Initial Data and Evaluation from the Community Assessment and Service Center [CASC] in Service Planning Area 3 [SPA-3; San Gabriel Valley]

A Report by
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Overview of Program

The Community Assessment and Service Center (CASC) located in the San Gabriel Valley of Los Angeles County, California, is a project of PROTOTYPES: Centers for Innovation in Health, Mental Health, and Social Services.

The CASC is designed to screen referred individuals for substance abuse and mental health problems. Individuals whose problem levels meet the criterion for services are referred to Los Angeles County substance abuse and mental health system providers. The CASC uses a standardized assessment instrument to code the assessment interviews.

Referral Sources

Clients are referred to the program from one of four sources:

- **CalWORKs** clients are referred to the CASC by the Los Angeles County Department of Social Services;
- **General Relief** clients are referred to the CASC by the Los Angeles County Department of Social Services;
- **Proposition 36** clients seeking substance abuse treatment as an alternative to incarceration for a drug-related offense, are referred by the Los Angeles County courts and the Probation Department; and
- **Community Referrals** are individuals who seek to enter the treatment system through self-referral directly to the CASC or through referral from one of the Los Angeles County substance abuse providers.

Assessment Instruments

All clients are assessed with the Addiction Severity Index (ASI) – in one of three forms – a semi-structured interview coding form developed by McLellan and his associates (McLellan, Kushner, Metzger, Peters, Smith, Grissom, Pettinati, & Argeriou, 1992).

- **ASI Adult, 5th Edition;**
- **ASI Lite**, a somewhat abbreviated version of the ASI Adult, 5th Edition; and
- **BSAP (Behavioral Severity Assessment Program)**, the ASI Adult supplemented with additional questions that permit coding of DSM-IV psychiatric diagnoses and related information.

Scoring Systems

The core ASI items were scored using five alternate scoring systems which use somewhat different items within the overall ASI. The alternate scoring systems were used because there is no strong

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consensus within the scientific literature on the “best” method for scoring the ASI. Note that the standard program from Accurate Assessments used by CASC-3 only automatically scores the ASI for one of three alternate sets of scales; the alternative scalings were done by The Measurement Group using scoring keys published in the literature. The following sets of scores were developed:

- **Composite Scores**, the standard indices used by McLellan and associates (McLellan, Kushner, Metzger, Peters, et al., 1992), a set of seven scales combining information about problems in both the past 30 days and over the client’s lifetime using a set of weighted items;
- **Evaluation Factors**, an alternate set of five scales developed by McLellan and associates (Alterman, McDermott, Cook, Metzger, Rutherford, Cacciola, & Brown, 1998) based on problems occurring in the prior 30 days;
- **Clinical Factors**, an alternate set of eight scales developed by McDermott and associates (McDermott, Alterman, Brown, Zaballero, Snider, & McKay, 1996) based on problems occurring in both the past 30 days and over the client’s lifetime;
- **Patient Ratings**, a set of 14 items rated by the client; and
- **Interviewer Severity Ratings**, a set of seven items rated by the Interviewer at the end of each section within the ASI interview.

Data

Data were obtained from two of three SPA-3 CASC sites in El Monte and Pasadena. Data were collected between September 14, 2000, the start-up date for the CASC, and June 5, 2002, the time at which these analyses were started. Data from 3,361 client assessments were downloaded from 8 different computers and combined. After eliminating duplicate cases either caused by assessments and subsequent re-assessments or because of computer data entry errors, there were 3,111 unduplicated cases. However, because the scoring systems for the ASI assume that there is no missing data, we eliminated cases that had more than one missing item on any of the ASI scales, estimating a small number of missing items per client with the median response of the overall sample. After eliminating cases, we were left with an effective sample size of 2,697 or 86.7 percent of the unduplicated sample. It should be noted that we used a very stringent criterion for eliminating responses so as to have a very clean dataset; more missing data probably could have been tolerated for the statistical analyses, and we found that sufficient data was present on the 3,111 unduplicated cases to make a valid clinical judgment about the client’s disposition.

Results

A PowerPoint presentation made to representatives of PROTOTYPES and Los Angeles County showed the results of detailed statistical analyses including more than 300 logistic regression analyses, more than 100 general linear model (analysis of variance) tests, and a multinomial logistic regression. The intent of this summary is not to list all of the results contained in those slides. As a way of summary, the following general results may be observed in the appended specific analyses.

- There are significant problem levels for clients from each of the four major referral groups. Further, while there are statistically significant differences among the problems levels in the referral groups on a number of indicators and scales, in general all groups show fairly high levels of problems.
- Individual clients have many different problems including co-occurring substance abuse, psychological distress, anxiety, criminal justice system difficulties, social functioning issues, and medical conditions. The typical client needs many different kinds of services.
- For a subset of about one-third of the sample who received a detailed mental health diagnostic work-up, 66.8 percent had an Axis I or Axis II disorder noted, not including substance abuse. Including substance abuse as an Axis I disorder, 95.4 percent had a diagnosable condition noted.
- A total of 69.6 percent of the women and 21.0 percent of the men in the sample said that they had experienced at least one of three forms of trauma (emotional, physical, or sexual) during

their lifetime. The experience of trauma was highly correlation with psychological functioning levels, although not as highly correlated with substance abuse levels.

- The type of treatment a client is referred to can be predicted with about 82.4 percent accuracy. Referral to substance abuse treatment is predictable from the referral source, the ASI drug composite score, and the ASI alcohol composite score. Referral to mental health treatment is predictable from referral source and the ASI psychiatric composite score. Referral to a combined mental health and substance abuse program is predictable from referral source, the ASI alcohol composite score, the ASI drug composite score, and the ASI employment problem composite score. It is not statistically necessary to include predictor factors of the ASI legal composite score, the ASI relationships composite score, or gender.
- Overall 73.4 percent of the men referred to any type of treatment enroll in a program, and 74.5 percent of the women referred enroll in a program.
- While there are differences in enrollment rates based on the referral source (to the CASC) of the client, the major ASI scores do not predict whether or not the client who is referred to treatment will enroll in the program.

Specific Conclusions

The following specific conclusions were drawn from the analyses.

- In addition to substance abuse, there are high levels of co-occurring mental illness as measured by ASI psychiatric functioning indices, supplemental items on psychological functioning, and DSM-IV diagnoses.
- There are significant differences among the clients who are sent to the CASC from the four different referral sources.
- CalWORKS clients tend to have more psychological problems and diagnosable conditions.
- Proposition 36 clients are most likely to have substance abuse involvement with the courts.
- Clients are primarily referred to treatment of various kinds – substance abuse, mental health, substance abuse and mental health – based on the appropriate information in the ASI.
- Among those referred to treatment, enrollment is not predicted by any of the ASI scores. While the ASI is a screening instrument for deciding who has problem levels that require a referral to treatment, differences among those referred in their problem levels of varying kinds does not predict who actually enrolls.

Overall General Conclusions

Based on the data from the 2,697 clients assessed in the first 21 months of the operation of the SPA-3 Community Assessment and Service Center, we conclude the following.

- The staff of this CASC working in the two locations studied – El Monte and Pasadena – appropriately identify high-need individuals to refer to treatment.
- Although constrained by the referring agencies to make certain types of referrals, staff of the CASC appear to use appropriate information to make differential referrals based on the needs of the clients.

References Cited

Alterman, A. I., McDermott, P. A., Cook, T. G., Metzger, D., Rutherford, M. J., Cacciola, J. S., & Brown, L. S. (1998). New scales to assess change in the Addiction Severity Index for the opioid, cocaine and alcohol dependent. *Psychology of Addictive Behaviors, 12*, 233-246.

McDermott, P. A., Alterman, A. I., Brown, L., Zaballero, A., Snider, E. C., & McKay, J. R. (1996). Construct refinement and confirmation for the Addiction Severity Index. *Psychological Assessment, 8,* 182-189.

McLellan, A. T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., Pettinati, H., & Argeriou, M. (1992). The Fifth Edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment, 9,* 199-213.

Najavits, L. M., Weiss, R. D., Reif, S., Gastfriend, D. R., Siqueland, L., Barber, J. P., Butler, S. F., Thase, M., & Blaine, J. (1998). The Addiction Severity Index as a screen for trauma and posttraumatic stress disorder. *Journal of Studies on Alcohol, 59,* 56-62.