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

Two years after joining Bob Caulk’s team, Toni Moore sighed as she realized the depth of her problems implementing the Alcohol and Drug Treatment Initiative (AODTI). It was 1996, and Moore had all of her target employee-groups trained. Most staff members had been enthusiastic about the training sessions and felt empowered by what they had learned. But staff had left the trainings only to return to a "business as usual" work environment. To Moore’s dismay, the word within DHHS was that many staff members appeared unwilling to apply the skills they’d acquired in AODTI training. The Department’s program managers were apparently not working with staff to accomplish what amounted to fundamental changes in the way they viewed and conducted their jobs. In fact, most of the DHHS middle managers had not even shown up for the AODTI trainings.

Moore realized that the mid-level managers continued to think of the AODTI as “Bob Caulk’s project” — something in which they were not necessarily invested professionally or personally. It was not surprising that they had done nothing to integrate the Initiative into their departments’ way of doing business.

Toni Moore looked back at the painstaking work she and others had done to implement this innovative project. She was afraid that it was now in danger of unraveling. Could she still pull enough pieces together to have the AODTI take hold throughout the Department of Health and Human Services?

Moore's First Steps

When she had begun laying the foundation for the large-scale AODTI training effort in 1994, Moore knew that she needed to involve a wide range of constituencies in the AODTI planning and implementation processes. First, she wanted to assure community-based organizations (CBOs) that they were part of the picture. She wanted their support for the project, as well as their expertise in the area of drug and alcohol counseling. During her first two months on the job, Moore invited the CBOs to be on a special AODTI advisory...
board, whose goal was to develop the design and implementation of the Initiative. Moore purposely built the advisory board to reflect a broad cross-section of the stakeholders involved in county alcohol and drug treatment, and she convened the first Advisory Board meeting in September 1994. (See Attachment 1.)

Sacramento County also had a standing Alcohol and Drug Advisory Board, whose primary purpose was to provide oversight and counsel to the county's Alcohol and Drug Bureau. This board encouraged community participation in its activities, and most of the CBOs attended the meetings. Knowing that this was another important arena in which to reach her CBO audience, Moore got on the agenda at these meetings and discussed the AODTI. She stressed the fact that DHHS would continue using the CBOs at the same level, and that the AODTI was not a threat to the CBOs' key role as providers of alcohol and drug treatment services.

In addition to involving the CBOs in the decision-making process via their membership on the AODTI advisory board, Moore would eventually hire a staff member from a CBO—the Chemical Dependency Center for Women—as one of two curriculum development specialists to work on design of the AODTI training sessions. Moore also consulted with other local agencies as she developed the training and made sure that each session gave CBO representatives a chance to attend and discuss the roles their respective agencies played in the delivery of Sacramento County’s alcohol and drug treatment services.

**Moore Lobbies Within DHHS**

As she’d worked to bring community-based organizations into the AODTI fold, Toni Moore had begun to realize that no staff education about the AODTI had taken place within the ranks of DHHS itself. Robert Caulk had informed his division chiefs of his plan, but that was the extent of it. Therefore, during the summer of 1994, Moore launched a series of informational meetings, first with the division chiefs and then more broadly with general staff, designed to educate departmental employees about the AODTI. In September, Moore launched focus groups to get input from front-line staff on how to develop the AODTI. She held focus groups with key AODTI participants: DHHS alcohol and drug counselors, Family Preservation and Child Protection staff, Public Health staff, and employees from the neighborhood-based Oak Park Multiservice Center.

In addition to DHHS staff, Moore recognized the need to include actual recipients of current alcohol and drug treatment services in this information-gathering effort, so she held three focus groups with clients. Moore's focus group members were people who had open child-welfare cases within DHHS or who attended alcohol and drug treatment groups run by local CBOs. Moore wanted these clients' ideas about how DHHS staff could better support them in treatment efforts.

From the beginning of her planning for the AODTI, Moore knew that the expectation that DHHS staff would integrate alcohol and drug identification, assessment and treatment into their workload could be a potential problem with the unions. The majority of DHHS
employees were unionized. The UPE (United Public Employees' Union), representing the department's social workers and eligibility workers, was the largest and most active union. Moore was keenly aware of the importance of involving the unions in the development of the AODTI, and she felt that her extensive union background would certainly help her with this project.

As she had done with the CBOs, Moore invited the unions to participate on the AODTI advisory board. Her hope was that the unions would be active and involved in developing the AODTI. However, Moore observed that, though union representatives attended the advisory board meetings, they hung back and did not participate extensively. Moore thought that there was a good deal of apathy within the unions. She also felt that the union representatives on the board did not do as effective a job as she’d hoped communicating information back to the union membership.

"I assumed that one of the responsibilities of advisory board representatives was to take information from the meetings back to their group members—and the union reps did not do a good job of this. In fact, no one did," Moore said. At every advisory board meeting, Moore continued to urge attendees to report meeting discussions back to the groups they represented. But nothing changed. "You know, I was doing it all—I had no staff assistance, no one to prepare meeting minutes and get them distributed. I made a deliberate decision that I had to trust these board members to carry their weight and do their jobs; I did not have the time or resources to do their job and mine, too."

The AODTI Training Programs Take Shape

By August 1994, Toni Moore had hired two AODTI curriculum development and training consultants: Pamela Smithstan of Four Seasons Consultants, and a representative from the Chemical Dependency Center for Women, a local community-based organization. In conjunction with Moore, the consultants developed the curriculum for all levels of AODTI staff training.

The training component of the AODTI consists of three levels of training.

- **Level I** training provides core information about alcohol and other drug issues, abuse, impact on the individual and family, how to identify the problem, raise the issue with the client and support their move toward recovery.

- **Level II** provides more in-depth information on identification, assessment and treatment. It provides critical skills useful in differentiating a client's level of abuse and functioning.

- **Level III** provides participants with basic skills for providing and co-facilitating support group services.

Level I training was targeted at all county employees that had contact with AOD affected clients or consumers. Level II training was originally aimed at staff that had primary contact with clients in the system. Level III was for volunteers from any system, who had
been through Levels I and II, and were interested in providing interim education and support services to consumers from their systems.

Moore and the training consultants piloted the training programs and fine-tuned them before settling on a final version of each training level. They expected that, from the trainings, DHHS staff would take away knowledge and new skills in the following subject areas:

- identification of personal values and attitudes related to alcohol and drug use
- ability to provide information and education to others regarding alcohol and drug abuse
- interview skills
- assessment skills
- treatment interventions
- case planning and case management

This new skill-set would be instrumental to achieving Bob Caulk’s ultimate goal: to give DHHS line-workers the authority to requisition alcohol and drug treatment services for their clients. Supported by a new management information system that would permit DHHS employees to identify departmental and community-based treatment openings, line workers would, according to Caulk’s vision, assume a more far-reaching role in effectively matching clients to appropriate treatment resources.

The AODTI Curriculum

Once their training objectives were clearly defined, Toni Moore and her curriculum development team designed a three-stage training program designed to cover the following topics in depth:

**Level I**
- overview of chemical dependency
- beginning to intermediate-level information
- introduction to assessment and treatment

**Level II**
- advanced level information
- assessment and treatment skill building
- Substance Abuse Subtle Screening Inventory (SASSI)
- certification training

**Level III**
- special topics
- delivery of group services
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Specifically, Level I and II trainings were designed to give county staff a basic knowledge of alcohol and drug abuse and assessment and treatment options. AODTI Level I and II training graduates—especially those in Child Protective Services—would be expected to do alcohol and drug screenings and assessments of their clients, using an assessment instrument designed as part of the AODTI, which included a tool called the Substance Abuse Subtle Screening Inventory (SASSI).

Before implementation of the AODTI assessment and SASSI, there had been no single, consistent tool that county staff used to assess alcohol and other drug issues among their clients. The SASSI is an industry-wide, pen-and-paper screening tool which poses over 60 questions measuring a person's attitudes, values, and beliefs. Twenty-six follow-up questions regarding alcohol and drug use are then asked. Pam Smithstan of Four Seasons Consultants estimated that it took about fifteen minutes for a staff member and client together to work through the SASSI. SASSI's own statistics suggest that the SASSI is accurate in more than 90% of the cases.

Regarding the SASSI, Moore stated that, "before the AODTI and use of the SASSI, if a client denied she or he had an alcohol or drug problem, our staff often felt stuck."

Curriculum development specialist Pamela Smithstan concurred. "The SASSI is a screening test that the DHHS staff member and the client could do together. If the SASSI shows that the client has an alcohol or drug problem—and the client continues to deny this—the staff member now has a tool that she or he has worked through with the client."

Kathleen Henry, director of DHHS’ Mental Health Department, commented that her staff members were trained in mental health counseling, not alcohol and drug treatment assessment or counseling. But everyday the staff saw clients who had alcohol or drug problems. "I think my staff members were sophisticated enough to recognize alcohol and drug problems and had been frustrated that they were not trained to deal with them. They welcomed the AODTI trainings and viewed them as tools to help them do their jobs."

In addition to using the SASSI as a screening tool and the AODTI assessment, those county staff who eventually completed the Level III training were expected to start new information, education and support groups, thus expanding the county's capacity to respond to client needs. Clients in need of more intensive treatment would continue to be referred to the CBOs. Clients receiving referrals to CBOs would also be referred to an AODTI group to get them treatment ready or provide them with support services until they could get into the more intensive services.

How did this work in practice? Caseworkers like Sally Johnson would now be properly equipped to deal with the alcohol and drug abuse they saw daily among their clients. When Sally completed the AODTI training, instead of going solely on instinct, she would be able to accurately recognize an AOD involved client, and she would be trained to speak competently with this person about his or her problem. Sally would then work through the AODTI assessment form, using the SASSI screening with her client, if necessary.
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When this process was completed Sally would have a more solid picture of her client's problem, and a better sense of the appropriate treatment referral. If Sally happened to be a Level III training graduate, she might suggest that her client join the support group she co-facilitated, or another group: new ones begun by AODTI Level III training graduates, or existing groups facilitated by the Alcohol and Drug Bureau staff or CBO counselors.

Joanne O’Callaghan, evaluation coordinator, had this to say about the new support groups formed after the first series of employees graduated from Level III trainings: "We knew we needed groups that would attract clients, and we encouraged our staff to be as creative as possible in forming treatment groups—groups that would work. For instance, we had staff members who started a group for women called 'Sisters', with the focus on education, peer support, and parenting issues. Another group was 'First Step', which focused on recovery, with an emphasis on education and self-assessment."

Initial Feedback Positive... Up to a Point

As a result of the AODTI trainings, employees like Sally Johnson were relieved to have a broader skill-base, reliable screening and assessment tools to use with their clients, and more group-treatment options. By the time several hundred staff members in the DHHS priority departments had been through Level I and II trainings, overall staff support for the trainings was running high. People were excited and empowered by the trainings. Pam Smithstan, the AODTI curriculum consultant and trainer said: "Toni Moore did a lot of things right in setting this up. She took a multi-disciplinary approach and had a range of participants from departments in each training group—from clerks to medical staff—all mixed in. This did a lot for team building, and lots of connections were made. I saw a county culture where employees were suspicious of each other, and these trainings brought people together and got them communicating. People's enthusiasm for the trainings was high, and they told me that they felt better equipped to deal with their clients, and that they felt more compassion for them. Training graduates were so enthusiastic that they were 'selling' the trainings to their peers. However, I did get a lot of feedback that they didn't like using the SASSI. More paperwork was not something anyone was real happy about."

Many staff members still felt apprehensive about the weighty responsibility of assessing the need for—and then actually requisitioning—alcohol and drug treatment services for their clients. Furthermore, in some key parts of the agency, a strong resistance to change persisted; most case workers felt overworked and overburdened by administrative requirements. The last thing they needed was additional work in the short-term, no matter how rosy a picture was painted by Caulk and Moore about the long-term. The AODTI assessment, as well as the SASSI were viewed by many staff as more paperwork that they couldn't possibly undertake. Some staff observed that, if they were expected to take on a whole new level of work, including use of the assessment and SASSI, why weren't their managers attending the AODTI trainings and encouraging them in this new effort?

Educating Elected Officials
Even as she ran to keep up with the challenges of managing the AODTI training program, Toni Moore could not afford to lose sight of other important aspects of the Initiative. The Sacramento County Board of Supervisors, with jurisdiction over DHHS, was another entity that Moore had to cultivate in order to successfully implement the Treatment Initiative. Despite having approved the initial private funding for the AODTI, the Board of Supervisors still had concerns about it. One board member wondered about the utility of training people to identify drug and alcohol problems among clients. Wouldn't this just lead to an increase in the number of clients needing treatment without addressing the real need for adding more treatment resources? Wouldn't it just add more clients to an already overburdened treatment system? Several board members asked if it was really the county's business to provide services that community-based organizations already offered.

In order to educate the Board of Supervisors, Moore gave an informational presentation to the group about the AODTI soon after she was hired. She then met with the board member’s chiefs of staff and made herself available for questions from board members. When Moore heard their concerns, she reiterated how one primary goal of the AODTI was to eventually have training graduates launch more support groups, thus expanding capacity. She described how, with the AODTI, DHHS hoped to train county staff to provide front-end intervention and support services, which were defined as assessment, short-term one-on-one or support groups for higher functioning clients, and referrals to the CBOs for clients in need of more intensive services. On the other hand, what was known as “high-end” treatment, i.e. specialized services such as methadone maintenance and residential programs for more serious clients, would be left to the programs that specialized in this arena—the CBOs. As the board understood more about the AODTI, they became more comfortable with the project. Moore was clear with the board that the county had no financial commitment to the Initiative, and that private funding would continue to be its major source of support.

**Smooth Sailing and Then...**

By early 1996, Toni Moore had several hundred DHHS staff trained under the AODTI and a file folder full of other counties and agencies expressing interest in the Initiative. "From the beginning, we designed the AODTI to be able to market it," recalled Robert Caulk. "I called up my colleagues and told them about the AODTI and asked them if they would be interested in buying the entire training package for $50,000 to $100,000. When they said 'sold', I knew the price was right."

In order to sell the AODTI training package to other jurisdictions, Moore and Caulk needed to get approval from the Board of Supervisors. Board budget approval for the next fiscal year was also necessary. At the upcoming April 2, 1996 Board of Supervisors meeting, Caulk and Moore planned to request board approval:
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- To accept $400,000 private funding for fiscal years 1996/1997 and 1998/1999 to support program expansion, plus development of an instructional document for replicating the AODTI within California and across the country;
- To accept $150,000 state funding over three years for program evaluation;
- To market and sell the AODTI to other jurisdictions to offset program costs;
- To add an additional AODTI program position.

Caulk and Moore made this request during a stressful and highly-politicized time for DHHS. Three months earlier, three-year-old Adrian Conway had been killed by his mother, a drug user, two months after the family's child welfare case had been closed. A special committee had been convened to review Sacramento County's Child Protective Services. Moore realized that the board would be affected by the atmosphere of intense scrutiny that the Child Protective Services unit was under during this time.

Moore's fears were realized when, at the April 2 meeting, the Board of Supervisors began to balk at the prospect of AODTI training materials being marketed and sold to other jurisdictions. Several Board members expressed concern about the philosophy of harm reduction which they felt was portrayed favorably in the Level I manual. Unlike traditional drug treatment programs, which tend to be founded on "zero-tolerance" of alcohol or other drug use among clients, harm reduction’s first priority is to reduce the harm substance abusers do to themselves and those around them, whether or not they are still using drugs or alcohol. The Board of Supervisors voiced concern about this controversial issue, deciding to delay their vote supporting AODTI marketing until they’d had more time to review the training materials.

Toni Moore believed that the board took this small issue out of context and blew it out of proportion; harm reduction was really just “one small part” of the AODTI's comprehensive package of training materials. "I think a couple of things happened," said Moore in retrospect. "In addition to the pressure the board felt as a result of the Conway case, they got nervous about the AODTI actually going outside of Sacramento County. It was one thing when the program remained within our county, but it became another thing when we wanted to sell it as a county product to others. The board had always been supportive of the AODTI until this point."

Despite Moore and Caulk's efforts at the subsequent April 12 board meeting, members were still not satisfied, and they continued to feel uncomfortable about how the issue of harm reduction was treated in the AODTI training material. Board member Dave Cox seemed to speak for the entire board when he said "I do believe the board must have the opportunity to critique the [training] material." However, after two more delayed votes, the Board of Supervisors finally voted to approve DHHS' original requests from the April 2 meeting, but it did not grant approval until DHHS had modified the harm reduction section and insisted that a disclaimer about the issue of harm reduction be inserted in the AODTI manual.
Meanwhile, Back at the Ranch...

Moore had barely recovered from the battle with the Board of Supervisors when she faced another dilemma, this one from within DHHS.

Joanne O’Callaghan, Evaluation Coordinator, had the task of determining if DHHS staff members were actually using the AODTI assessment and SASSI after their completion of AODTI training. O’Callaghan knew that staffers were excited about the trainings themselves and felt empowered by the knowledge they had gained, but the issue of added paperwork continued to be a sticky one. She then discovered that a minority of staff from child welfare were using the screening and assessment instruments. Toni Moore was frustrated, but not surprised, at this news. Caulk had worked hard to sell his division directors on the idea of the AODTI, and she knew she had done an excellent job of getting DHHS front-line workers trained. But what kind of message did it send to staff when their own managers did not participate in AODTI trainings? The Child Protective Services division, for example, had not demonstrated leadership helping the staff to integrate the assessment and SASSI, or other pieces of the AODTI, into their jobs.

Toni Moore and Bob Caulk knew they had to do something drastic to really ensure that the AODTI would take hold within the county. They had put so much time and energy into designing and delivering the training sessions. It was becoming clear that staff training was just one piece of the puzzle.
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Attachment 1

ALCOHOL AND OTHER DRUG TREATMENT INITIATIVE ADVISORY BOARD

Consultants/Project Staff
• Project Coordinator – Toni Tullis 855-5640
• Evaluation Coordinator – Joanne O’Callahan 366-2788
• Training Consultant – Pam Smithstan 739-0866
• Evaluation Consultant – Nancy Young (714) 505-3525

Department of Health and Human Services Representatives
• Alcohol and Drug Bureau – Judy Casaroli 732-9753
• Oak Park Community Project – Bert Bettis 732-9779
• Primary Health Services – Stan Stewart 366-2580
• Family Preservation Child Protection – Leland Tom 366-2355/Betty Dues 366-2380
• Public Health Promotion and Education – Jacque Cramer 366-2171
• Adult Services – Don Stair 732-3063
• Mental Health – Kathleen Henry 732-9600
• Research and Product Development – Bill Mitchell 366-2746

Provider Community Representatives
• Bi-Valley Medical Clinic – Jack McCarthy 442-4985
• The Effort – Trish Stanionis 444-6294
• Chemical Dependency Center for Women – Mary Kennedy 448-2951
• National Council on Alcoholism and Drug Dependence – Barbara Woodard 922-9217
• Mexican American Alcoholism Programs – Daniel Ortiz 394-2320
• Sacramento Black Alcoholism Center – Joe Ganaway 454-4242
• Southeast Asian Assistance Center – Janice Hunt 421-1036
• Residential Programs – Lynne Scaggs 442-3979/Kristina Ketcherside 451-9312

System Collaboration Representatives
• Alcohol and Drug Advisory Board – Gordon Stirling 487-1362
• Dept. of Human Assistance – Lin Batten 978-2120/Carol Salami-Goswick 978-2127
• Juvenile Court – Judge Alice Lytle 855-8466
• Child Abuse Prevention Council – Sue Bonk 568-8375
• Probation Department – Kathy Nelson 386-7872
• CSUS Division of Social Work – Sylvia Navari 278-6593
• County Executives Office – Marilyn McGinnis 552-8437
• Client/Consumer Representatives – Delora Old Elk 646-1138

Unions/Employee Representatives
• Supervisors (Local 535) – Harry Leisk 648-0313/Dick Dobbins 366-2464
• Social Workers/Eligibility Workers (UPE) – Karen Guckert 855-8124
• California Nurses Association (CAN) – Carol Stumpf 366-4235
• Alcohol & Drug Counselors (AFSCME) – Don Stair 732-3063