IMPLEMENTING A NEW DRUG AND ALCOHOL TREATMENT MODEL IN SACRAMENTO COUNTY (A)

"Drug Counseling by Social Workers Planned"
The Sacramento Bee—Monday April 18, 1994

Frustrated with the growing need for more drug and alcohol treatment, Sacramento County officials plan to train nurses, child welfare workers, and front-line social workers to do substance abuse counseling. "Current treatment services meet less than a fourth of the demand, and about 800 people are on the waiting lists for treatment," said Robert Caulk, director of the county's Department of Health and Human Services. "The system is saturated. The best thing you can do about drug and alcohol abuse is treat it. We might as well train our labor force to deal with it. The new program [the Alcohol and Drug Treatment Initiative] calls for every social worker, mental health counselor, conservator, and public health nurse to provide drug and alcohol treatment.

It was June 1994. Toni Moore had just been hired by Robert Caulk, director of Sacramento County's 1200-member Department of Health and Human Services, as the project manager for the department's Alcohol and Other Drug Treatment Initiative (AODTI). Moore's job was a big one: to take an idea in the developmental stages, build it into an actual program, and make it an integral part of employees' daily work lives.

Sacramento County's Department of Health and Human Services (DHHS) had been in operation for two and a half years, following a 1992 countywide reorganization of the health and human services delivery system. The department consisted of seven divisions. Five of these provided multi-disciplinary health services to the county, while two divisions performed administrative functions. Each of these divisions was headed by a director, who in turn supervised several program managers. (See Attachment 1 for organizational chart.)
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As conceived by Robert Caulk, the AODTI fit nicely with DHHS' mission statement:

- We deliver health, social, and mental health services to the Sacramento community.
- We direct resources toward creative strategies and programs that prevent problems, improve well being, and increase access to services for individuals and families.
- To further our mission, we seek close working relationships among staff, with other government offices, and within the community.

Having the AODTI fit the department’s mission statement and gaining support for it from staff and managers were two different things—and Toni Moore knew this. Her first task was to convince the department's staff and managers of the importance of the AODTI; only with their support could she move the initiative forward. Little groundwork had been laid, and, for many staff, the Sacramento Bee article was the first mention they had had of this far-reaching initiative. Some DHHS staff members were leery of the thought of more work and more trainings that might not be relevant to their jobs. Others wondered about the liability issues involved in taking on treatment work as a part of their work. And still others—especially DHHS’ few trained alcohol and drug counselors—were concerned about bringing people with limited training and experience into treatment work. Finally, few DHHS employees were enthused about the possibility of an increased workload. Workload issues were a constant struggle, and one with which the predominately-unionized DHHS staff wrestled constantly.

Similar feelings were rampant among the staff and administrators of the community-based organizations (CBOs) with which DHHS contracted to provide the lion’s share of the county's alcohol and other drug (AOD) treatment services. Alcohol and other drug treatment was the CBOs domain, so what would happen to their contracts if DHHS staff began providing the same services? Furthermore, every year, without exception, the AOD programs had to cope with budget cuts. How would the AODTI, a whole new program, affect their access to the funds that they already competed over? The CBOs, as a group, were uniformly concerned.

Toni Moore, in her deliberate and thoughtful way, re-read the first public mention of the initiative—the April 18 Sacramento Bee article—and thought about the challenges that lay ahead for the department.

Robert Caulk's Vision

Long before Toni Moore had even heard of the AODTI, its development was unfolding in the mind of Robert Caulk, the director of Sacramento County's Department of Health and Human Services. Caulk had directed six or seven different agencies in his twenty-year career by the time he came to Sacramento County in 1991, and he came with a reputation as a highly-driven, problem-solver. Caulk exuded a restless energy in every area of his life—perhaps best displayed in his intensive training for competitive triathlons. From his experiences with other agencies, Caulk had come to believe that alcohol and other drug abuse was the underlying cause of nearly every problem the human services system saw,
including child welfare, public health, mental health, education and criminal justice, among others.

Caulk's thoughts were precise as he began to put the pieces of his plan together. "Eighty percent of criminal justice cases are alcohol- and drug-related. Eighty percent of child abuse cases are alcohol- and drug-related. Emergency room and healthcare workers see huge numbers of alcohol- and drug-related cases. Alcohol and drug abuse drives everything, so we need to deal with this as the underlying problem."

In addition to statistics, Caulk knew from talking with his division directors that staff in the five DHHS direct-service divisions ran up against alcohol and drug abuse among the majority of their clients everyday.

A typical scenario within one of these divisions unfolded something like this:

  Sally Johnson [fictitious name] was a caseworker in the Family Maintenance Program of the Family Preservation and Child Protection division of DHHS. She was charged with providing case management and in-home services to families with abused or neglected children. Her goal was to keep children in their homes and prevent foster home placement. Sally would visit a family and feel certain that both parents were abusing drugs. She knew that until this underlying issue was addressed, there was little hope of improving the family dynamics that often led to abuse. But, because Sally was not trained in drug assessment or treatment, all she could do was suggest to the clients that they seek treatment and give them the phone numbers of either a DHHS alcohol and drug counselor or a community-based treatment organization. If the clients denied that they had a drug problem, Sally felt stuck because she had nothing concrete to suggest that they did—it was her word against theirs. Sally also knew that, even if the clients did decide to seek treatment, treatment resources were overloaded. Waiting lists were long enough to deter all but the most determined seekers of treatment, and Sally's clients did not generally fall into this category.

Caseworkers like Sally Johnson had two referral options for their clients: 1) in-house services, or 2) community-based services. Internally, DHHS had a total of 10 alcohol and drug counselors on staff to serve the entire county, with approximately $439,500 of departmental funds supporting them for fiscal year 1993/94. In addition to these counselors, DHHS worked with twenty-four community-based organizations (CBOs) to provide alcohol and drug treatment services. The CBOs received state and federal funding of approximately $6.7 million for fiscal year 1993/94, administered by DHHS. This contracting relationship between DHHS and the CBOs had "been around forever", according to Judy Caseroli, the department's Alcohol and Drug Bureau Chief. "The CBOs, for the most part, had been long-time, stable providers of alcohol and drug services. The Department, through the years, had a good relationship with the CBOs, but
the budget was always a big problem. Each year we had less money from our funding sources and had to make cuts."

DHHS drug and alcohol counselor-caseloads and CBO clients came from referrals from front-line staff like Sally Johnson, or from self-referrals, e.g. people who had seen community fliers announcing treatment groups and had called requesting a place in such a group. Department counselors served approximately 194 clients for fiscal year 1993/1994. They provided front-end treatment services: one-on-one and group counseling for substance abusers who did not need more intensive services, like detoxification or residential treatment, which the CBOs provided. The CBOs' data were not always reliable due to unusual record-keeping practices, but these local agencies served approximately 2,500 individual clients during fiscal year 1993/1994.

Caulk understood these numbers and heard what his staff told him: treatment resources in Sacramento County were overloaded. But just how overloaded? Caulk had his division directors do some research and discovered that waiting lists for alcohol and drug treatment services in the county numbered approximately 800, with prospective clients waiting, on average, nine weeks before receiving treatment.

Caulk did more investigating and discovered that initial alcohol and drug treatment was often provided at the CBOs by people who had little professional training in the field. Counselors did not need master's degrees or doctorates to lead treatment groups. Group leaders were often equipped only with street-smarts and a few training sessions; they were nonetheless capable of running support groups for clients who recognized that they had a problem, and who sometimes just needed the support of peers to help them move toward recovery.

Reflected Caulk: "You know, there had always been this mystique around alcohol and drug treatment—it was best left to the professionals, para-professionals cannot handle this sort of thing, etc. But that wasn't true. I discovered that people with six weeks of training led alcohol and drug groups! I was convinced that my staff, with the appropriate training, could do the same thing." Thus was born the cornerstone of Caulk's plan. He wanted to provide Sally Johnson and all of her co-workers with the skills and tools necessary to assess and provide alcohol and drug treatment to DHHS clients, thereby improving their chances of leading healthy and productive lives.

Caulk gathered his seven division chiefs together and told them of his plan to have all front-line DHHS workers become adept at drug and alcohol assessment and counseling. He asserted that he expected treatment work to become an integral part of all staff members’ range of skills. He was to stress this idea repeatedly to his division chiefs over the following months and, because he had kept them informed of his vision for the AODTI, he assumed he had their full buy-in for his project.

Caulk Lines Up the Resources
As enthusiastic as he was about AODTI, Caulk knew that the department's internal alcohol and drug budget for counselors—money that went directly for alcohol and drug treatment—was limited. For this new project, Caulk needed new money. He also knew that the CBOs would be sensitive to the AODTI's impact on their always-tenuous budgets. So Robert Caulk began promoting the Initiative among his many contacts, both locally and nationally, sounding them out on what they thought about it, and, more important, hoping that someone might come up with funding for his project. The Annie E. Casey Foundation offered the possibility of a $200,000, two-year grant for the AODTI, if Caulk would focus the initiative on improving the child welfare system and present a proposal describing just how he intended to do that. With Family Preservation and Child Protection being under his department's purview, Caulk knew that he could easily meet this child-focused requirement. Family Preservation and Child Protection would later be one of the first departments targeted by Toni Moore for implementation of AODTI.

Caulk then enlisted Marilyn McGinnis, a planning, evaluation, and development specialist with the county, to write a concept paper supporting his idea, a paper that could double as a proposal for the potential funder. McGinnis captured the essence of Caulk's idea in this excerpt from her subsequent October, 1993 report:

The drug and alcohol service delivery system was developed on the premise that drug and alcohol services could best be provided by experienced, specialized providers in the community. However, the current system has deluded us into believing that it is addressing the community's substance abuse problems. For instance, county workers typically refer clients to specialized drug and alcohol service providers. Those providers lack the capacity to treat all who need services. Given the accessibility problems and a service system that operates largely outside the mainstream of health and human services, we need to implement an innovative drug and alcohol strategy.

Drug and alcohol services must become an integral part of all health and human services. This means that every mental health counselor, social worker, conservator, and public health nurse becomes a drug and alcohol service provider. (Page 11, 1993 Concept Paper)

McGinnis met with CBO providers to get their input as she wrote the concept paper for the AODTI. She and Caulk also shared the concept paper drafts with the DHHS leadership team, which included division directors, at its monthly meetings. With this concept paper, Caulk and McGinnis hoped to ensure that county staff would view identification and assessment of alcohol or drug problems as integrated parts of their daily work, tasks just as important as helping their clients secure employment or obtaining food stamps.

"The idea with the AODTI was that county staff could provide front-end assessment of clients and also provide peer-treatment groups, and that the CBOs could continue to offer treatment groups as well as continue to be the providers of primary treatment, that is
specialty areas such as detox, methadone, and residential treatment," said McGinnis. Primary treatment was considered a specialty because medical intervention and more intensive resources were required for clients. Clients in detoxification treatment required medical attention as they withdrew from alcohol or drugs, and methadone clients required daily dosages of methadone administered by a medical professional to block their need for heroin. Residential treatment clients had tried to quit using with help from support groups and had failed, so they needed the extra support of being removed from their daily environment to have a chance at succeeding in ending their alcohol or drug abuse.
Caulk Enlists Toni Moore

Supported by Marilyn McGinnis' concept paper, Robert Caulk secured the two-year, $200,000 foundation grant to support implementation of the AODTI. He then sought and received approval from the Sacramento County Board of Supervisors, which oversaw the work of his office and was responsible for approving any revenue-producing grants of over $50,000. With funding approved, the Board of Supervisors behind his efforts, his division directors informed about the initiative, and the public announcement made about the AODTI, Caulk began to think about who could help him implement the project and get the massive staff training effort underway as soon as possible.

Caulk felt that the best way to proceed with this new and revolutionary idea was to bring in a new person as project manager—someone from outside the alcohol and drug treatment arm of DHHS. He purposely created a reporting structure in which the AODTI project manager would report directly to him—and not to the director of the Alcohol and Drug Bureau or to the Chief of Primary Health Services, under which alcohol and drug programs had traditionally fallen. Caulk knew he needed a person who was calm and unflappable, who would work hard and get results. He wanted someone who would balance his own fiery style and who could make this big idea a reality—someone whom his managers would respect.

Caulk's selection of Toni Moore as the AODTI project manager met all of these criteria and more. Moore had worked for eleven years in the Family Preservation and Child Protection division, first as a social worker, then as a supervisor, and finally as the training officer for the department. As a social worker, Moore had gained the respect of her colleagues and her managers. When she moved to a supervisory position, Moore was active in the supervisors' union and was an officer for three years. As the training officer, Moore became part of the division's management team. She was one of the few people within DHHS who had the respect of social workers, the unions, and management. Moore approached her work objectively and had an inclusive manner, a trait that was sorely needed in a division whose workers often felt excluded from management and the decision-making process. Despite his commitment to focusing the AODTI on the Child Protective Services division, Caulk anticipated resistance from this staff, as he knew they already felt overworked and would potentially see the AODTI as just one more administrative fad they’d have to deal with on top of their regular job duties. He hoped that, by hiring Moore, a Family Preservation "insider," he would gain an advantage in moving the AODTI into this and other key service-delivery arms of the agency.

How to Proceed?

As Toni Moore surveyed this landscape, she saw that a number of obstacles lay in her path. She felt a sense of urgency, as AODTI trainings were slated to begin in the fall, only a few months from now. With her usual confidence, Moore felt sure that she could take the steps needed to make the AODTI a reality. She sat back in her chair and wondered where to begin.
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Attachment 1