was that allowing medical services in treatment homes would make them clinics, subject to Public Health's regulation.

Harris, the adviser to the California Society of Addiction Medicine, said the industry doesn't care too much which department takes over. The main concern is that programs are not treated like chemical dependency recovery hospitals, which are licensed by the Department of Public Health and must adhere to extensive standards similar to those applied to other types of hospitals.

One possibility is dual licensing, with the portion of the program that delivers medical care regulated as a clinic by the Department of Public Health and the treatment program itself handled by the Department of Alcohol and Drug Programs or the entity that inherits its current licensing responsibilities. But some, such as Dilkes of CRC Health Group, worry that such an arrangement would be very expensive for programs, whose fees cover the cost of licensing.

Peters, the adviser to the California Association of Addiction Recovery Resources, said if programs want to do real medicine, they should create separate units overseen by Public Health and be required to show that they are competent.

The department that takes over licensing of an industry that employed medical professionals would need to have investigators capable of evaluating whether improper medical care played a role in bad outcomes for clients.

State may need to beef up regulations

Is it enough to simply strike the statute limiting programs to providing “non-medical” care? Or does the Legislature need to add other provisions, or the licensing department promulgate regulations, to assure that the medical care taking place in residential settings is serving clients well?

“The state needs to put some teeth in its regulations if they’re going to allow it to occur,” Senella said. As it is, Senella said, the state doesn’t have any regulations to hold programs accountable for medical care provided in residential settings, since it’s against the law. The state should check the credentials of medical professionals, for instance, and assure that clients get a physical exam within a set time. Some of the regulations could be copied from Department of Public Health requirements for hospitals, Senella said. But hospitals provide a much higher level of care, so regulators should not apply all of the rules to treatment houses, he said.

Sack, the CEO of Promises, said that the state could check the credentials of medical professionals, make sure they have malpractice insurance, check references, and require medical professionals and their licensing boards to notify the department if there’s a change in license status.

One measure that could help, Stone said, would be to require that doctors affiliated with programs are certified in addiction medicine.

The main concern of the California Association of Addiction Recovery Resources is that the state not mandate that programs hire medical professionals, as some other states do. Many of the non-profits represented by the association are operating on tight budgets and might be forced to shut down if they had to pay doctors and nurses, Peters said. The only residential programs left would cater to rich clients who could afford monthly fees of tens of thousands of dollars, he said.

Could accrediting agencies do part of the job?

Some in the industry don’t think that allowing medical care would require much if any change in the status quo. The job of making sure that programs are properly serving clients, they say, can be entrusted to national accrediting agencies, such as the Joint Commission and CARF, the Commission on Accreditation of Rehabilitation Facilities. The failed bills included provisions that programs offering medical care get this type of accreditation.

But in one case in Tennessee, the accrediting agency issued a positive report about a program that was found by state regulators to be riddled with problems.

The accrediting agencies provide thorough oversight and are already accrediting programs, such as methadone centers, that offer medical services, Dilkes said. In addition, he said, professional licensing bodies such as the Medical Board of California discipline wayward practitioners.

Many California programs that want to be accredited prefer CARF instead of the Joint Commission, Senella said, because CARF is less expensive. The Arizona-based CARF was founded in 1966 to be an independent, nonprofit accreditor of human service providers.

The organization's standards are constantly evolving to keep up with industry practices, said Darren Lehrfeld, CARF's chief accreditation officer and general counsel. A survey consists of 800 to 1,000 ratable elements, he said.

CARF's accreditation is good for three years. In addition, the organization responds to consumer complaints, Lehrfeld said. CARF assesses whether the complaint is related to one of its standards, as well as taking into account its credibility and the history of the program. CARF may suspend the program's accreditation, revoke it, impose requirements, or change the frequency of surveys. CARF is fully funded by the fees programs pay to be accredited.

But is CARF sufficiently rigorous?

In the Tennessee case, the thoroughness of CARF's inspections was called into question. In 2011, *The Tennessean*, the daily newspaper in Nashville, reported that CARF had given a "glowing review" to a troubled drug and alcohol program later sanctioned by the state.

In July 2010, a young man in New Life Lodge's detox program stopped breathing and was rushed to the hospital, where he died, the newspaper reported. A month later, the program tried to transport a young woman with pneumonia to a hospital 30 miles away, instead of a much closer one. She stopped breathing en route and died.

Several months later, a summary of CARF's survey for a three-year accreditation made no mention of the deaths but praised the program for "tremendous improvements," *The Tennessean* wrote, including strong communication by leadership and satisfied patients. Later in 2011, the Tennessee department that licensed the facility found that it failed to "consistently provide appropriate medical services and testing." CARF at some point suspended its accreditation but refused to tell the newspaper whether it had done so because of its own inspections or as a result of the actions of two state departments.

Our office requested a CARF survey summary for A Better Tomorrow, the program where four deaths occurred over two-and-a-half years. CARF gave the program – including its outpatient clinic, detox homes and residential treatment homes - a three-year accreditation in February 2012. The survey found that, in 11 of 13 areas, A Better Tomorrow did a better job of meeting CARF standards than the average for similar programs. In the category of health and safety, for instance, A Better Tomorrow met 100 percent of CARF standards, compared to 94.4 percent for the industry as a whole.

Clients in A Better Tomorrow’s detox program “reside in homes that are stately, spacious, decorated with lovely furnishings and appliances, and well landscaped, and provide a very comfortable, homey environment,” the survey summary stated.

CARF found fault with the program in a few areas, including financial management and getting input from clients. But on balance, the survey concluded, A Better Tomorrow was a leader in its field, with leadership and staff committed to “achieving and maintaining the CARF standards and a level of excellence of service delivery.”

Lehrfeld said he could not comment further on the survey reports for New Life Lodge or A Better Tomorrow because they are the property of the programs.

But in general, he said, the CARF surveys represent a snapshot in time. While they may consider the track record of a program, they are more focused on what’s happening now. If a program had problems in the past, CARF wants to see that it is taking steps to remedy them. In that sense, CARF’s approach is different than that of a state regulatory body responsible for sanctioning past actions.

“CARF is not a substitute for government oversight,” Lehrfeld said. “It’s a tool government can use in its oversight.”

Harris said if CARF were to be given some share of responsibility for overseeing California detox facilities, the state would have to assure that someone did immediate investigations of complaints.

“You need a complaint process that’s more than just once every two or three years,” Harris said.

Dilkes said there’s another way that programs could be held accountable: approval by insurers. If the state created a requirement that programs

obtain third-party insurance, he said, the insurers would assure that the programs were run well.

Senella is skeptical. It may be true that insurers will stop referring to providers that generate a lot of complaints or fail to respond to the concerns of the insurer's case managers. "But it's not the gold seal you would think it is," he said.

Can corporations legally employ doctors?

Another question is whether allowing treatment facilities to offer medical services would violate the state's prohibition against the corporate practice of medicine. The Department of Alcohol and Drug Programs says that one reason it forbids programs paying medical professionals is that such arrangements run afoul of that statute.

The current law is understood to prohibit "corporations or other entities that are not controlled by physicians from practicing medicine, to ensure that lay persons are not controlling or influencing the professional judgment and practice of medicine by physicians," according to the Medical Board of California.

But what if the doctors contract with the facilities rather than working directly for them?

The Medical Board wrote in response to a question from our office that such arrangements may be acceptable if the doctor is on contract, not employed directly. The contract should specify that the program cannot control or interfere with the doctor and that the doctor retains the ability to make decisions. It should also make it clear that the doctor is paid a flat fee or by the hour, not for the types or amount of services provided.

Recommendations

The Department of Alcohol and Drug Programs is slated for elimination on July 1, 2013, with its duties, including the licensing and certification of residential treatment programs, assigned to other departments. Although the department has made significant improvements in the past two years in its oversight of programs, it's important that these changes be adopted and formalized by whatever department inherits these duties.

With this in mind, we make the following recommendations:

- The Legislature should consider approving a bill allowing medical care in residential facilities. Many experts believe that medical care is an integral part of successful treatment. However, it would not be enough to simply lift the ban on medical care. Legislation should also address what other steps must be taken to assure that the delivery of medical care is serving clients well. A simple example would be a requirement for the licensing department to check the credentials and malpractice insurance of medical professionals affiliated with programs.
- The Legislature should consider requiring programs that offer medical detoxification to retain a medical director. Those that offered only non-medical detox, or no detox at all, would not be subject to the requirement. Such a requirement would be consistent with the practice of several other populous states.
- The licensing department may want to consider higher fees for programs that offer detoxification to cover the costs of greater oversight.
- The Legislature should consider a bill to establish death investigation requirements for the department that oversees residential treatment. The template could be the Department of Alcohol and Drug Program's recent death investigation policy (if that is found to be effective.) Legislation is needed so that the department that takes on oversight of treatment homes does not return to a legacy of delayed, inadequate death investigations.

- The Legislature should consider a bill to mandate follow-ups of Class A deficiencies in residential programs if the problem involves a routine procedure that cannot be immediately shown to have been corrected. If a program has admitted clients too ill for its capabilities, for instance, the department that oversees residential treatment should make periodic follow-up visits. The bill could include a provision requiring the program to pay for these follow-up inspections. Experience has shown that requiring programs to submit amended action plans is not sufficient to stop practices that pose an imminent danger to clients.
- The department that takes over regulation of residential programs should establish clear and consistent guidelines defining when it will suspend a program's license immediately because of imminent danger to clients. While the Department of Alcohol and Drug Programs already has such authority, its use has been inconsistent, with some programs allowed to continue operating despite serious problems.
- The department that takes over residential licensing should also establish a formal procedure for sharing information with boards that license medical professionals. Although the state now prohibits medical care in residential settings, it is widespread. Cases against medical professionals by their licensing boards can take years. Yet the practices alleged by these boards may pose an immediate danger to clients in residential treatment. The Department of Alcohol and Drug Programs says it shares information with professional licensing boards, but cooperation and sharing of information appears to have been spotty.

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