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File No. 09977.00000

11 September 2018

House Judiciary Committee
Subcommittee on Constitution & Civil Justice

Re: Testimony about "Sober Living Homes"

Dear Chair and Members of the Committee:

Thank you for your interest in the legal and policy aspects of "sober-living homes." I welcome the opportunity to provide testimony on this pressing issue.

My Perspective

I am an attorney with the law firm of Best Best & Krieger LLP, a California-based municipal law firm that advises cities and other public agencies across the country on a variety of issues, including questions about "sober-living homes."

To be clear though, the ideas and opinions expressed in this testimony are my own.

What is a "sober-living home"?

There is no precise legal definition of "sober-living home." Really, the term is used to describe a wide range of residential-recovery uses.

In its purest sense, a sober-living home is a resident-run household composed of people in recovery who choose to live together as roommates, i.e., as a single-"family" residential use. The household members choose each other as roommates. Together, they decide who joins the household. They share responsibility for household expenses and chores. They contract for the housing collectively by buying

or, more often, renting the property together. And they have resident-created house rules for sobriety and conduct. The members of the household support each other independently of any third-party house-manager or service provider. They might, and usually do, each participate in an on-going 12-step program or other outpatient recovery-support program, and they might even decide collectively that, as a rule of the house, they all commit to and hold each other accountable for continuing to attend their off-site recovery meetings. But no care or supervision of any kind is provided on-site by any third party.

This "pure" form of sober-living home is relatively rare. More commonly, a third party operates the home. The operator contracts with individual residents and provides them with housing and with care and services to support them in their on-going recovery. Some operators allow residents more autonomy and control. For example, one common model was developed in which residents decided by a majority vote whether to admit a new member to the household, and residents were required by the operator to work and pay rent (individually), as well as to follow other house rules. The third-party operator enforced the rules and removed residents for misconduct; the operator proposed new members of the household (subject to resident approval); the operator collected rent from each resident individually; the operator provided basic care and supervision to residents; and the operator provided referrals and transportation to additional recovery support services off-site. These "sober-living homes" are not purely resident-run. They don't operate strictly as residential homes or households. But the operator allows a substantial amount of autonomy on the part of the residents that it places there. This is rather a hybrid sober-living model.

But by far the most common form of "sober-living home" is the for-profit business-run residential facility in which the operator alone determines who will join the household (residents don't have a say); the operator dictates house rules; the operator contracts with each resident, or with another person or company on behalf of each resident, for their housing, care, and supervision; and the operator largely dictates the residents' diet, schedule, and activities. In nearly every case, the operator controls access to residents' medication and supervises their self-administration, if the operator doesn't actually administer the medications

themselves. In nearly every case, operators set or monitor recovery goals, and they often subject residents to drug testing, gathering samples as the house. They provide extensive care and supervision to satisfy varying standards imposed by public and private insurers who pay for residents to be there and cared for.

This last type of "sober-living home" is big business. Operators commonly get several thousands of dollars a month for each resident. Six residents is a common number, but that's at the low end. Many operators push for 10 or 12 residents. They tend to be housed two to a room, at a minimum, often with more. The overhead is largely the same as head count rises. But the revenue is much, much higher.

Unless a "sober-living home" is truly resident-run and there is no care or supervision provided there, many states regulate it as a residential treatment facility or group home, usually requiring a license.

Since true resident-run sober-living homes are rare, I will use the term "residential-recovery facility" or "recovery facility" to refer to any third-party operated home for people in recovery.

The Need for Residential Recovery

I grew up in the 70s. For nearly my entire life, America has been waging a "war on drugs." Drug-related incarcerations skyrocketed when I was a boy. Alcoholism and drug abuse took their toll on all classes of people.

Even today, nearly every one of us has someone close to us — family or friend — who is either in the grip of or struggling to recover from drug or alcohol addiction. No American is entirely immune from this issue. No community is free of it.

As parents, families, communities, and a country, we are trying our best to help people recover. And we're learning.

Before the 1970s, care for recovering addicts was primarily provided in institutional medical settings. In this medical model, people were sent to hospitals

to dry out and get clean. Many people ended up in these institutional settings even though, with just basic care, they could function well in our community. That fact gave rise to an alternative, nonmedical social-model of care.

At the heart of the social model is this: People in recovery are often more successful in staying in recovery after completing a detox program if they have a chance to transition back into the broader community by spending a time living with other recovering addicts in a mutually supportive environment, in a situation that approximates that of a typical residential household in a residential setting that gives the residents opportunities to interact regularly with neighbors. In short, the goal is to allow patients to learn or re-learn how to be neighbors — but for that to work, they have to be in a neighborhood that is actually residential.

The Importance of a Residential Neighborhood

Residential neighborhoods are vital assets to the health and well-being of communities. They are home to local parks, schools, houses of worship, and neighborhood watch groups. Residential neighborhoods have a rhythm — mail is delivered every day, except Sunday; trash is picked up weekly; children go to school in the morning and return in the afternoon; things quiet down by 10 pm. These routines are built around people living together in a shared household, with neighboring households sharing values such as nighttime quiet and safe and clean streets. These neighborhoods provide residents with a place to belong and live their lives, to interact with neighbors and be mutually trusted and accountable.

These benefits accrue to everyone in a residential neighborhood — including and especially to people in recovery.

For them to get these benefits, people in recovery need to live in a setting that (1) closely approximates a residential household, both in scale and function; (2) they need to be surrounded by neighborhood residents, with whom they have opportunities to interact in normal, neighborly ways; and (3) of course, facilities need to be run responsibly.

Conflicting Interests

The best residential-recovery operators are motivated above all else by a desire to support their recovering residents by providing them with a truly residential recovery experience. They keep the facilities small. They locate their facilities away from other facilities and non-residential uses to ensure that residents have ample opportunities to interact with other people in the neighborhood. They ensure that facilities are well-staffed by trained, qualified house managers and counselors (when they're needed), and they make the investments that are required to ensure the safety and well-being of those who live there.

Unfortunately, not all operators take this approach. Many are drawn by the potential to make money — sometimes vast sums of money — off of taxpayers and private insurers. Profit-motivated operators too often stack recovering residents into a home to increase the bed-count. For these operators, six is good money, but eight, 10, 12, or even 14 is much more profitable. Meanwhile, the residents are literally stacked on bunk beds, sharing small residential bathrooms, crowding into kitchens, and find themselves corralled like cattle. They bide their time, if they don't get frustrated first. They don't benefit from a typical "family"-household experience. It's more like a prolonged, extended family reunion that came to roost in one relatively small home. It doesn't feel residential to the residents. It feels like an overcrowded hotel, shoehorned into what might have been an otherwise residential neighborhood.

Except that these same grow-the-bed-count operators also frequently try to concentrate recovery facilities next to each other as well. Adjacent facilities might share staff and amenities, reducing costs for the operator. Soon it becomes a recovery-dominated cul-de-sac or campus. As long-term residential households are displaced by recovery facilities, recovery operators enjoy better economies of scale, but recovering residents are left wondering where the neighbors went. They don't get the benefit of interacting with long-term residents. Ironically, they find themselves institutionalized in a recovery-only setting of the operator's making.

It bears repeating that people in recovery need residential-recovery facilities that are (1) small, (2) spread out, and (3) well-run.

The social model does not work when recovering addicts live in large, institutionally sized industrial dorms. Nor does it work when the facility is surrounded by other recovery facilities, effectively stuck in a recovery cul-de-sac or campus.

When operators increase occupancy, concentrate facilities together, and cut corners to make more money, they do so at the expense of recovering residents.

If left unchecked by government regulation, the promise of higher profits is too strong for too many operators, and recovering residents will continue to suffer from the institutionalization and overconcentration of the facilities in which they reside.

Boots on the Ground

Government needs to regulate the size, location, and operation of residential-recovery facilities. It can only be done with a boots-on-the-ground presence, because residential-recovery facilities are inherently lcoal, scattered throughout the local residential fabric of America's cities and towns. The federal government can't do it directly, without creating and funding a veritable army of analysts, inspectors, and enforcers. Even with more hearings and sizable budgets, it wouldn't be enough to evaluate each proposed facility in light of the particular circumstances and decide how big is too big, how close is too close, and what operational standards are appropriate.

State governments, while closer to the people, are similarly constrained by distance and centralized authority and resources. They, too, lack the proximity, local knowledge, and resources to consider each case, much less to respond to particular problems at each facility as needed.

Local government is in the best position to appropriately regulate residential-recovery facilities both in their establishment and in their on-going operation.

Through their well-established zoning power, cities are in the best position to ensure that recovery facilities remain small and spread out, to allow their residents to have a truly residential experience. Through their regulation of businesses, cities are in the best position to impose reasonable operating standards and to see that operators comply with them. Cities are close to the people. They have boots on the ground. They can learn about and respond to problems at irresponsibly run facilities much faster than state or federal investigators can.

Local governments want to help residential recovery work and work well; they want to help keep it truly residential; and they're ready to do it, but they just need Congress to clear the way.

The Federal Problem

The biggest impediment to local regulation for the protection of people in recovery is the threat of a discrimination claim under federal law.

The Federal Fair Housing Act Amendments of 1988 amended the Civil Right Act of 1968 to, among other things ensure that people with a disability have equal opportunity to use and enjoy a dwelling of their choice. The need for this was obvious. No one should be denied the chance to rent an apartment or buy a home because he or she is wheel-chair bound or blind — or in recovery. Nor should anyone be denied because a member of their household is disabled.

In the years that have followed the enactment of the FHAA, courts have been called on to consider a variety of situations, including some where a business that caters to people with a particular disability seeks to shield itself from local business and land-use regulation because the facility serves disabled persons.

Early cases dealt with business-run group homes for Alzheimer's patients. Courts found that the patients were not capable of taking care of themselves and using and enjoying a dwelling of their choice on their own; that they needed care and supervision; and that the only real option they had to get that care and supervision outside of an institutional medical setting was through a business,

operating what amounted to a boarding house and care facility in a residential neighborhood. Therefore, the business had to be allowed under the FHAA.

Other cases involved businesses that focused on serving people with other disabilities, such as mentally illness and addiction recovery. Courts haven't always agreed on how the FHAA applies to those situations. Sometimes courts have taken a hard look at the kind and degree of care and supervision that the business provides and whether and how necessary that care might be for disabled persons to use and enjoy a dwelling. Other times, courts seem to take the Alzheimer's decisions as mandating a free pass from local zoning and business regulation if a business serves disabled people, regardless of the nature and extent of their disability.

Without wading into and dissecting the development of case law in this arena, I mention it to explain the risk for cities that want to regulate recovery businesses to better protect the people in recovery that submit to the care and supervision of those businesses.

The FHAA does not specifically address residential-recovery facilities. It does not spell out whether and how a city may appropriately regulate the size, location, and operation of these businesses for the good of the vulnerable population that they serve. Operators tend to make broad claims, based on federal protections for the disabled. HUD and DOJ often adopt aggressive interpretations of these federal protections, too. And Circuit courts do not always agree. Cities need the ability to appropriately regulate recovery businesses — not regulate them out of existence, but regulate them to ensure that their disabled customers or clients get the full benefit of truly residential recovery. Small. Spread out. And well-run. Each of these is vital to the social model of recovery, but the latter is particularly important.

Small and Spread Out Preserve Residential Character, But Well-run Preserves Lives.

Local governments are not now doing all that they could do, all that they are in a position to do, to help people in recovery — they want to, but because of the ambiguity of the law today and the risk that creates for them, they bite their

tongues and sit on their hands too often as recovery facilities grow large and proliferate in concentrated pockets in what used to be residential neighborhoods. The institutionalization of the social model of care is bad enough, but inadequate local regulation has much more dire consequences.

Without local regulation to ensure that recovery facilities are responsibly run, more people will relapse in the very facilities that are supposed to help them. More residents will be trafficked, abused, and raped. More will overdose, and more will die, because all of these things are happening in recovery facilities in communities in every congressional district in our nation right now.

When operators evade local regulation, terrible abuses often follow. A small sampling of articles describing some of these abuses is attached with this document. Examples include operators selling drugs to residents, house managers trading drugs to residents for sex, sexual assault, and resident and house-manager overdoses.

Next Steps

Congress needs to confirm that local government may reasonably regulate recovery businesses to protect people in recovery.

Please, make it plain that permissible regulation includes

1. maximum-occupancy limits — so that residents get the benefit of living somewhere that's comparable to a typical residential household;

2. minimum separation requirements — so that residents get the benefit of living in an actual residential neighborhood, not in a recovery cul-de-sac or campus, and can have meaningful, normal interactions with neighbors; and

3. minimum operational standards — so that those who care for recovering residents are qualified and accountable and facilities are safe and well-run.

The Safe Recovery and Community Empowerment Act, H.R. 472, would go a long way toward doing exactly that. Please do all that you can to move it forward.

Also, consider defining “current, illegal use of a controlled substance” using objective criteria, such as “any illegal use of a controlled substance within the last 90 days” or “since successfully completing an in-patient drug detoxification or treatment program.” Or whatever else might be objectively applied. The current definition is too ephemeral to be usable. “Reasonably recent past” (as proposed in H.R. 472) just leaves question for the courts about what “reasonably recent” means.

Thank you for the opportunity to provide testimony to the committee. Please feel free to contact me if I can be of further assistance to you.

Kind regards,

Todd R. Leishman
for BEST BEST & KRIEGER LLP

Attachment: Articles Describing Abuses at Inadequately Regulated Residential-recovery Facilities

Attachment

Articles
Describing Abuses at
Inadequately Regulated
Residential-recovery
Facilities

99+ LIVE

Man accused of dealing drugs out of rehab center he operates

Updated: Nov 13, 2017 - 7:40 PM

Neighbors say David Francis did a lot of good work in their community, but today he was formally arraigned on charges that he dealt heroin out of the rehab center he ran for recovering addicts.

People in McKees Rocks know the name "David Francis." Everyone knew the rehab center Francis ran on the main drag in town and the tax preparation business he had next door.

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- Three medical helicopters called to scene of crash
- Tractor-trailer driver admits to using heroin, marijuana before crash
- Fire chief caught having sex with teenager in car suspended indefinitely
- VIDEO: Texas church reopens as memorial

Last month, the feds raided the rehab center and Francis's home, charging him with intent to distribute heroin.

"I didn't know he was doing that, I was shocked to see that on the news," said neighbor Edward Smith.

DEA agents say Francis was dealing heroin in the rehab center and that he kept heroin and fentanyl at his home on Chartiers Avenue. The feds say addicts shot up behind the house.

"The original allegations consisted of him and fentanyl but we are heartened to learn -- and this is our position from the start -- that Mr. Francis never had any dealings with any fentanyl," said Casey Smith, Francis's attorney.

Francis was a drug counselor and a recovering heroin addict himself. The feds say he was responsible for a spike in overdoses in McKees Rocks.

Roxbury Sober Home Operator Charged With Giving Drugs to Recovering Substance Abusers for Sex

By Marc Fortier

Published at 12:26 PM EDT on May 10, 2018 | Updated at 6:46 PM EDT on May 10, 2018

David Perry, a lawyer who runs a sober home in Boston's Roxbury neighborhood, is accused of giving drugs to recovering substance abusers in exchange for sex.

(Published Thursday, May 10, 2018)

The owner of a sober home in Boston was indicted this month for allegedly giving drugs to recovering substance abusers in exchange for sex.

David Perry, 57, of Reading, was indicted on May 4 on 34 charges, including evidence tampering, conspiracy to distribute illegal drugs, possession of illegal drugs and sex for a fee. He had previously been indicted in February on charges of fentanyl distribution and conspiracy to distribute illegal drugs.

He pleaded not guilty at his arraignment Wednesday in Suffolk Superior Court. Bail was set at $10,000, with the conditions that he be monitored by GPS and subject to home confinement.

Perry is the owner and operator of Recovery Education Services Inc., a nonprofit organization that runs a residential facility for men in recovery from alcohol and drug addiction in Roxbury.

Dulles Airport Debuts Facial Recognition Technology

Dulles International Airport has implemented facial recognition software for international travelers; the system will be used to identify visa holders as they leave the country. Passengers have their pictures taken before boarding, and those photos are compared to their visa photos.

(Published Thursday, Sept. 6, 2018)

The Massachusetts Attorney General's Office said Perry, who is a lawyer, was distributing drugs to men seeking help for their addictions at his sober home. The sexual activity occurred in Perry's personal room at the facility and at his home in Reading. He was also distributing drugs to his legal clients who were substance abusers.

The attorney general's office also alleges that Perry falsified letters he sent to various probation departments on behalf of numerous individuals, including clients and people living at his sober house. In the letters, he falsely stated that the individuals had been tested for drugs and those tests came back clean.

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LOCAL NEWS

113 COMMENTS

Orange County Register

July 30, 2018 at 9:23 am

LOS ANGELES — A self-dubbed “Rehab Mogul” who operated more than 13 drug treatment centers in Southern California was convicted Monday of rape and drug dealing.

In all, Christopher Bathum, 56, was found guilty of 31 criminal counts. A Los Angeles jury also found him not guilty on 12 similar counts and deadlocked on three others.

Before he was arrested in 2016, Bathum owned and operated 13 “Community Recovery” treatment centers in Los Angeles and Orange counties, as well as six in the state of Colorado. He faces a maximum sentence of 65 years in state prison for the sex conviction and lifetime registration as a sex offender.

Los Angeles County Deputy District Attorney Reinhold Mueller said Bathum preyed on especially vulnerable addicts who were at the lowest point of their life.

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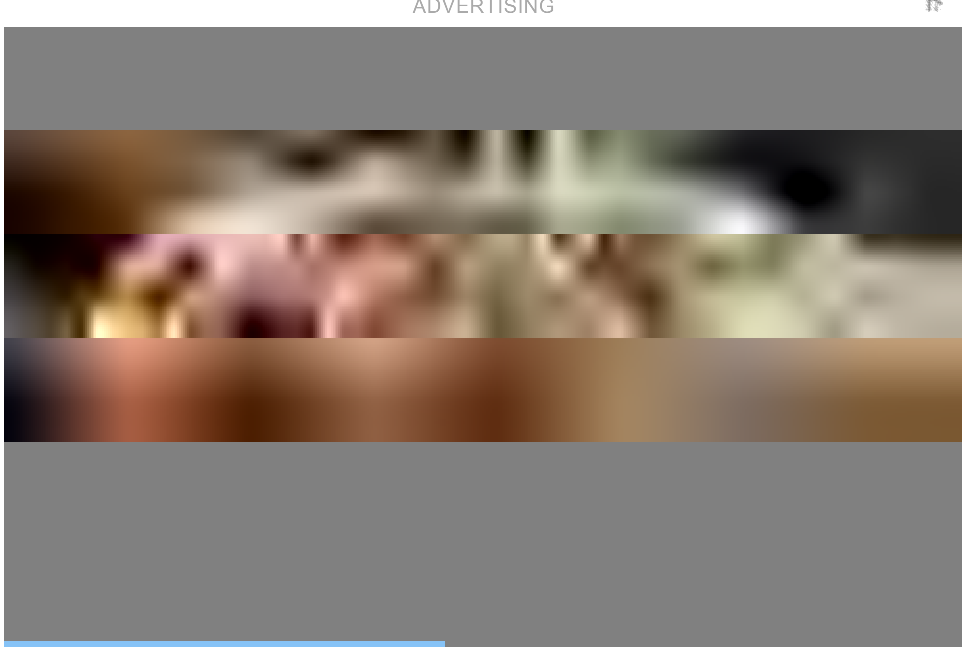

“They were easy targets,” Mueller said in his closing argument. “They were perfect victims.”

Bathum came to the industry with a criminal background and with no education in health care. An investigation by the Southern California News Group found his situation isn’t unique, and that the drug and alcohol rehab industry is rife with fraud and abuse.

Southern California, with more than 1,100 centers, is a hub of the industry, nationally, and is known in some circles as “Rehab Riviera.”

Though insurance companies have filed suit against rehab operators and claimed hundreds of millions of dollars in losses, and federal authorities are investigating the industry, the number one consumer complaint against rehab centers is related to sexual assault.

Since 2015, state regulators have investigated and closed 78 complaints of alleged sexual misconduct at rehabs, according to the Department of Health Care Services, the state agency that now oversees the recovery industry.

Additionally, the news group found that nearly 75 statewide complaints of sexual harassment, sexual assault and inappropriate counselor-client relationships were made to the California agency that regulated addiction treatment centers between 2009 and 2013, before Health Care Services took over regulation.

Despite the complaints, no background checks are done on would-be employees at rehab treatment centers to look for criminal pasts.

As the first verdict was read against Bathum on Monday — guilty for forcible rape — a woman in the first row of the courtroom clapped loudly and began sobbing. She was consoled by friends as the clerk read the rest of the verdicts.

Bathum was also convicted of one count of rape by force of fear, two counts of forcible oral copulation and two counts of sexual penetration by a foreign object — all involving the same victim — as well as 12 counts of sexual exploitation and 13 counts of offering controlled substances to clients, including methamphetamine and heroin.

The five-man, six-woman jury found that Bathum sexually exploited multiple victims, clearing the way for an enhanced sentence.

Jurors acquitted Bathum of 11 counts of sexual exploitation and one count of offering a controlled substance, methamphetamine. They deadlocked on one count of rape by use of drugs and two counts of sexual penetration by a foreign object.

Los Angeles Superior Court Judge Charlaine F. Olmedo ordered Bathum to return to court on April 17 to set a date for sentencing.

Bathum — who offered enthusiastic rebuttals to local media when asked about charges of exploitation — gave his patients drugs even as they were trying to quit their addictions, the prosecutor said. He used drugs with some patients, and taught them how to beat drug tests.

Bathum also used his position as a counselor, and his victims' addictions, to portray himself as a father figure to women in their 20s and 30s. Mueller said Bathum also offered some special privileges, such as internships, company cars and access to iPhones, in return for sex.

Bathum's attorney, Carlo A. Spiga, told the jury that the rehab centers did a lot of good and credited his client. Spiga downplayed the assaults, telling jurors in his opening statement that the "evidence is not going to show that any of these acts were forcible."

The defense attorney said he would leave it to the jurors to judge the credibility of the women testifying against Bathum, but also offered comments like, “She knew what she was doing at all times” and “How many of them were hitting him up for money?”

In his closing argument, Spiga said he was “not just passively going to sit here … and accept this character attack on Mr. Bathum.”

Bathum remains in custody. He is scheduled to appear in court Tuesday for a pretrial hearing on a separate case, this one alleging money laundering, grand theft, identity theft and insurance fraud. Prosecutors say Bathum and his companies submitted $175 million in fake claims, keeping patients in a never-ending cycle of treatment and addiction.

The news group investigation found that such cases aren’t rare though, if true, the numbers involved in the charges against Bathum could make it exceptional.

State Insurance Commissioner Dave Jones has called that case, in which Bathum is charged alongside his 44-year-old chief financial officer, Kirsten Wallace, “one of the largest health insurance fraud cases in California.”

About $44 million was paid out by five insurance companies, including Anthem Blue Cross, Blue sheild, Cigna, Health Net and Humana, before the fraud was uncovered prosecutors said.

Bathum is being held in lieu of more than $11 million bail.

City News Service contributed to this report.

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Morning Mix

Drug rehab ‘mogul’ convicted of sexually assaulting 7 female patients at treatment centers

By Samantha Schmidt
February 27

Christopher Bathum built an empire in California’s lucrative addiction treatment industry despite the fact that he held no license in drug counseling and no college degree.

The self-described “Rehab Mogul” founded what was once known as Community Recovery Los Angeles, a chain of about 20 facilities in Southern California and Colorado for patients battling alcoholism and drug addiction. At some of Bathum’s luxurious sober-living houses, patients had access to private chefs, a pool, yoga, excursions and a wide array of therapy options.

Bathum presented himself as a trusted confidant and mentor to his patients — particularly to young, broken women wrestling with addiction. He made vulnerable young women feel special, showering them with “internships” and access to company cars and iPhones, prosecutors said in court, according to the Orange County Register.

But he also used their weaknesses — the addictions he was supposed to help them overcome — to lure the women with drugs, get them high, and then sexually assault them.

On Monday, Bathum was convicted of sexually assaulting seven women, according to the Los Angeles County District Attorney’s Office. The 56-year-old was found guilty of 31 counts, including rape, sexual penetration by foreign object, forcible oral copulation and sexual exploitation.

Prosecutors said Bathum preyed upon the female patients who were in their 20s and early 30s between 2014 and 2016. Several of the assaults took place at his treatment facilities, prosecutors said.

“They were easy targets,” Los Angeles County Deputy District Attorney Reinhold Mueller said in his closing arguments, according to the Orange County Register. “They were perfect victims.”

Bathum now faces up to 65 years in state prison when he is sentenced in April. He was acquitted Monday of several counts of sexual exploitation and one count of offering a controlled

substance, methamphetamine. The jury was hung on one count of rape by use of drugs and two counts of sexual penetration by a foreign object.

In recent years, Bathum has repeatedly denied all allegations of sexual misconduct to local and national news outlets. His attorney, Carlo A. Spiga, told the jury that the evidence did not show that “any of these acts were forcible,” according to the Orange County Register. He credited Bathum with helping scores of people at his treatment centers.

Bathum’s case is part of a wider pattern of sexual misconduct at rehab centers, according to state statistics cited by the Southern California News Group. The No. 1 complaint from clients involving the rehab industry is sexual misconduct, according to a 2013 investigation by the California Senate Office of Oversight and Outcomes. Since 2015, state regulators have investigated and closed 78 complaints of alleged sexual misconduct at rehab centers, according to the Department of Health Care Services, the Southern California News Group reported.

Bathum faces additional charges in a separate case accusing him of running a $175 million fraudulent health-care billing scheme to lure addicts to his treatment centers, according to prosecutors. Bathum and his former chief financial officer, Kirsten Wallace, were each charged in November 2016 with 31 counts of money laundering, eight counts of grand theft, six counts of identity theft and five counts of insurance fraud. Both pleaded not guilty.

State Insurance Commissioner Dave Jones described the scheme as “one of the largest health-insurance fraud cases in California.”

“Bathum and Wallace’s alleged conspiracy victimized hundreds of people addicted to drugs and alcohol by keeping them in a never-ending cycle of treatment, addiction, and fraud — all the while lining their pockets with millions of dollars from allegedly fraudulent insurance claims,” Jones said.

Bathum and Wallace allegedly stole patient identification information to obtain health insurance policies in their names without them knowing, according to a California Department of Insurance investigation. Bathum continued to bill insurance companies even after the patients completed their treatment.

About $44 million was paid out by five insurance companies, prosecutors said.

Through these alleged treatment marketing schemes, Bathum managed to earn a fortune. In 2015, the company earned nearly $30 million in annual revenue with a profit of 30 percent, Bathum told ABC for a “20/20” investigation last year. A 90-day stay at one of his residential treatment centers typically cost about $40,000.

"I'm not complaining" Bathum told ABC. At the time, he was living with his wife and four children in $3 million home in Santa Monica, Calif.

Bathum first surfaced in headlines in a lengthy December 2015 cover story in LA Weekly, amid investigations by major California insurance companies as well as the FBI, Los Angeles Police Department, Los Angeles County District Attorney and California Department of Health Care Services. The LA Weekly story described him as an "enigmatic, wild-haired" mogul who built the prosperous Community Recovery Los Angeles chain in only three years. Though he stepped down as CEO earlier in 2015, he remained "firmly in charge," according to LA Weekly.

Bathum, LA Weekly reported, previously ran a pool cleaning business, and is certified to practice hypnotherapy. In 2002, he pleaded guilty to four federal felony counts of mail and wire fraud for selling computers and exercise equipment on eBay that he never delivered. He was sentenced to six months of house arrest and ordered to pay $29,733.

Then, in spring 2016, lawsuits filed by former clients and employees accused Bathum of engaging in insurance fraud and sexually abusing his patients. Former employee Roseann Stahl claimed she was wrongfully fired after she discovered Bathum was taking drugs and having sex with clients, according to a lawsuit cited by Courthouse News Service.

Former clients Stephanie Nicole Johnston and Jennifer Irick also sued Bathum, saying he gave them drugs and preyed on them sexually by moving them into "isolated hotel rooms and remote locations, encouraging them to use drugs with him, and sexually molesting them when they were high and/or incapable of consent." Johnston and Irick accused him of taking them to a hotel room in April 2014, where they "engaged in a drug-fueled threesome."

Detectives with the Los Angeles County Sheriff's Department's began investigating him in May 2016 after receiving a sexual assault complaint. Lt. Todd Deeds told the Los Angeles Times that more than a dozen former patients had accused him of sexual assault between 2012 and 2016 at the treatment centers.

The next month, in June 2016, "20/20" aired its investigation into Bathum, focusing on accounts from three former patients suing him for fraud and sexual battery.

Amanda Jester was a 29-year-old alcoholic from Seattle when she was offered a free-ride scholarship to one of Bathum's treatment centers, she told "20/20." "It sounded like an answered prayer," her mother said.

But her rehab experience took a disturbing turn when, she claimed, Bathum invited her into a makeshift sweat lodge for a "guided meditation session."

"It's very small, it's tight, it's pitch-black dark, you can't see anything," Jester said of the sauna-like lodge. Once inside, she said, he started rubbing her leg up and down and began molesting her.

"I felt stuck, I guess," Jester told "20/20." "I mean, he's the owner."

A few days later, she said, she was told to meet him in a hotel room in the area, where he demanded that she take off her clothes as he performed oral sex on her. He told her she was high on meth, she said.

Bathum told "20/20" her allegations were "completely untrue" and "bizarre." He denied that he used meth, but said he has "experimented with every drug that's out there. ... I think it's important to do that ... a long time ago."

"You gotta understand something," Bathum told 20/20. "You're in a world of accusation that's amazingly complex that has people saying things, all kinds of crazy things that come out in a trauma-filled world. I can tell you there's certainly easy ways to explain that."

Correction*: An earlier version of this story incorrectly described Roseann Stahl as a former employee and client of Community Recovery Los Angeles. She was only an employee, not a client.*

More from Morning Mix:

Colbert to Trump: 'What are you going to do, run in there and stab them with your bone spurs?'

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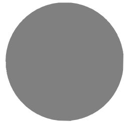

Samantha Schmidt
Samantha Schmidt is a reporter for The Washington Post's Morning Mix team. Follow

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Several overdoses at Sarasota treatment center c
arrests

A resident of First Step of Sarasota, Inc., allegedly brought a dru
the facility and several residents were transported to the hospital
investigation is underway.

By Tiffany Tompkins

HEROIN EPIDEMIC

Overdoses happen often at drug treatment centers. Sarasota facility had eight at same time

BY JESSICA DE LEON
jdeleon@bradenton.com

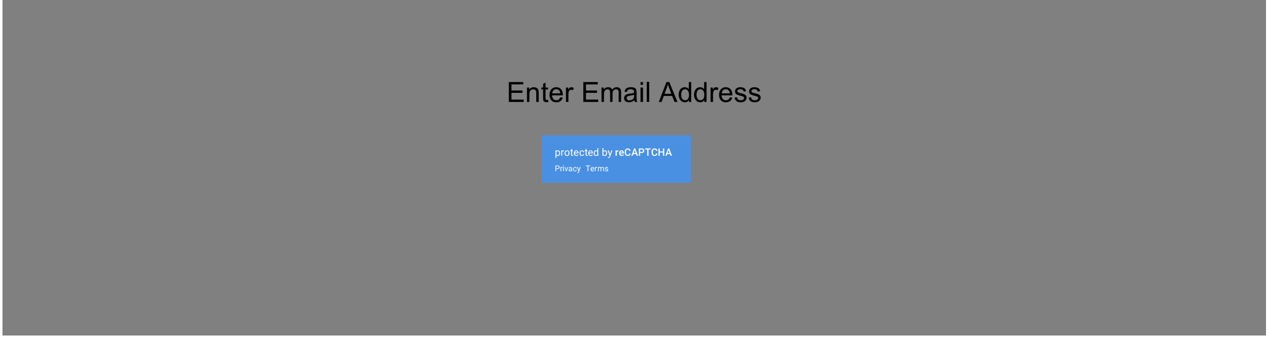
May 11, 2018 02:03 PM

MANATEE — While substance abuse facilities try to help people overcome their addictions, overdoses sometimes occur on those very grounds as happened recently at a Sarasota facility where eight patients overdosed at the same time.

At 6:30 p.m. May 1, the Sarasota County Sheriff's Office and paramedics were called to a First Step of Sarasota residential facility, 4579 Northgate Court, to a report of multiple overdoses.

A resident at the facility had brought GHB, known as "liquid ecstasy," onto the campus, according to Phillip "P.J." Brooks, vice president of outpatient and youth services. The odorless and colorless drug is often abused in a nightclub setting because of its euphoric effect but in larger doses it can causes seizures.

"We had seven other individuals along with that client ingest that chemical on campus," Brooks said.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When they discovered what was happening, staff at First Step called 911, and all eight had to be rushed to Sarasota Memorial Hospital.

"At this point, everybody is medically stable," Brooks told the Bradenton Herald. "We want to do whatever we can to ensure that those that need the treatment and we are able to justify them staying on campus, we will do so. But we also have an investigation going on with law enforcement, working closely with them."

Law enforcement records list numerous times officers and deputies have responded to First Step, Centerstone of Florida in Bradenton and other drug treatment centers.

"Situations like this happen to most residential facilities," Brooks said.

Detectives with the Sarasota sheriff's office and staff at First Step are working to determine what happened when the eight patients overdosed.

"There are likely going to be charges that come out from the circumstance because, again, we want to make sure the campus is as safe as possible," Brooks said.

The sheriff's office investigation remained active as of Friday.

Over the past five years, the sheriff's office has been called to First Step for a report of an overdose several times.

The most recent prior incident occurred on April 1, 2017. Deputies arrived to find paramedics treating a 31-year-old man who had been found slumped over in the bathroom by his roommate after hearing him fall. The man's roommate had alerted First Step staff, who after finding a syringe in the sink, gave him a dose of Narcan.

While at Sarasota Memorial Hospital, the 31-year-old admitted to deputies that he had snorted some narcotics but seemed otherwise confused about the time period leading up to his overdose. He had only been at First Step a week and had the drugs with him when he arrived, he told deputies.

As a result, the 31-year-old was involuntarily hospitalized under Florida’s Marchman Act.

On June 29, 2016, the sheriff's office was called to a report of an overdose at First Step. The 29-year-old man, a heroin user, was unconscious and blue in the face, and he had to be given two doses of Naloxone by deputies before he became responsive. Deputies later learned from his roommate that he had bought five bags of heroin earlier in the day .

Deputies found two bags of heroin and one bag of cocaine, according to the report. The 29-year-old was taken to Sarasota Memorial, where he admitted to deputies that he had snorted one bag of heroin, but said "the amount he snorted typically wouldn't get him high." He was hospitalized involuntarily under the Marchman Act.

"I believe that without the proper medical attention, (he) could cause further harm to himself," the deputy wrote.

On Jan. 11, 2015, paramedics had to transfer another heroin user to Sarasota Memorial Hospital from First Step.

Centerstone not immune to problem

Relapses and fighting cravings are parts of the disease of addiction. It's a struggle officials at Centerstone of Florida deal with on a regular basis, according to chief executive officer Melissa Larkin-Skinner.

In the past five years, the Manatee County Sheriff's Office has responded to 40 reports of overdoses at Centerstone's residential addiction center at 2020 26th Ave. E., Bradenton. Patients are there voluntarily, except for those sent under the Marchman Act.

The doors are locked, however patients can request to leave when they are there voluntarily. Staff will urge them to stay, and even let them return in hopes of helping them overcome their addiction.

But since the facility does keep patients behind locked doors, most overdoses occur in the facility's lobby just before someone checks in.

"People may use in the parking lot before they come in and they overdose in the lobby or they are in our lobby and go into our bathroom and use," Larkin-Skinner said. "That's a common occurrence. ... They want to get that once last fix before they come in."

The two most-recent calls for service for an overdose to the residential facility were just that.

On April 22, a woman was brought into Centerstone by her mother after she ingested an unknown drug and displayed odd behavior. Deputies responded and took her to Manatee Memorial to be treated after being given Ketamine by paramedics.

On May 7, deputies responded to a report of a man overdosing in the lobby. The man, who had been brought in by his significant other, was incoherent and disoriented so he was taken to Manatee Memorial Hospital and hospitalized involuntarily center under the Marchman Act.

Sometimes patients manage to sneak drugs into the facility, finding novel ways such as hiding drugs in their bras or belts.

Patients have also been known to have their visitors sneak them drugs, which is why Centerstone no longer allows patients in the addiction center to have visitors during the first few days following their arrival.

"One thing we were dealing with was dealers were putting drugs right outside the fence," Larkin-Skinner said. "People are very resourceful."

Patients are allowed outside several times a day to get fresh air and sunshine, which are healing, she stressed. So to combat that problem, staff will walk the perimeter of the fence looking for drugs.

On Dec. 28, 2016, Bradenton police responded to Centerstone's outpatient facility at 379 Sixth Ave. W. to a report of someone possibly overdosing, according to an incident report. The 33-year-old woman had been found in the parking lot unconscious and was given two doses of Narcan by paramedics before police officers arrived.

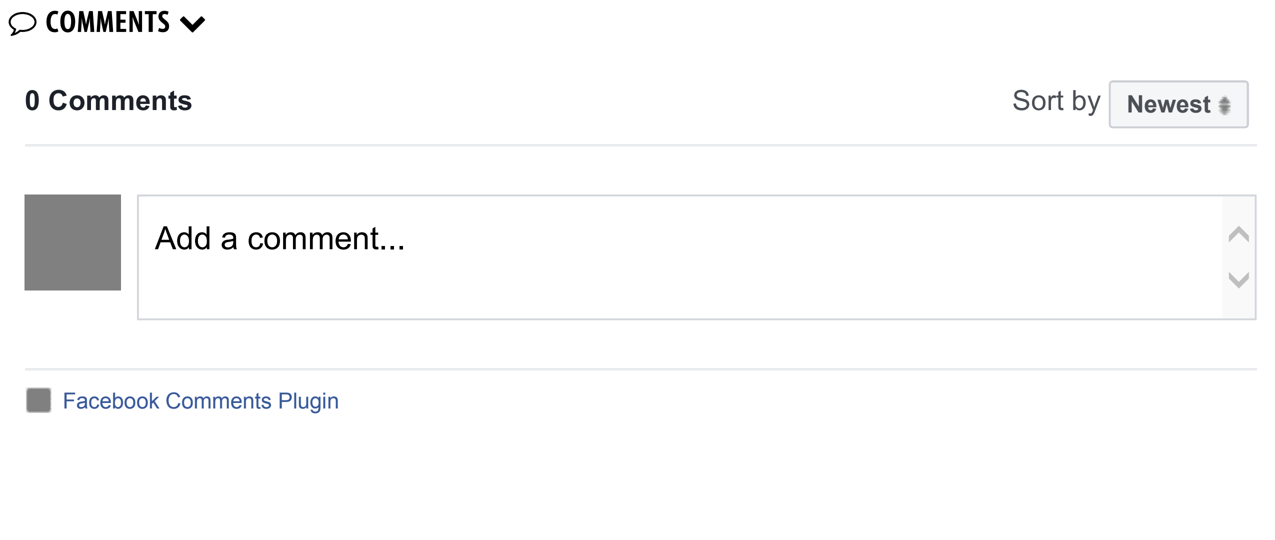
The 33-year-old was alert enough to admit to police that she was a heroin user but claimed she had not used heroin that day, according to a report. Instead, the woman told police she had taken a medication that is prescribed to her along with an unknown narcotic. Paramedics told police she had admitted to taking "rockys" before they arrived, and that she claimed to just want to get high, not hurt herself.

On Aug. 11, 2016, police were called to the outpatient facility after a counselor reported someone in a rehab class was overdosing. The 22-year-old had appeared fine when arriving, the counselor told police, but started to appear out of it at some point and then began to enter in and out of consciousness.

Paramedics were able to revive the 22-year-old with a dose of Narcan, police reported. Later at Manatee Memorial Hospital, the 22-year-old told police he had taken a pill before he went to class. The pill was blue with a "30" and an "M" on it, possibly Oxycodone, he told police. He said he had gotten it from someone who lived near Centerstone.

At times, the sheriff's office also is called out to Operation PAR, the only methadone clinic in Manatee County. Deputies have been called out twice to the clinic at 6253 14th St. W., Bradenton, over the past five years after reports of overdoses.

COMMENTS



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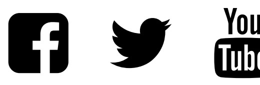

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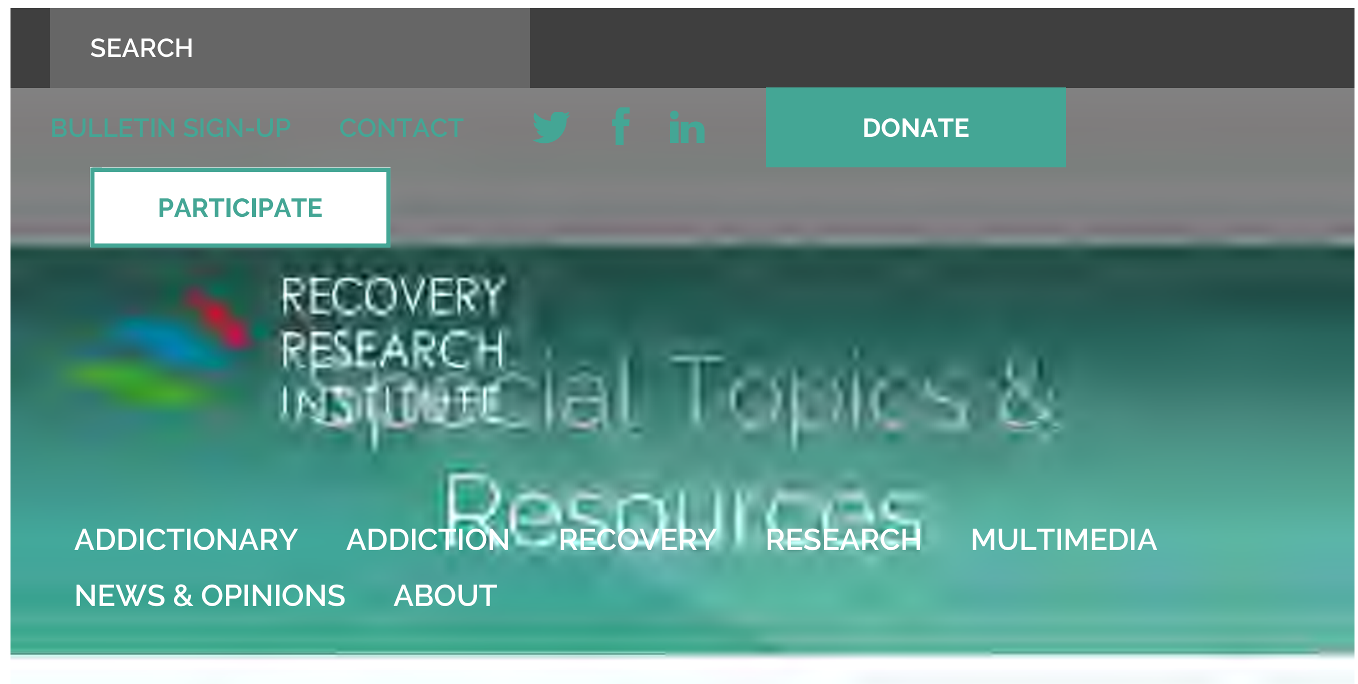

Co-occurring Disorders

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The Scams & Corruption of the Addiction Industry Explained

The unethical addiction marketing practices that are putting vulnerable individuals at risk.

Substance use disorders affect millions each year, and overdose is now the leading cause of accidental death in the United States and the overall leading cause of death among Americans under the age of 50. As a result, the need for treatment and recovery services has never been greater. This increasing demand has led to the rapid growth in the number of detox and treatment service providers, which has collectively and quickly burgeoned into a massive $35 billion dollar a year industry. The majority of these programs and service providers are working hard to provide honest, quality-care, to save lives and help people achieve long-term remission.

There are instances of unethical and illegal conduct in any area of medicine and health care you care to look, but the field of addiction treatment and recovery services has historically been largely unmonitored in comparison to other medical conditions, and so has very publicly been riddled with perhaps more than its fair share of deceits and deceptions that have exploited vulnerable addicted individuals for profit. Like the old saying, "one bad egg spoils the batch," despite the vast majority of programs and providers providing high quality and scrupulous addiction care, we have seen the popular news saturated with stories about "rehab" scams and various patient abuses.

When looking at unethical marketing practices in addiction treatment, it is important to be able to identify and educate others on some of the more prominent forms that these corrupt practices have taken.

Guide to Effective Addiction Treatment: 11 Indicators of Quality

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Here are the most common:

1. PATIENT BROKERING

- **Lead Selling:** Paying brokers a per-head *finders-fee* or *kick-back*for referring patients to their treatment facility (e.g. financial compensation ($500-$1000 per patient) or special future consideration. This type of patient brokering is not only happening with patients new to treatment, but also in agreements made between recovery residences (e.g. sober houses) and treatment centers, or between two separate treatment centers.
- **Lead Buying:** When treatment centers bid for patient referrals and leads. Call centers are set up to generate commission based on their number of placed referrals, with call center agents posing as caregivers, and unbeknownst to the patient, auctioning off the patient to the highest bidding treatment center. Treatment facilities that appear as separate actually may all route to the same call center.

**Patient Brokering often entails what is called "Addiction Tourism," which is the practice of sending a patient out of their home state to receive treatment at a facility in a different state.*

2. PATIENT ENTICEMENT

Unethically incentivizing patients to enter, stay, or switch addiction treatment facilities through money, gifts, free rent, flights, food, or other amenities.

3. LISTING THEFT

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The hijacking of Google business or Google Maps listings through the *suggested edits feature*. Unaffiliated individuals can go into an organization profile and change listed phone numbers to reroute calls and online correspondences to other treatment programs or call centers, and change listed addresses to deceive patients of actual location.

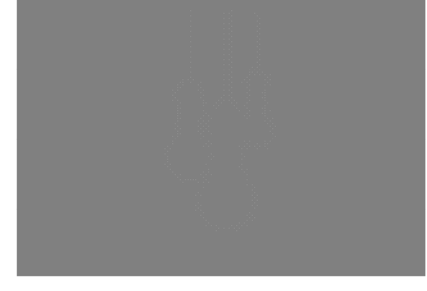
4. MISREPRESENTATION OF SERVICES

When treatment facilities deny their affiliations to other facilities or organizations or inaccurately portray the services they provide, their status of accreditation, the types of conditions they treat, the credentials of their clinical staff, what insurance providers they accept, or misrepresent their facilities, locations and amenities in any way.

5. PATIENT PRIVACY VIOLATIONS

The common practice of a patient's health information, such as their treatment plan or diagnosis, discussed in a sales or marketing context, and shared with individuals outside the patient's care team, without medical necessity or the patient's consent. This is in violation of HIPAA and other patient privacy protection laws that work to protect sensitive health information of the individual.

6. INSURANCE OVER-BILLING



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The process of billing insurance companies excessively for unnecessary treatment or services. This was commonly seen in urine drug screens, where $10 drug tests were being conducted every 2 days and billed at $1000 or more to insurance.

7. INSURANCE FRAUD

Under the guise of free insurance or care, patients, sometimes multiple at a time, are enrolled in insurance plans utilizing false addresses to take advantage of the "*change in address*" exception, which allows for year-round insurance enrollment. Patients are often unknowingly signed up for premium plans with generous coverage (e.g. out-of-network coverage and low out-of-pocket costs) available in states that the patient does not live in, nor has ever lived in, but serve to reimburse the ultimate treatment center at a higher rate than other plans or providers.

Unethical addiction marketing practices take advantage of vulnerable patients and families in desperate need of medical treatment and care.

Awareness is the first step in combating unethical addiction marketing practices, and greater

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awareness of these practices has led to new legislation, and increased scrutiny of addiction treatment providers by law enforcement, and even for-profit corporations such as Google.

In response to these corrupt practices, beyond ongoing criminal investigations led by local and state law enforcement agencies, the National Alliance for Recovery Residences (NARR) officially instated a code of ethics for recovery residences (e.g. sober homes) in 2016. More recently however, Google has temporarily ceased sale of pay-per-click (AdWords) advertisements on thousands of rehab-related search terms (e.g. rehab near me, alcohol treatment) that previously garnered sums of over $100 per click for Google, in attempt to thwart aggregate call centers. Google has been criticized for their role in perpetuating treatment fraud. In addition, beginning in 2018, the Joint Commission (JACHCO) will roll out a new outcome measures standard requiring evidence based practice (through the use of standardized measurement tools) for treatment facility accreditation.

Protecting patients from corrupt addiction marketing practices will be the first step in creating honest and effective treatment for substance use disorder. While decisions on what treatment facility to enter are often made in states of distress, it is important to emphasize that individuals and families should protect themselves by learning about what constitutes quality addiction treatment, where to search to find trusted local providers, and how to ultimately decide which option is best.