Addiction Serverity Index Handouts

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ASI Handouts

A SHORT GUIDE TO THE ASI

(VERSION 5 UPDATE)

Information on:

Introducing the ASI to a Patient
Use of "N" in the ASI
List of Commonly Abused Drugs
Abbreviated Hollingshead Categories
Severity Rating Procedure
Critical Items by Section
ASI Composite Scores
Items for Cross-checking the ASI
Follow-Up Procedures

Please Note: This short guide is designed to be used in conjunction with but not instead of the full Instruction Manual for the Addiction Severity Index.

FROM

The University of Pennsylvania – Philadelphia VA
Center for Studies of Addiction

With support from NIDA, NIAAA and the Veterans Administration

POINTS TO INCLUDE WHEN INTRODUCING THE ASI

- All patients get the same interview.
- All information gathered is confidential and will be used only by the treatment or research staff.
- The interview consists of seven parts, i.e., medical, legal, drugs, alcohol, etc.
- There are two time periods expressed, the past 30 days and lifetime data.
- Patient input is important. For each area I will ask you to use a scale to let me know how bothered you have been by any problems in each section. Also, I will ask you how important treatment is for you for the area being discussed.

The client rating scale is:

0	Not at all
1	Slightly
2	Moderately
3	Considerably
4	Extremely

- If you are not comfortable giving an answer, simply decline to answer.
  Please do not give inaccurate information!

The interviewer should mention each of these points.

The most important considerations are that the patient understands the purpose of the interview and that it is confidential

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Inform the patient of any follow-up interviews that will occur at a later date.

PLACEMENT OF THE "N" ON THE ASI

General Information:

If #G19 is coded "1" for "no", then #G20 is an "N".

Medical Section:

If #M1 is coded "00", then #M2 is coded "N N".

Employment/Support:

If #E8 is coded "0" for "no", then #E9 is coded "N".

Drug/Alcohol Section:

If #D15 is coded "00", then #D16 is coded "N".
If #D19 "Alcohol Abuse" is coded "00", then D21 "Alcohol Abuse" is coded "N".
If #D20 "Drug Abuse" is coded "00", then #D22 "Drug Abuse" is coded "N".

Family/Social Section:

Items #F12 - #F17 and Items #F18 - #F26 are the only items in this section where an "N" may be used. To understand when to use an "N" think in terms of the client's opportunity to have a relationship with the person/people referred to in each item. For Items #F12 - #F17 and "N" would be coded only if the relative didn't exist (as in the case of a client who has no children). For items #F18 - #F26, the rule of thumb is that if there was no opportunity to experience the relationship in question (e.g., if someone in a particular category is deceased or if there has been no contact), then an "N" is coded. If the client reports that there has never been a relationship in a particular category (like no children, never any friends, never a relationship with father, etc.) then an "N" would be coded in both the "Lifetime and "Past 30 Days" boxes.

If #F11 in the F/S section is coded "0", then #F24 in the "Past 30 Days" column is coded "N". In such cases, the interviewer probes to see whether there had ever been any close friends to determine if an "N" is also be coded under "Lifetime" in #F24.

If #E11 in the E/S Section is coded "00" or if the client is self-employed with no employees or coworkers, then #E26 in the F/S section is coded "N" for the past 30 days.

Psychiatric Section:

There are no circumstances under which an "N" would be coded in this section.

Close ASI Section:

If the interview has been completed, code G12 as "N".

LIST OF COMMONLY USED DRUGS:

Alcohol: Beer, wine, liquor

Methadone: Dolophine, LAAM

Opiates: Pain killers: Morphine, Dilaudid, Demorol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Syrups, Fentanyl.

Barbiturates: Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol.

Sed/Hyp/Tranq: Benzodiazepines: Valium, Xanax, Librium, Ativan, Serax, Quaaludes, Tranxene, Dalmane, Halcion, Miltown.

Cocaine: Cocaine Crystal, Free-Base Cocaine or "Crack" and "Rock"

Amphetamines: Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, speed, Ice, Crystal Meth.

Cannabis: Marijuana, Hashish, Pot

Hallucinogens: LSD (Acid), Mescaline, Mushrooms (Psilocybin), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstasy.

Inhalants: Nitrous Oxide, Amyl Nitrate, Whippits, Poppers, Glue, Solvents, Gasoline, Touene, Etc.

Over-the-Counter: Robitussin, Cough/Cold medicines, Diet pills, etc.

Synthetics: Bath Salts, K2, Spice, G-Four,

HOLLINGSHEAD CATEGORIES:

1. Higher execs, major professionals, owners of large businesses.

2. Managers of medium sized businesses, nurses, opticians, pharmacists, social workers, teachers.

3. Administrative personnel, managers, minor professionals, owners/proprietors of small businesses: bakery , car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.

4. Clerical and sales, technicians, bank teller, bookkeeper, clerk, draftsperson, timekeeper, secretary.

5. Skilled manual – usually having had training (baker, barber, brakeperson, chef, electrician, fireperson, lineperson, machinist, mechanic, paperhanger, painter, repairperson, tailor, welder, policeperson, plumber).

6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).

7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter).

8. Homemaker.

9. Student, disabled, no occupation.

SEVERITY RATINGS

Severity – defined as the need for new or additional treatment based on the amount, duration and intensity of symptoms within each area.

All ratings are based on objective and subjective data within each area.

A systematic method has been developed for Severity Ratings.
Reliability is increased if this method is used.

2 – Step Method:

1. Consider objective data with particular attention to critical items.
(Why are these critical – because over time they have been found to be the most relevant to a valid estimate of Severity).

At this point the interviewer makes a preliminary rating, a 2-3 point range – based only on objective items.

2. Interviewer looks at subjective items and fine tunes his rating to a single score.

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REMEMBER: We are not rating potential benefit but the extent to which treatment is needed (regardless of availability or potential efficacy).

Interviewer Rating Scale:		**Patient Rating Scale**
0-1	No real problem, treatment not indicated.	0-None, Not at all
2-3	Slight problem, treatment probably not indicated.	1-Slightly
4-5	Moderate problem, some treatment indicated.	2-Moderately
6-7	Considerable problem, treatment necessary	3-Considerably
8-9	Extreme problem, treatment absolutely necessary.	4-Extremely

CRITICAL OBJECTIVE ITEMS BY SECTION

SECTION	ITEM	DESCRIPTION
Medical	M1	Lifetime Hospitalizations
	M3	Chronic problems
Employment/Support	E1 & E2	Education and Training
	E3	Skills
	E6	Longest Full-time Job
	E10	Recent Employment Pattern
Drug /Alcohol	D1 – D13	Abuse History
	D15 & D16	Abstinence
	D17 & D18	OD's and DT's
	D19 & D20	Lifetime Treatment
Legal	L3 – L16	Major Charges
	L17	Convictions
	L24 & L25	Current Charges
	L27	Current Criminal Involvement
Family/Social	F2 & F3	Stability/Satisfaction – Marital
	F5 & F6	Stability/Satisfaction-Living
	F10	Satisfaction with Free Time
	F12 – F17	Lifetime Problems
	F30 & F31	Serious Conflicts
Psychiatric	P1	Lifetime Hospitalizations
	P4 – 11	Present and Lifetime Symptoms

COMPOSITE SCORES

There is a composite score for each problem area of the ASI that has been derived from sets of items within each of the ASI problem areas. The same items are used in initial and follow-up scores. We feel the composite scores are better indicators of overall problem severity and change in problem status, than any single item would be. We have also found that the composite scores are highly correlated with interviewer severity ratings. The time period for composite scores is the 30 days prior to the interview.

An example is the composite score for the Alcohol Section:

1) Days of alcohol use in the past 30 days.
2) Days of alcohol use to intoxication in the past 30 days.
3) Days bothered by alcohol problems in the past 30 days.
4) How much troubled by alcohol problems in the past 30 days.
5) How important is additional treatment for these alcohol problems.
6) How much spent on alcohol in the past 30 days.

These items are combined using a mathematical procedure that insures equal weighting of each variable in the total composite score. There is a manual for the derivation of Composite Scores from the ASI (MacGahan et Al., 198), which details the items from each area to be used and the mathematical procedure to produce the composite scores.

RECOMMENDED ITEMS FOR CROSS CHECKING INTERVIEWER ACCURACY OF THE ASI INTERVIEW

1. If the patient tells you IN THE General Information section, item #G19 that he/she has been in a controlled environment in the last 30 days, make sure this information is reflected in the appropriate area of the ASI (e.g., if the patient was in jail, this would be reflected under the Legal section; if in the hospital – under the medical section, etc.)
2. If the patient tells you in the Medical section (item #M4) that he/she is taking prescribed medication, check to see that you have noted this medication under the D/A section. Also, where appropriate add the medication under the grid.
3. If the patient tells you in the Medical section (item #M5) that he/she gets a pension, check to make sure you have entered the amount of money he gets under the E/S section (item #E15).
4. If a patient tells you that s/he spent a lot of money on drugs/alcohol (D/A section, items #D23-#D24) check the E/S section (items #E12 - #E17) to see if the patient reported enough income to cover the amount spent. EXPLAIN – Sometimes a patient may be living off his/her savings – but not very often.
5. Sometimes patients will inform you in the D/A section (item #D18) of an O.D. that required hospitalization, which they forgot to tell you about under the Medical section. Go back and clarify items #M1 and #M2 under the Medical section.
6. If the patient admits to engaging in illegal activities for monetary benefit (cash) in the Legal section (item #L27) check the E/S section (item #E17) to make sure you entered the amount of money he made illegally in the past month.
7. Sometimes a patient will admit to currently living with someone under the F/S section (item #F4), however they may not have informed you of this under the E/S section. Some probes you may want to ask are, "Does this person work?", "Does this person help out with the bills?", pertaining to E/S section items #E8 & #E9.).
8. If the patient tells you of a psychiatric pension in the Psychological section (item #P3), check the E/S section (item #E15) to make sure you entered the amount of money received in the past month for the disability.
9. Check the patient's age, against the number of years he/she has been using drugs and alcohol regularly, and with the number of years he/she has been incarcerated. Compare the total years of regular substance use reported (D/A items #D1 -#D13) and the total number of years of incarceration (Legal item #L21) to see if the patient is old enough to have used the substances as long as was reported. If this seems unlikely, an extra probe may be, "Did you use drugs/alcohol regularly while you were incarcerated?"

****Check to see if the whole interview makes sense.****

FOLLOW-UP INTERVIEWS

They differ from initial evaluations in a number of ways:

- Only a subset of items are applicable and therefore used.
- Thus f/u interviews are briefer – 15 to 20 minutes.
- You can even get good information doing follow-ups over the phone.
- Interviewer Rating Scales are not used at f/u.
- Circled items are used at f/u interview.
- Asterisked items need to be rephrased to record cumulative data since the time of the last interview.
- Lifetime questions are not asked in D/A items #D1 - #13, F/S items #F18 - #F26, or Psych items #P4 – P11.

How to achieve high follow-up rates:
1. Inform patient at **initial** interview that f/u evaluation will be conducted X-months later.
2. Get names, addresses and phone numbers of more than one family members and/or friends. Be sure that they are different addresses and numbers. Check these numbers and addresses **immediately**, while the patient is in treatment.
3. Get information about other people patient is involved with, like Probation Officer, other Treatment Agencies, etc.
4. Insure confidentiality – a non-revealing telephone number for the patient to call when you leave messages for the patient.
5. Insure patient confidentiality – let patient know that the references will not be questioned concerning patient's status but would only be used in locating the patient. Have a story handy to explain curious relatives the reason for the call to the patient.
6. Keep detailed records of all follow-up attempts including times attempted and the results. This helps to reduce overlap of attempts and aids in spreading out efforts.
7. Can also mail a non-revealing but personalized letter stating times a patient can call you or for him to mail back information when you can contact him.

Be sure that people who do follow-ups are not involved in patient's treatment.

ADDICTION SEVERITY INDEX

This tool will tell us more about you such as the areas of need you have that brought you to this agency and how we can help you. We will ask you questions in seven potential problem areas.

1. **Medical Status**
2. **Employment/Education Support Status**
3. **Alcohol/Drug Status**
4. **Legal Status**
5. **Family History Status**
6. **Family/Social Status**
7. **Psychiatric Status**

It is important that we receive honest accurate information from you to better know what your needs are and how to help you. You can refuse to answer a question if it becomes too uncomfortable or personal to answer. All clients receive the same interview. All information gathered is **confidential** and will only be released with your permission.

There are two time periods we will discuss:

1. The past 30 days
2. Lifetime

CLIENT RATING SCALE

Your input is important. For each area I will ask you to use a scale to let me know how troubled or bothered you have been by any problems in each section and how important getting help (counseling, treatment, etc…) is for you in each area being discussed.

The scale is:

0 – Not at all
1 – Slightly
2 - Moderately
3 – Considerably
4 – Extremely

***Please remember to not give inaccurate information and that this is an interview and not a test.**

Interviewer Rating Scale: Patient Rating Scale

0-1 No real problem, treatment not indicated.

2-3 Slight problem, treatment probably not indicated.

4-5 Moderate problem, some treatment indicated.

6-7 Considerable problem, treatment necessary

8-9 Extreme problem, treatment absolutely necessary.

Additional Questions to be Added to the ASI to Meet Biopsychsocial Standards

1. Identification of consumer's strengths, needs, abilities and preferences. (SNAP)
2. History of domestic violence to include batterer's treatment or victim services.
3. History of Trauma. (Questions F27-29 address abuse defined as pervasive in the case of physical/emotional abuse and single incident sexual abuse with touch). Abuse is by no means the entirety of trauma. Trauma is defined not so much by the person's reaction to the event. These events could include car accidents, witnessing violent acts, tornado, earthquake, and maybe even the death of a pet. Caution should be used in probing too deeply into these issues. This is an assessment and not a counseling session. Clinical staff does not want to risk raising consumer's level of discomfort.
4. Educational attainment to include difficulties with educational history.
5. Cultural and religious orientation. This is not simply ethnicity, race and religion. This encompasses groups or populations the consumer identifies with the includes traditions, practices and beliefs, and world view that influence how a person thinks or acts. (the lens through which one sees the world. "We don't see things as they are, we see things as we are." Anais Nin)
6. Vocational and occupational history is included in ASI questions E2, E3, E6-7, and E10. Service in the military and brief description of that history, if applicable is required.
7. Sexual history including STD, HIV-AIDs status. This should also address gender identification and, in general terms number of partners and frequency.
8. Recreational and leisure history. This is broadly addressed in ASI questions F9-11. What the clinician needs to determine is if the consumer has hobbies or recreational practices that do not include drinking/using.
9. Current support system including family members, friends, church and/or mutual aid or self help groups that support recovery.
10. Current medications (addressed in ASI in Medical, Drug use and Psychiatric sections). Specifics as to prescribing physician, name of medication, strength, dosage, and length of time consumer has taken the particular medication.
11. Consumer's expectations in terms of service.
12. Assessment summary(sometimes referred to as "integrated summary of assessments") and signature of assessor and date of the assessment.

All items that begin "history of" must go into some detail. These are not simply yes/no questions.

ASAM

Handouts

ASAM PPC, II-R

Dimension 1: Alcohol Intoxication and/or Withdrawal Potential

The information used to complete this dimension can be taken from the ASI sections on 1) Medical, 2) Alcohol, and/or 3) Drug.

Dimension 2: Biomedical Conditions and complications

Information for this dimension will come from ASI section on Medical Conditions.

Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications. The information to complete this section will primarily be found in ASI sections on 1) Psychiatric and 2) Family/Social.

Dimension 4: Readiness to Change

This dimension is directly related to the "Stages of Change" model. While there is no specific ASI section correlate, the clinician should be easily able to discern the consumer's readiness to change (or stage of change) during the interview while completing the ASI.

Dimension 5: Relapse, Continued Use or Continued Problem Potential

As in dimension 4, the ASI has no direct correlate, but the ASI sections on both 1) Alcohol and 2) Drugs contains questions about previous attempts at abstinence and relapse. If a psychiatric disorder is also suspected, and if significant problems exist across any or all other ASI sections, the "continued problem potential" can be expected to be higher than if those conditions did not exist.

Dimension 6: Recovery Home Environment

The purpose of this dimension is to assess the type environment the consumer will return to upon discharge from treatment. If the "home" environment and living situation is considered non-supportive of recovery, alternate housing should be considered (e.g., sober living homes, halfway or three-quarter way housing.)

ASAM Assessment Dimensions

Assessment Dimensions	ASI Sections	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Medical and Alcohol/Drug	Assessment for intoxication and/or withdrawal management. Detoxification in a variety of levels of care and preparation for continued addiction services.
2. Biomedical Conditions and Complications	Medical	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services.
3. Emotional, Behavioral or Cognitive Conditions and Complications	Psychiatric	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services.
4. Readiness to Change	Alcohol/Drug, Legal, Family/Social	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change.
5. Relapse, Continued Use or Continued Problem Potential (Internal)	Drug/Alcohol	Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies.
6. Recovery Environment (External)	Family/Social, Employment/Education, and Legal	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services.

To assist in understanding the assessment dimensions and assessing the severity of each dimension, examples of brief questions include, but are not limited to, the following:

Below is a list of ASAM dimensional questions that can be asked as additional probes on the ASI.

These questions will help you bridge the gap between the minimum set of standardized ASI questions and organize it into ASAM's placement criteria.

Dimension 1, Acute Intoxication and/or Withdrawal Potential: Is acute intoxication and/or withdrawal potential contributing to, or complicating the patient's conditions? What risk is associated with the patient's current level of acute intoxication? Is there serious risk of severe withdrawal symptoms or seizures based on the patient's previous withdrawal history, amount, frequency, and recency of discontinuation or significant reduction of alcohol or other drug use? Are there current signs of withdrawal? Does the patient have supports to assist in ambulatory detoxification if medically safe?
Dimension 2, Biomedical Conditions and Complications: Are there current physical illnesses other than withdrawal that are contributing to or complicating the patient's condition that needs to be addressed? e.g., pregnancy, bleeding, cancer, heart disease etc. Are there chronic conditions that affect treatment? e.g., wheel chair bound; chronic pain with narcotic analgesics.
Dimension 3, Emotional/Behavioral/Cognitive Conditions and Complications: Are there one or more psychiatric disorders contributing to, or complicating the patient's condition? Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed? Are there chronic conditions that affect treatment because of continued symptoms or disability? e.g., stable, but chronic schizophrenic, affective or personality disorder problems. Do any emotional, behavioral or cognitive problems appear to be an expected part of addiction illness or do they appear to be separate? Even if connected to addiction, are they severe enough to warrant specific mental health treatment?
Dimension 4, Readiness to Change: Does the patient feel coerced into treatment or actively object to receiving treatment? How ready is the patient to change? If willing to accept treatment, how strongly does the patient disagree with others' perception that s/he has a mental health or a substance problem? Is the patient compliant to avoid a negative consequence, or internally distressed in a self-motivated way about his/her mental health or alcohol or other drug use problems?
Dimension 5, Relapse/Continued Use or Continued Problem Potential: Is the patient in immediate danger of continued severe distress and/or drinking/drugging behavior? Does the patient have any recognition and understanding of, and skills for how to cope with his/her mental health and/or addiction problems and prevent relapse or continued problems and/or continued use? What severity of problems and further distress will potentially continue or reappear, if the patient is not successfully engaged into treatment at this time? How aware is the patient of relapse dangers, triggers, and ways to cope with reappearance of psychiatric symptoms and/or cravings to use and skills to control impulses harmful to self or others and/or prevent continued alcohol/drug use?
Dimension 6: Recovery Environment: Are there any dangerous family, significant others, living or school/working situations threatening treatment engagement and success? Does the patient have supportive friendship, financial or educational/vocational resources to improve the likelihood of successful treatment? Are there legal, educational, vocational, social service agency or criminal justice mandates that may enhance motivation for engagement into treatment?

General Overview of ASAM Levels of Care

ASAM PPC-2R Levels of Care: (Detoxification Services for Adults)	Level	Placement Criteria: (Note: There are not separate Detox, Services for Adolescents)
Ambulatory Detoxifications without Extended Onsite Monitoring	I-D	Mild withdrawal with daily or less than daily outpatient supervision: likely to complete detox and to continue treatment or recovery.
Ambulatory Detoxifications with Extended Onsite Monitoring	II-D	Moderate withdrawal with all day detox. Support and supervision at night, has supportive family or living situations; likely to complete detox.
Clinically-Managed Residential Detoxification	III.2-D	Moderate withdrawal, but needs 24hr support to complete detox and complete increase likelihood of continuing treatment or recovery.
Medically-Monitored Inpatient Detoxification	III.7-D	Severe withdrawal and needs 24hr nursing care and physician visits as necessary; unlikely to complete detox.
Medically-Managed Inpatient Detoxification	IV-D	Severe unstable withdrawal and needs 24hr nursing care and daily physician visits to modify detox regimen and manage medical instability.

ASAM PPC-2R Levels of Care:	Level:	Placement Criteria: (Same levels of care for adolescents except level III.3)
Early Intervention	0.5	Assessment and education for at risk individuals who do not meet diagnostic criteria for substance-related disorder.
Outpatient Services	I	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.
Intensive Outpatient	II.1	9 or more hours of service/week for multidimensional, instability, not requiring 24 hour care
Partial Hospitalization	II.5	24 hour structure with available trained personnel; at least 5 hours of clinical service/week.
Clinically-Managed Low-Intensity	III.1	24 hour structure with available trained personnel; at least 5 hours of clinical service/week.
Clinically-Managed Med.-Intensity	III.3	24 hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community.
Clinically-Managed High-Intensity Residential	III.5	24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community.

Medically-Monitored Intensive Inpatient	III.7	24 hour nursing care with physician availability for significant problems in dimensions 1,2, or 3. Sixteen hours/day counselor ability.
Medically-Managed Intensive Inpatient	IV	24 hour nursing care and daily physician care for severe, unstable problems in dimensions 1,2, or 3. Counseling available to engage patient in treatment.
Opioid Maintenance Therapy	OMT	Daily or several times weekly opioid medication and counseling available to maintain multidimensional stability for those with opioid dependence.

ASI Treatment Planning Handouts

Addiction Severity Index
Treatment Planning Manual

The Addiction Severity Index (ASI) is one of the most widely used tools for the assessment of substance use-related problems. Clinicians all over the world use the ASI to get a better understanding of their client's treatment needs and outcomes.

One of the things that distinguishes the ASI from most other addictions assessment tools is it's focus on the "big picture". Instead of just considering the client's substance use, the ASI also aims it's spotlight on the individual's medical, employment, legal, family, social and psychiatric status. This wide angle view is designed to help you--and your client--get a better understanding not just of the substance use, but also other problems that affect the client and his or her recovery.

While many people use the ASI as an instrument for monitoring progress and outcomes, it can also be used to develop treatment plans. The purpose of this manual is to help you develop effective treatment plans using the ASI. Afterall, when an ASI is done well, it contains a substantial amount of valuable information. It is our hope that better treatment plans will lead to higher rates of recovery and better overall treatment outcomes.

Table of Contents

The Organization of this Manual

The manual begins by examining, Mary's completed ASI. We have attempted to highlight key elements in each problem area, and to indicate the significance of each element for treatment planning.

Following the examination of the actual ASI, a "Master Problem List" is presented. This is an important step in the treatment planning process because it pulls together on one page all of the problems that the client presents.

Next there is a presentation of Mary's treatment plan along with some commentary as to why certain action steps were selected and other delayed. In addition, we have included a description of how our imaginary client responded.

Following the case presentation there is a brief section that covers some of the technical aspects of treatment planning. You may feel free to go right to this section first if you are relatively new to treatment planning and want to get some technical assistance. Even if you are an experienced counselor, you might still find this section useful because it demonstrates how ASI data can be used to develop treatment plans.

Treatment Philosophy

Before we consider Mary's case, it might be a good idea for us to first consider treatment philosophy. This manual incorporates two fundamental principles which guide the treatment planning process. These principles are: "Address Client Needs" and "Affirmative Care".

Address Client Needs

The first treatment planning principle is that clients will do best when there is a comprehensive effort to address their needs. By recognizing and addressing the client's needs in a variety of domains (e.g. medical, legal, psychiatric, etc.) treatment programs demonstrate to the client that they acknowledge their client's concerns and are interested in working with the client towards solutions.

In addition, when a client tells us about specific issues that they perceive as obstacles to their recovery, we can create a powerful alliance by joining them in working to improve their total situation. Of course, the purpose of all this collaboration is not just for the sake of establishing rapport. Ultimately, research has shown that by directly addressing client needs, programs and counselors will be more effective in assisting their clients in progressing towards a lasting recovery.

Affirmative Focus

Our second treatment principle recognizes the benefits of praise and acknowledgement in the treatment process. Specifically, when a client chooses health and moves in the direction of recovery, the counselor should affirm, support and praise the client in a variety of ways (for example, verbal recognition, graduation ceremonies, award cerficates, etc.).

On the other hand, when a client chooses to move in a direction that is self-destructive (that is, noncompliant with treatment goals) the counselor should work to maintain contact with the client, and search for some aspect of the client's behavior or actions that can be praised or given positive recognition.

In some cases, the counselor needs to make a special effort at finding something to praise. For example, when a client reports a relapse, the counselor should lavishly praise the fact that the client "successfully interrupted the relapse and returned to treatment!" The counselor might also acknowledge the client for his or her honesty, courage and commitment to recover.

Naturally, it is important that we remain authentic when we praise a client. If our comments come off as phony or insincere, our whole credibility can be compromised. However, if we honestly consider the challenges that our clients face, we usually will come to the conclusion that their gains are in fact "extraordinary" and more than worthy of our compliments and recognition.

Regulatory Requirements

Most States require licensed drug and alcohol treatment programs to conduct assessments and develop treatment plans according to specific standards. Similarly, programs that are accreditted by the Joint Commission for Accreditation of Health Care Orgranizations (JCAHO) must utilize assessment and treatment planning processes that comply with their standards.

While the ASI offers an excellent start towards complying with State and JCAHO assessment standards, it is important to recognize that it is not a comprehensive biopsychosocial assessment. For this reason, many treatment programs initially utilize the ASI as the basis for developing an initial or preliminary treatment plan. They then supplement the information obtained in the ASI with a more comprehensive assessment. Then, using all of their assessment information (including the ASI), they develop their diagnostic summary and treatment plan.

It is important to point out that ASI-based treatment planning as described in this manual is just one part of an ongoing assessment process that builds upon and supplements information from the ASI with other types of assessment from other areas in the client's life. Effective treatment planning and counseling is enhanced when we obtain the clearest understanding of our client's personal challenges and treatment needs.

Privacy & Confidentiality

As you can imagine, sharing personal information with a complete stranger is difficult. As the assessor, you need to insure the client's privacy during the interview and confidentiality afterwards. Otherwise, the client may be motivated to distort or hide important information.

Timing

It is important that we capture information about our client as early as possible so that we can use that information to guide the treatment process. Clients whose needs are recognized and addressed early are more likely to engage and remain in treatment. On the other hand, we need to be careful not to conduct an ASI assessment too soon. For example, two of the worst possible times to conduct an ASI is when your client is intoxicated or in the thick of withdrawal. These conditions will severely limit the usefulness of your assessment.

Using the ASI to Develop the Treatment Care Plan

Whether you have received an ASI from intake personnel or completed the ASI interview yourself, you will notice that it provides information on more problems than just alcohol and drug use; and that it asks the patient about how much they are bothered by each of these problems. These aspects of the ASI are discussed below.

Client Ratings

Clients should be active participants in their treatment planning. The ASI client ratings of problem importance and treatment need are our way of involving the patient directly in the discussion of the treatment plan. You will want to review the completed ASI with the client prior to developing the treatment care plan. There is a usually a good relationship between the intensity and duration of symptoms reported in a problem area and the client's rating of need for treatment services in that area. In turn, as the need for treatment increases there will usually be a need for more immediate and/or more intensive services.

If the patient has reported rather serious evidence of problems in an area but has rated his/her need for treatment low, this could be a misunderstanding. In these cases, probe for further clarification of problem status and check with the client to be sure that nothing has been missed. When there is agreement between you and the client, he/she will feel "heard" and this will help to engage them in the work of treatment. If there is disagreement, it will be important to resolve it early.

Addressing Client Problems

Clients may have problems in many areas. A client's problems in any ASI area can affect their recovery. Assessing these

problems, acknowledging them with the client and discussing potential strategies for dealing with them are important to the recovery effort - *even when your agency does not have on-site services for those problems*. You may need to offer a client a referral for additional, out-of-program services.

Balancing Treatment Priorities

No single problem area is always the most important or the one that should be treated "first." *Concurrent treatment of multiple problems is generally better than sequential treatment.* Addiction occurs in the context of other problems that may either contribute to or result from substance abuse. You will rarely be able to identify causal relationships between problem areas and it is important not to assume that any single problem is the "key" to resolving all other problems.

You have to start somewhere and it is not always easy to prioritize treatment goals. You may need to defer goals in some areas until the patient is stabilized or till you can get a referral for additional out-of-program services. While the initial treatment plan may focus on reducing substance use first, the master treatment plan should address *all problem areas for which treatment is indicated*.

Now, as you read this manual, you will see how we use the ASI to design treatment plans.

Key ASI Items for Treatment Care Planning

The ASI is designed to assess client status in many different areas of life functioning. The following ASI items are important to consider when you are developing a treatment care plan:

General Information

Demographic data reported in this section may provide important information early on that will be relevant to treatment care planning. Does the client report gender (**G10**) or cultural (**G17**) issues that may affect participation in treatment? Does the client's age (**G16**) present special considerations, i.e., medical, employment or housing problems? If the client reports hospitalization, incarceration, psychiatric or substance abuse treatment in the past 30 days (**G19/20**), are follow-up services indicated?

Medical Section

Does the client report chronic medical problems (**M3**) that require ongoing care or daily monitoring, such as asthma, diabetes, high blood pressure? Has the client been prescribed medication (**M4**) on a regular basis for a medical problem? Is the medication taken as prescribed? Does the medication prescribed need to be re-evaluated by a physician? How many days (**M6**) has the client experienced physical medical problems and what symptoms have they experienced? Does the client have a chronic pain problem that will need to be evaluated? Is the client currently receiving services for a medical problem? If so, is the client satisfied with the treatment? Is further assessment indicated? What level of distress is reported (**M7**) and how important is it to the client to receive treatment services (**M8**)?

Employment /Support Section

Does the client have a high school education, GED, or marketable trade or skill (**E1-3**)? Items **E4/5** are important considerations if the client does not have access to public transportation for employment or if the client is seeking employment that requires driving.

Look at the client's work history (**E6/7**) and usual employment for the past 3 years (**E10**). Has the client ever been able to maintain a period of steady employment? Is the client currently employed? If not, how long has he/she been out of the job market?

Items **E8/9** are an indication of the client's current ability to maintain self-sufficiency. Does the client have a family to support (**E18**)? What has been the client's source of income in the past 30 days (**E12-17**)?

You will want to look at item **E19**. If unemployed, has the client actively looked for work in the past 30 days? If employed, is the client's job in jeopardy? How important is it to the client to get

help with employment problems (**E21**)?

Drug/Alcohol Section

Items **D1-14** tell you about the client's substance abuse history and current drug/alcohol use. Has the client ever been able to maintain a month or more of abstinence and, if so, how long has it been since the last period of abstinence (**D15/16**)?

Look at indicators of the severity of the addiction, such as overdoses (**D17**), delirium tremens (**D18**), and treatment history (**D19-22, D25**). How much money is the client actually spending for alcohol/drugs (**D23/24**)? How many days has the client experienced problems related to substance abuse (**D26/27**)?

How does the client assess his/her level of distress or desire for treatment for substance abuse problems (**D28-31**)? If a significant history and current substance abuse problems are reported and client ratings (**D28-31**) are low, denial may be indicated.

Legal Status

Items **L1/2** tell you something about the relationship between the client's legal status and the client's treatment status. Is the client court stipulated to treatment or currently on probation or parole? Will the client suffer legal consequences as a result of noncompliance with treatment? Look at the client's criminal history (**L3-17**). If an extensive legal history is reported, are there issues, attitudes or behaviors that you will want to address as part of treatment?

Are there any pending legal charges (**L3-16, L18-20**)? Is the client awaiting charges, trial or sentence (**L24-26**)? Has the client reported engaging in days of illegal activity in the past 30 days (**L27**)? Look at the client ratings (**L28-29**). Does the client indicate a need for legal services for current legal problems?

Family/Social Section

Look carefully at the client's marital status, usual living arrangements, and use of free time (**F1-6**, **F9/10**)? Is the client satisfied with current status in theses areas or merely resigned to his or her situation? Does the client report stable living arrangements or is there a need for referral for housing?

Consider problems like loneliness, social isolation, and the need for a sober support network (**F9-11**). Is the home environment supportive of recovery (**F7/8**)? Has the client ever been able to maintain a close mutual relationship with others (**F12-17**)? Look at items **F18-26**. Does the client report a history of lifetime or current serious relationship problems? How might these problems impact on treatment? Are past or current abuse issues reported that may undermine recovery efforts (**F27-29**)? Is the client in a life-threatening situation (**F28/29, F30/31**)? Have there been any serious family or social conflicts in the past 30 days (**F30/31**)? How important is it to the client to receive treatment for family/social problems (**F34/35**)?

Psychiatric Section

Has the client ever received professional treatment for psychological or emotional problems (**P1/2**)? Is follow-up treatment recommended? If the client reports an extensive treatment history (**P1/2**) or receives a pension for a psychiatric disability (**P3**), you will want to pay particular attention to past 30-day symptoms (**P4-10**). Does the client need to be referred for a psychological evaluation? Has the client been prescribed medication for a psychological problem (**P4**)? Is the medication taken as prescribed? Does the medication prescribed need to be re-evaluated by a physician? How many days (**P12**) has the client experienced psychological medical problems? Does the client report a significant level of distress or desire for treatment for psychological problems (**P13/14**)? Carefully consider the interviewer's clinical impressions (**P15-20**).

Applying the ASI: Case Studies

Now that we considered the background to treatment planning with the Addiction Severity Index, we thought the best way to help you use the ASI in a practical way was to simply demonstrate with some sample cases. So let's talk about Mary.

Mary lives in a major urban center, is poly-drug dependent, has been earning money as a prostitute and has numerous medical, legal and family difficulties.

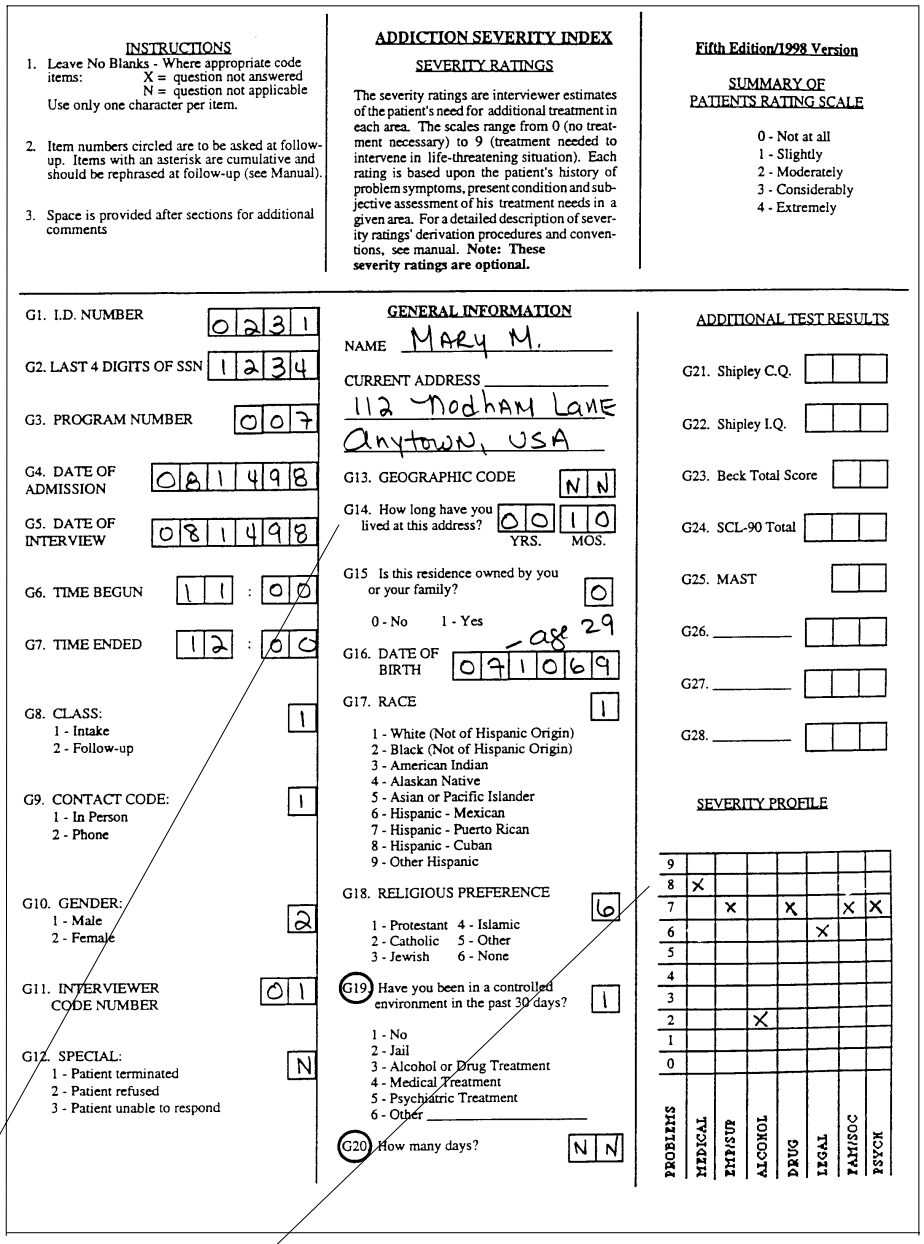
As a way of introducing the ASI for treatment planning, we will examine Mary's ASI. Critical items will be identified and we will think through the implications of these items. In a sense, we have attempted to "think out loud" so that you, the reader, can examine the thinking process behind developing an ASI-based treatment plan.

Meet Mary

As you can see from the first page of Mary's ASI, she is a 29 year old white female who lives in Anytown, USA. She has lived at the same location for about 10 months, which suggests at least some degree of stability. She doesn't have any religious affiliation and has not been in a controlled environment in the past 30 days (G19).

The only additional information that we can draw from this page is a snapshot provided by her "Severity Profile". As you can see, Mary has significant challenges in most areas of her life.

Let's move on to the Medical Section of the ASI.



INSTRUCTIONS

1. Leave No Blanks - Where appropriate code items: X = question not answered, N = question not applicable. Use only one character per item.
2. Item numbers circled are to be asked at follow-up. Items with an asterisk are cumulative and should be rephrased at follow-up (see Manual).
3. Space is provided after sections for additional comments

ADDICTION SEVERITY INDEX

SEVERITY RATINGS

The severity ratings are interviewer estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of his treatment needs in a given area. For a detailed description of severity ratings' derivation procedures and conventions, see manual. **Note: These severity ratings are optional.**

Fifth Edition/1998 Version

SUMMARY OF PATIENTS RATING SCALE

0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

GENERAL INFORMATION

G1. I.D. NUMBER: 0231
G2. LAST 4 DIGITS OF SSN: 1234
G3. PROGRAM NUMBER: 007
G4. DATE OF ADMISSION: 08 14 98
G5. DATE OF INTERVIEW: 08 14 98
G6. TIME BEGUN: 11 : 00
G7. TIME ENDED: 12 : 00
G8. CLASS: 1 (1 - Intake, 2 - Follow-up)
G9. CONTACT CODE: 1 (1 - In Person, 2 - Phone)
G10. GENDER: 2 (1 - Male, 2 - Female)
G11. INTERVIEWER CODE NUMBER: 01
G12. SPECIAL: N (1 - Patient terminated, 2 - Patient refused, 3 - Patient unable to respond)

NAME: MARY M.
CURRENT ADDRESS: 112 MODHAM LANE
Anytown, USA
G13. GEOGRAPHIC CODE: NN
G14. How long have you lived at this address? 00 YRS. 10 MOS.
G15 Is this residence owned by you or your family? 0 (0 - No, 1 - Yes)
G16. DATE OF BIRTH: 09 10 69 - age 29
G17. RACE: 1
1 - White (Not of Hispanic Origin)
2 - Black (Not of Hispanic Origin)
3 - American Indian
4 - Alaskan Native
5 - Asian or Pacific Islander
6 - Hispanic - Mexican
7 - Hispanic - Puerto Rican
8 - Hispanic - Cuban
9 - Other Hispanic
G18. RELIGIOUS PREFERENCE: 6
1 - Protestant 4 - Islamic
2 - Catholic 5 - Other
3 - Jewish 6 - None
G19 Have you been in a controlled environment in the past 30 days? 1
1 - No
2 - Jail
3 - Alcohol or Drug Treatment
4 - Medical Treatment
5 - Psychiatric Treatment
6 - Other _____
G20 How many days? NN

ADDITIONAL TEST RESULTS

G21. Shipley C.Q.
G22. Shipley I.Q.
G23. Beck Total Score
G24. SCL-90 Total
G25. MAST
G26. _____
G27. _____
G28. _____

SEVERITY PROFILE

	PROBLEMS	MEDICAL	EMP/SUP	ALCOHOL	DRUG	LEGAL	FAM/SOC	PSYCH
9								
8		X						
7			X		X		X	X
6						X		
5								
4								
3								
2				X				
1								
0								

Figure 1

Medical Status

Many of our clients have serious medical conditions that might never have been diagnosed. Some of these conditions, when left undiagnosed, can be fatal or disabling. Therefore, the purpose of this section is to find out whether--and to what extent--Mary may need help with medical problems.

In addition, some of our clients have a tendency to neglect their health. Even when they know they've got medical problems, they may choose to ignore them. Of course, this can lead to even more serious health problems.

Consequently, this is one of the most important sections of the ASI.

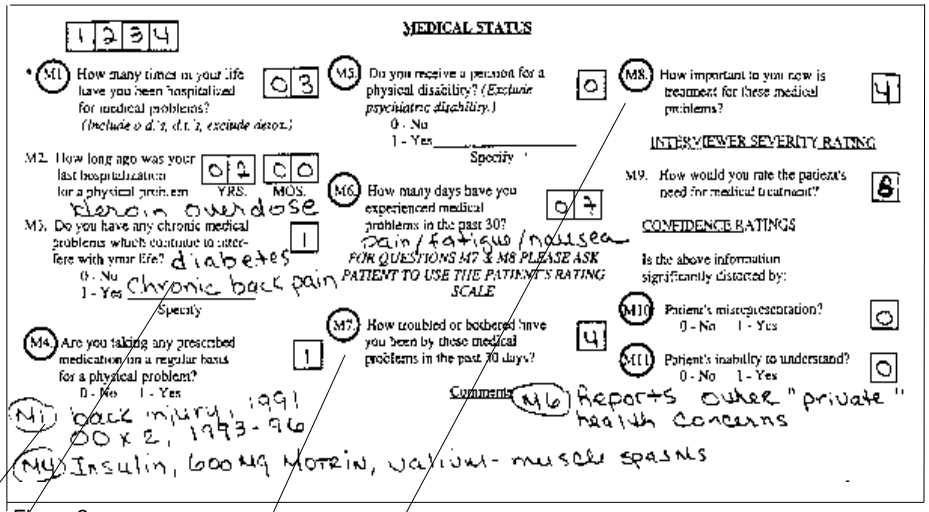


Figure 2

What About Mary?

Looking over the Medical section of Mary's ASI, we find the following:

M1 Mary's had three hospitalizations (two overdoses and a back injury). Notice, by the way, that the counselor's note is critical to our understanding here.

M3 Next we notice that Mary is diabetic. This is often a serious medical condition that requires ongoing medical management. We probably are going to want her to get this checked out by a doctor.

M4 Since Mary is using pain medication we'll need to have her pain thoroughly evaluated by a physician. Also, when we get to the ASI's "Drug and Alcohol" section, we'll want to review her medication use.

M6 The counselor note indicates: "pain/fatigue/nausea"; these could be signs of a serious medical problem. In addition, Mary is concerned about some "private" medical problems which she didn't want to discuss (at least, not yet).

M7 M8 These two items tell us that Mary is extremely concerned about her health. Consequently, we've got to be sure that her treatment plan will rapidly and effectively address her medical concerns.

Summing Up

Mary's got several medical issues that will require a physician's attention. When was the last time she has seen a physician? Has she been getting adequate medical attention? We will need to keep these questions in mind as we develop Mary's "Problem List" (the next step in developing a good treatment plan).

> *It is worth noting that although there's a lot of information on this page, we got most of the treatment planning elements from just six items--plus some important notes by the counselor*

Now let's take a look at the Employment and Support sections of Mary's ASI.

Employment/Support Status

In this section we're interested in determining to what degree, if any, Mary needs help in finding employment, vocational training or economic support. For many of our clients this can be an extremely important section.

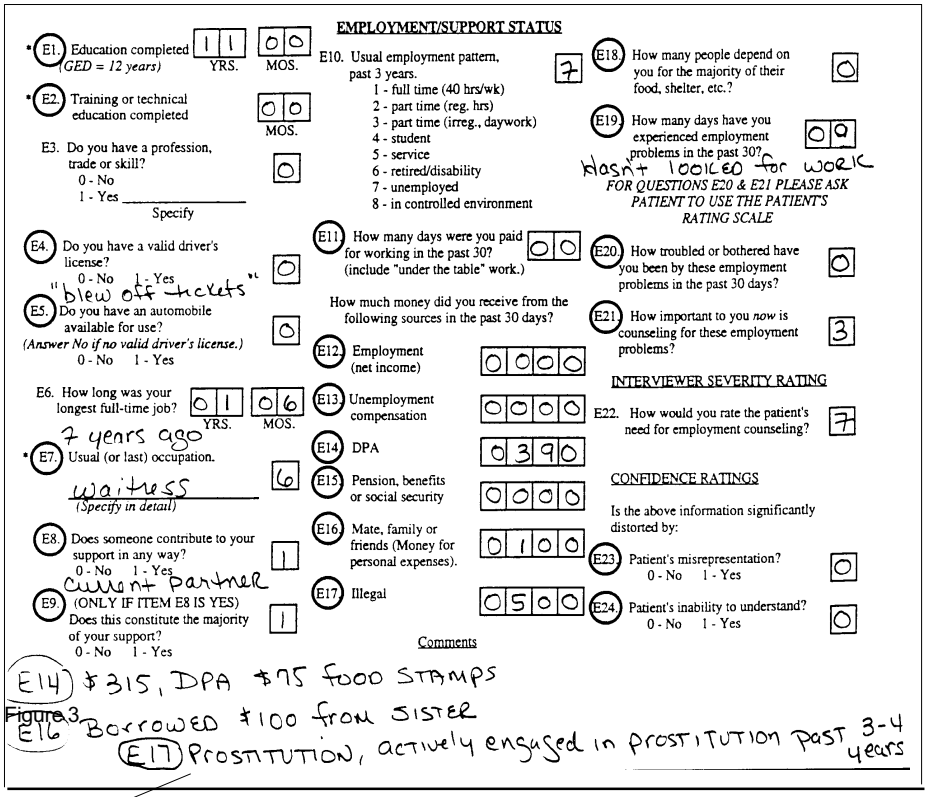


Figure 3

Chronically Unemployed...Sort of

E1, E2 and E3 reveal that Mary lacks technical and professional skills.

With items E4 and E5 her situation gets a little worse--she doesn't drive either so she is dependent upon public transportation.

In fact, Mary has been unemployed E10 for at least the past three years.

E14 Mary currently gets $390 a month from DPA and food stamps, but the majority of her income is derived illegally (prostitution) E17. This has been her primary means of support for the past 3 or 4 years.

Please notice that item E21 reveals that she is quite interested in being assisted with employment counseling.

Summing Up

Mary has significant employment challenges. She does not have a GED and reports that she has no job skills (E1, E2 & E3). The longest period of employment for Mary was only a year and a half (E6); she has been unemployed for the majority of the past 3 years (E17) and she is supporting herself through prostitution.

Consequently, our treatment plan should help Mary attain the employment skills she will need to find and maintain legitimate employment.

Hmmm. Mary's already got several challenges in front of her and we haven't even gotten to the drug and alcohol section yet.

A coincidence? Probably not. Problems multiply and then invite more problems along. On the other hand, our recognition of her employment needs could instill hope in Mary and strengthen our therapeutic relationship.

Drug and Alcohol Use

Now, what are Mary's substance use history and treatment needs?

D1 through D12 (plus the counselor notes) reveal the following to us about Mary:

Mary is shooting 5 bags of heroin just about every day. When we look over here (D15) we find that she can not recall ever being abstinent for a month. Mary's got a strong habit. One which demands obedience to it's call. And it calls about five times a day.

In addition, it appears that Mary is using "street" and prescribed medications whenever she can get them.

A Brief History of Her Addiction

As D13 indicates, Mary's been using substances in combination for seven years.

As the note on D5 suggests, Mary's drug use increased after a car accident in which her boyfriend died. Is this when her pain started? Since Mary was the driver, she might have some unresolved guilt and grief. We need to keep this in mind when we get to the Psychiatric section of her ASI.

Treatment History

Although Mary's been in treatment four times, a closer look reveals that three of those treatment experiences were "detox only". She was in a methadone program for six months, but continued using heroin the whole time she was there. We'll want to suggest a more intensive commitment to treatment this time.

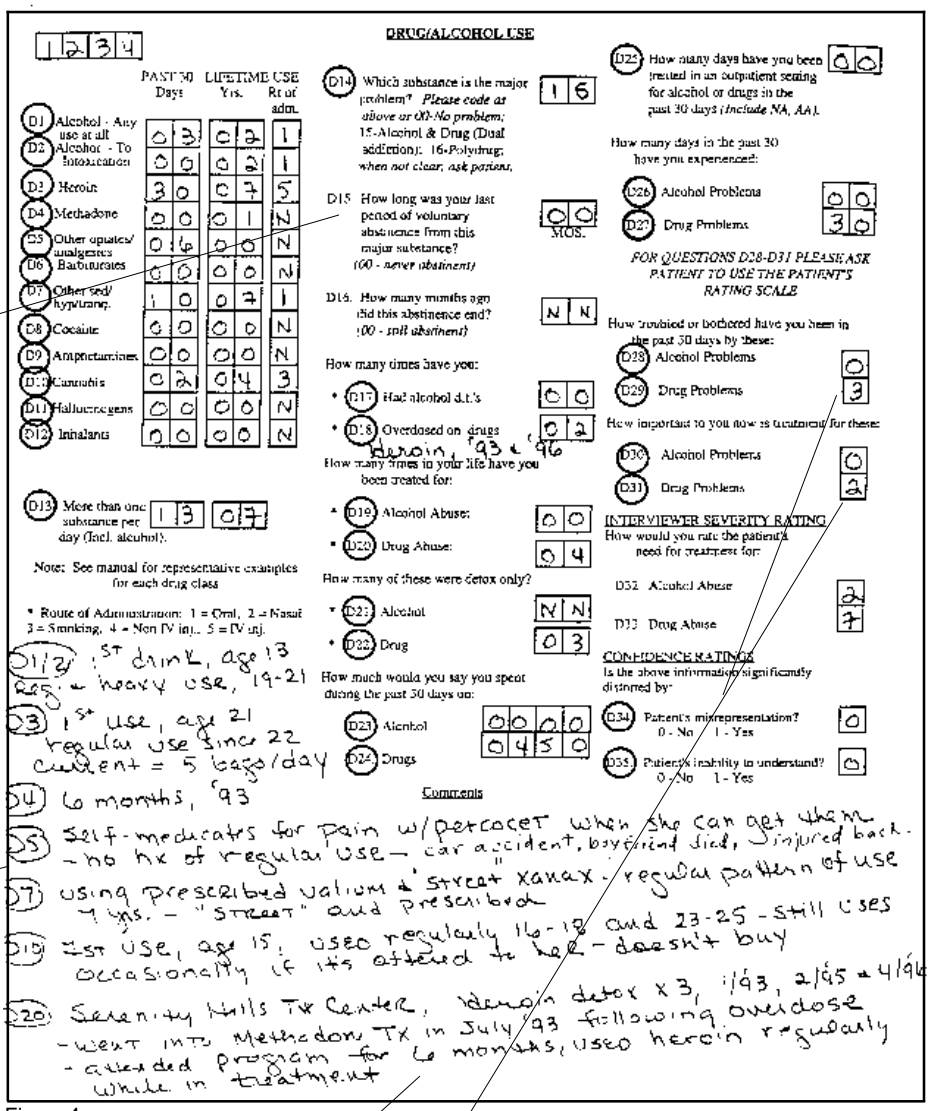


Figure 4

Readiness

Looking at her responses to D29 and D31, it appears that Mary is only moderately motivated to quit using heroin at this time. It will be a challenge to get her to examine her addiction and increase her readiness to make meaningful changes.

Summing Up

We need to develop a treatment plan with Mary that addresses her drug dependence. Methadone again? Drug-free? The ASI doesn't answer these questions, though it offers some clues. We'll need to discuss this issue with Mary. In addition, Mary's been taking pills for a long time. We may need to help her find alternative ways of managing her physical and emotional pain.

Arrest History

As you can see from L3-L17, Mary's been arrested 11 times and has had four convictions. However, one of the most important items in this section is right here:

One of the pressures leading Mary to seek treatment is that she is awaiting "charges, trial or sentencing" for her second probation violation.

Mary has been involved in prostitution for about four years L27 . This may be another habit which could be difficult for her to break. We'll want to bring that up when we sit down to do "treatment planning".

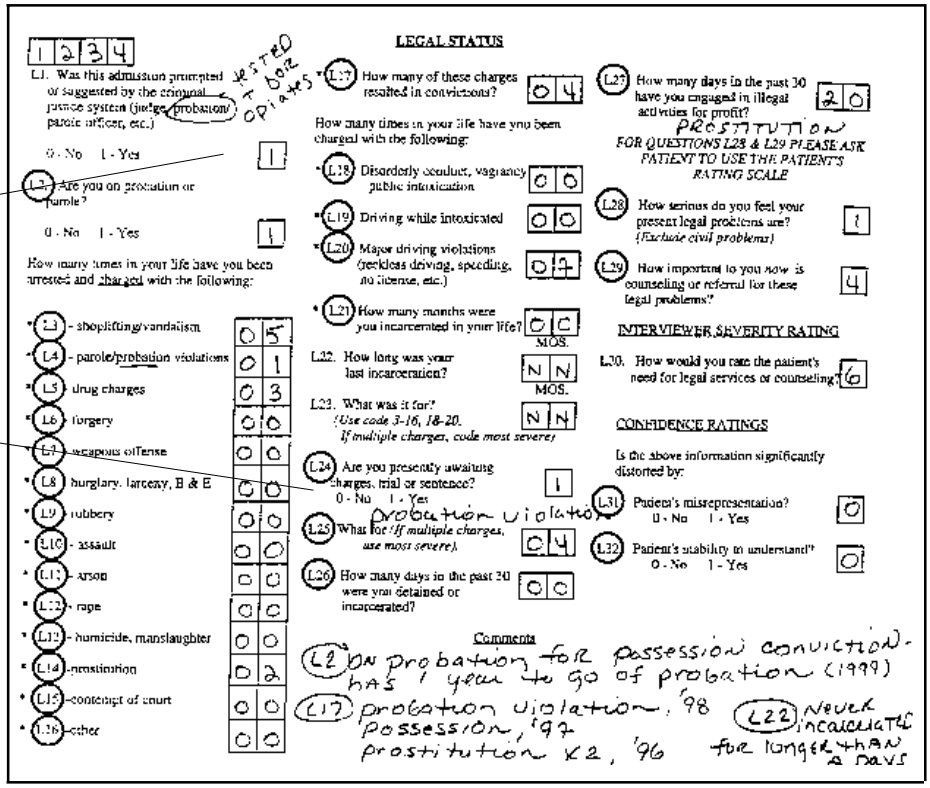


Figure 5

Mary's Motivation

Looking at L29, we discover that Mary is highly motivated to deal with her legal problems even though she doesn't think they're very serious. What do you suppose this means?

Perhaps Mary wants to get her probation officer "off her back" but doesn't think that she did anything that was too serious. Is this an aspect of her denial, or simply defiance? We will need to help her think through the seriousness of her legal problems and risks.

Prostitution

Typically, someone else--perhaps quite early in her life--introduced Mary to the idea of exchanging sex for money, security or protection. When we get to the Family section of the ASI, we will want to explore this aspect of her life to determine whether there is a history of sexual abuse.

Summing Up

We see from L1 that Mary's got a probation officer who thinks she's got a drug problem and that she needs help. That's the good news. The bad news is that Mary disagrees.

Nonetheless, because her probation officer is forcing her into treatment, Mary is willing to comply, if only minimally. If we can work with her in designing an attractive treatment plan, her compliance may become a new habit and the beginning of a new life.

Our challenge will be to use Mary's legal difficulties as leverage in gaining her compliance, while at the same time maintaining a positive, therapeutic relationship with her. To do this, it may be important to work closely with her probation officer. Consequently, we will want to get a consent from Mary so that you can interact with her probation officer.

Family History

Even a relatively quick examination of Mary's "Family History" adds some color to her clinical picture. What does this compact section tell us?

Mom's Side

From H1 to H5, we notice that on her mother's side, there is a strong history of alcoholism. Her grandmother, mother, at least one aunt and uncle were (or are) alcoholic. In addition, we can see now that there's a strong history of psychiatric problems on her mother's side, too.

Sibling Substance Use

In addition, H11 shows us that Mary's brother had, or has, both drinking and drug problems. In other words, Mary's addiction was not unusual in her family.

What about Dad's Family?

Mary never knew her father, and so we don't know anything about him or his side of the family.

Summing Up

Whether you subscribe to a genetic, an environmental or a combined view of addiction, Mary appears to have an extremely strong pedigree for addiction.

FAMILY HISTORY

Have any of your relatives had what you would call a significant drinking, drug use or psych problem- one that did or should have led to treatment?

	Mother's Side				Father's Side				Siblings			
		Alc	Drug	Psych		Alc	Drug	Psych		Alc	Drug	Psych
H1.	Grandmother	1	0	X	H6. Grandmother	X	X	X	H11. Brother (1)	1	1	0
H2.	Grandfather	X	X	X	H7. Grandfather	X	X	X				
H3.	Mother	1	0	1	H8. Father	X	X	X	H12. Sister (1)	0	0	0
H4.	Aunt	1	0	1	H9. Aunt	X	X	X				
H5.	Uncle	1	1	0	H10. Uncle	X	X	X				

Direction: Place "0" in relative category where the answer is clearly no for all relatives in the category; "1" where the answer is clearly yes for any relative within the category; "X" where the answer is uncertain or "I don't know" and "N" where there never was a relative from that category. Code most problematic relative in cases of multiple members per category.

(H8) Mary never knew her father - has no knowledge of his side of the family

Figure 6

Her ASI reveals three generations of addiction and two generations of psychiatric problems. Even without knowledge of her dad, we can see that Mary had powerful familial history.

So what does this mean for Mary's treatment plan?

First of all, Mary probably cannot expect to get a lot of healthy support from her addicted mom or brother if they are still active in their addictions. If they are not in recovery, we should probably begin thinking early on about encouraging her to establish a supportive network of other people. Along these lines we might want to explore whether she can get support from her sister.

Let's see if the next section: "Family and Social Relationships" sheds any more light on our understanding of Mary and her treatment needs.

Family/Social Relationships

What types of relationships has Mary had in her background? If we take just a minute to scan this page, a disturbing scenario begins to take shape:

Poor Relations

We know from F1 through F6 that Mary is single and reports no stable living arrangement for the three years prior to living with her current partner. While he does not appear to be abusive (F27-F29), he drinks heavily and uses heroin (F7-F8). Since Mary is expressing "indifference" with many important areas of her family and social relations, we will want to explore this aspect of her life later on.

In F9 Mary tells us that she spends most of her time with "associates" and later reports that she has never had a close friend (F11, F24).

Although she reports having had a close relationship with a sexual partner and with a sister (F14, F15), on balance, it does not appear that she has had much nurturance or support as a child or currently as an adult.

In addition, given Mary's involvement in prostitution, the fact that she reports being sexually abused earlier in her life takes on special meaning; we will want to address this in individual counseling.

Summing Up

Mary clearly wants help in dealing with her current family and social relations.

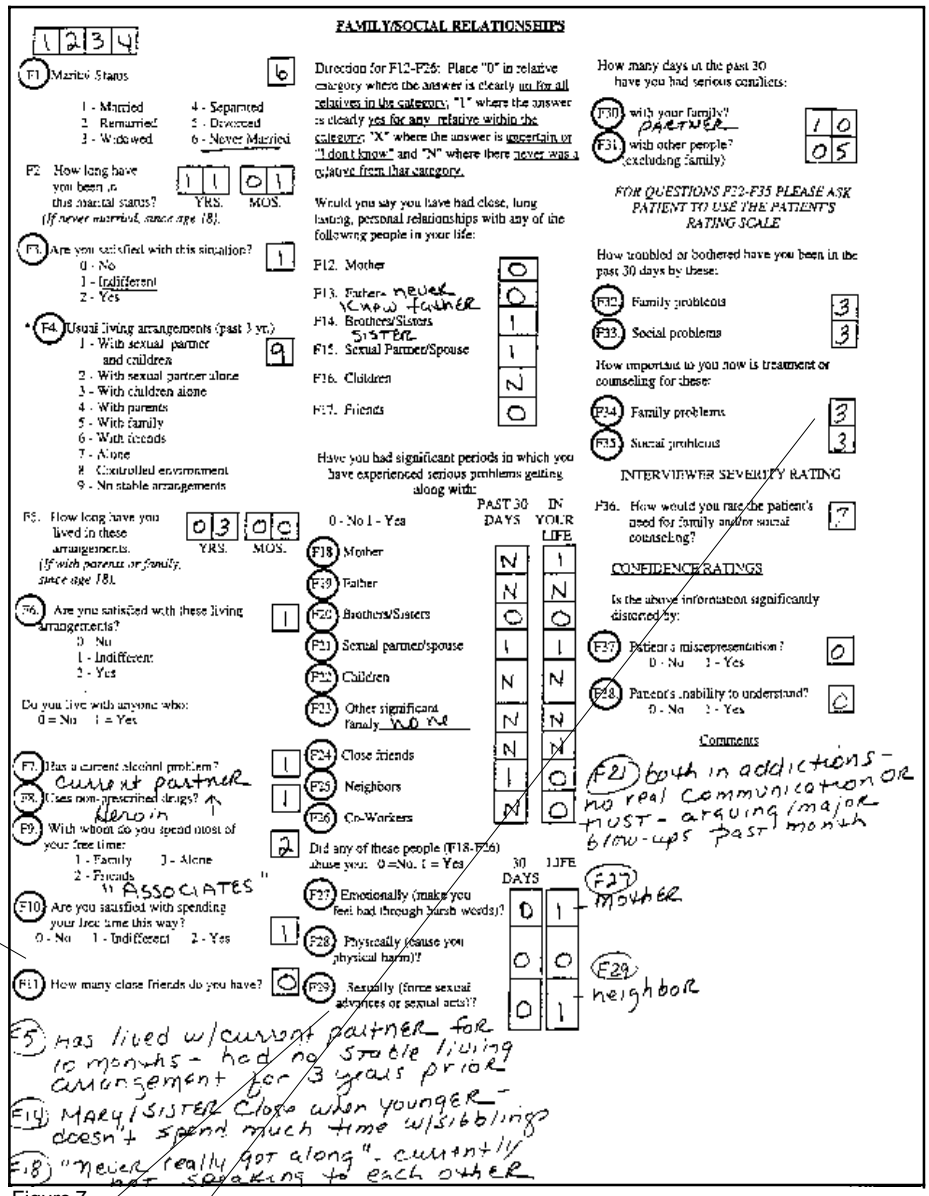


Figure 7

Mary wants to have better social and family relations (F34 and F35). Consequently, her treatment plan will need to provide her with guidance in addressing this important need.

Before we begin developing a treatment plan with Mary, we've got one more important ASI section: Psychiatric Status. Let's see what it tells us about Mary's treatment needs.

Psychiatric Status

This section of the ASI adds some very useful information about Mary's emotional problems and her treatment needs.

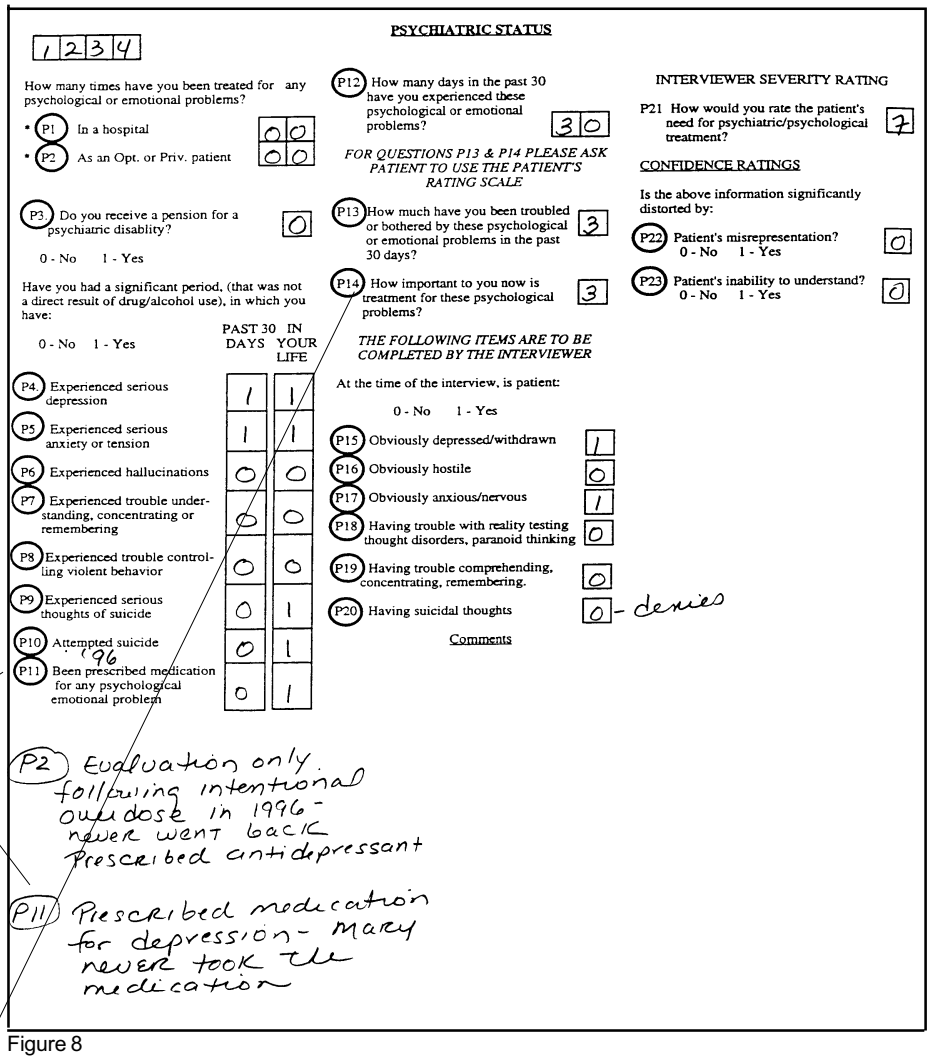
Untreated Depression

Her answers to items P2 P4 P5 P9 P10 and P12 present a clear picture of someone who may be suffering from clinical depression and anxiety. Every day, for the past 30 days, Mary has been experiencing anxiety and depression. She even reports to us that she had attempted suicide about two years ago.

Mary had been prescribed medication at least once for her depression. Why didn't she take it then? Were there obstacles to her complance? Misinformation? Side-effects? Did she take it long enough to get any relief? Most importantly, would she be willing to take an anti-depressant now?

It is interesting, and possibly significant to note that despite reporting a long history of depression, Mary only rates her emotional problems as being "considerably" bothersome rather than "extremely". Perhaps, this is an expression of the apathy that so often accompanies depression.

Another area that may require attention is the possibility of Post Traumatic Stress Disorder (PTSD). We will not know whether this is related to her sexual abuse until we discuss this with her, but we will want to be sure and keep this in mind, as well.



PSYCHIATRIC STATUS

1 2 3 4

How many times have you been treated for any psychological or emotional problems?

- P1 In a hospital: 00
- P2 As an Opt. or Priv. patient: 00

P3 Do you receive a pension for a psychiatric disablity? 0 (0 - No 1 - Yes)

Have you had a significant period, (that was not a direct result of drug/alcohol use), in which you have:

0 - No 1 - Yes	PAST 30 DAYS	IN YOUR LIFE
P4 Experienced serious depression	1	1
P5 Experienced serious anxiety or tension	1	1
P6 Experienced hallucinations	0	0
P7 Experienced trouble understanding, concentrating or remembering	0	0
P8 Experienced trouble controlling violent behavior	0	0
P9 Experienced serious thoughts of suicide	0	1
P10 Attempted suicide '96	0	1
P11 Been prescribed medication for any psychological emotional problem	0	1

P12 How many days in the past 30 have you experienced these psychological or emotional problems? 30

FOR QUESTIONS P13 & P14 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

P13 How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? 3

P14 How important to you now is treatment for these psychological problems? 3

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER

At the time of the interview, is patient: (0 - No 1 - Yes)

- P15 Obviously depressed/withdrawn: 1
- P16 Obviously hostile: 0
- P17 Obviously anxious/nervous: 1
- P18 Having trouble with reality testing thought disorders, paranoid thinking: 0
- P19 Having trouble comprehending, concentrating, remembering: 0
- P20 Having suicidal thoughts: 0 - denies

Comments

INTERVIEWER SEVERITY RATING

P21 How would you rate the patient's need for psychiatric/psychological treatment? 7

CONFIDENCE RATINGS

Is the above information significantly distorted by:

- P22 Patient's misrepresentation? 0 (0 - No 1 - Yes)
- P23 Patient's inability to understand? 0 (0 - No 1 - Yes)

P2 Evaluation only. following intentional overdose in 1996 - never went back Prescribed antidepressant

P11 Prescribed medication for depression - Mary never took the medication

Figure 8

Summing Up

Mary clearly needs to be evaluated for possible depression and anxiety disorders. Her depression has existed for several years and has been severe enough to lead to a suicide attempt (P10).

She had been prescribed antidepressants once, but ended up not taking the medication (P11). Now that Mary has returned to treatment, perhaps she will be willing to give medication another try. We should probably point out that there are some new antidepressants that are more effective yet have fewer side effects.
Our treatment plan will need to address Mary's long-term depression and anxiety. In developing that portion of her treatment plan, we will want to be sure to think through with her any possible objections she may have about taking medications and following through with counseling.

Having now reviewed the seven sections of the ASI, let's take a step back and develop with her a "Problem Summary" list--the next step in the treatment planning process.

Master Problem List

As we worked our way through the seven sections of the ASI, we were jotting down on Mary's "Master Problem List" all of the items that seemed to be important enough to address in her initial treatment plan. On review, it looks like Mary's ASI assessment revealed eight significant problems.

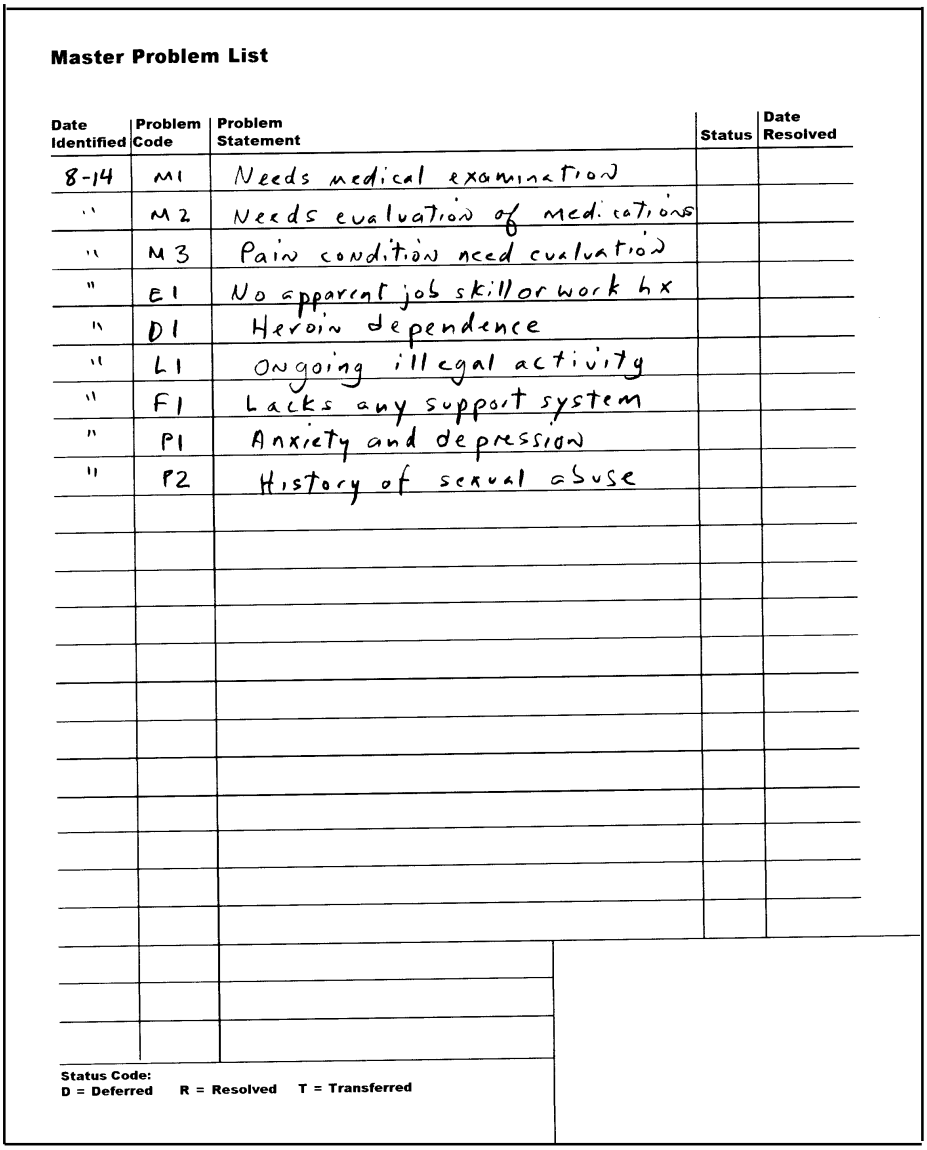
This isn't necessarily all of her difficulties, and if you were writing up the problem list for Mary you might have come up with some different items. In any event, as you can see, Mary's got challenges in just about every area of her life.

Take a Step Back

Before moving on to Mary's Treatment Plan, it a good idea to pause for a moment and ask Mary to consider how the various problems in her life might be prioritized and addressed. Since nobody likes writing lengthy documents, let's see if it is possible to come up with an efficient treatment plan for Mary--one which addresses her problems in the simplest manner and will be accepted by Mary.

Looking over Mary's Master Problem List, we see lots of medical issues. These can be addressed by getting her to the right physican. He or she will have to accept Medicaid insurance and should be aware of addictions and psychiatric issues.

Next, there's a cluster of problems that all seem to be somewhat interrelated: lack of education and job skills, poor support system and high risk occupation (prostitution). Fortunately, there are a number of excellent recovery houses for women which are ideally suited to meet Mary's needs in these areas. Here she'll get support for recovery, distance from her life on the street and, after she completes the recovery house "blackout period," they'll help her find a job. She'll need more training than the recovery house can provide, but in terms of priorities, this issue can wait until she's safe and settled in.



Master Problem List

Date Identified	Problem Code	Problem Statement	Status	Date Resolved
8-14	M1	Needs medical examination		
"	M2	Needs evaluation of medications		
"	M3	Pain condition need evaluation		
"	E1	No apparent job skill or work hx		
"	D1	Heroin dependence		
"	L1	Ongoing illegal activity		
"	F1	Lacks any support system		
"	P1	Anxiety and depression		
"	P2	History of sexual abuse		

Status Code:
D = Deferred R = Resolved T = Transferred

Figure 9

"Heroin dependence" and "anxiety and depression" are next on the Problem list. It's best if these three conditions can all be addressed in the same setting (a co-existing disorders program), but a fundamental issue still needs to be resolved: should Mary enter into a "drug-free" or "methadone maintenance" program? Of course, as we mentioned earlier, treatment planning is a collaborative process. The clinician needs to propose ideas, but it is up the client to carry them out. It's their life and it's their choice.

Mary's Turn

Having come up with some possible solutions for Mary, it's now time to sit down with her and see what she wants to do. Since she's sitting in our waiting room right now, let's talk with her.

Medical Care

Mary was clearly receptive to getting help for her pain so we thought we'd begin our treatment planning session on a point of agreement.

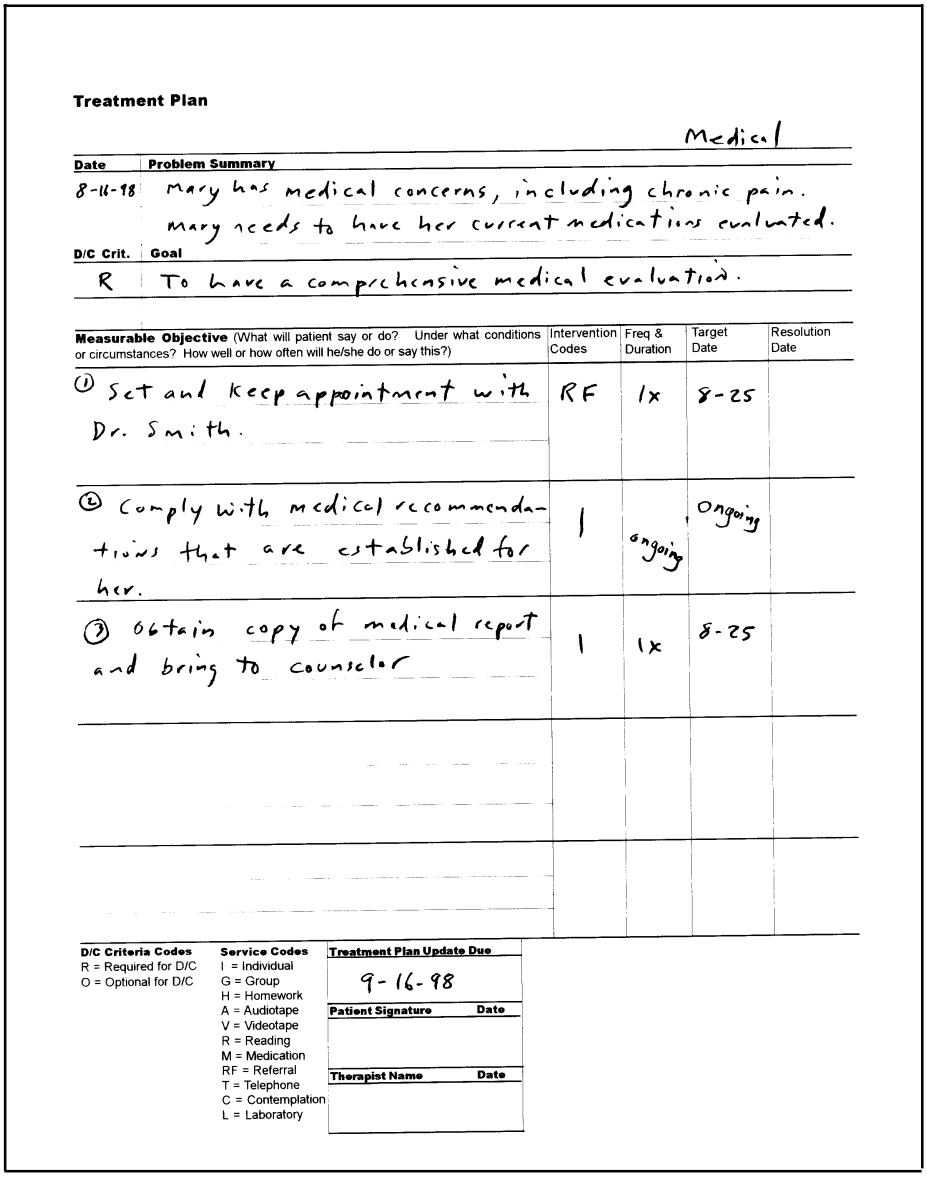
Although Mary was concerned about what problems might get uncovered by a physical exam, she was ready to move forward and we scheduled an exam while she was still in our office. She also promised to bring the findings of her exam to her outpatient counselor, including the results of any lab studies.

Follow-up

As it turned out, Mary did in fact have a significant chronic pain condition resulting from a car accident. Her counselor and physician have begun working together to get Mary into a pain management program involving physical rehab, medication and supportive counseling.

Although Mary did not contract the HIV virus (as she had feared), her lab work revealed that she has Hepatitis C. She has been referred to a specialist for this condition and is exploring treatment options now.

Finally, Mary's diabetic condition was seriously out of control. She has now returned to a regular routine for managing her diabetes and the recovery house has been able to accommodate her need for a special diet and exercise.



Treatment Plan

Medical

Date	Problem Summary
8-11-98	Mary has medical concerns, including chronic pain. Mary needs to have her current medications evaluated.

D/C Crit.	Goal
R	To have a comprehensive medical evaluation.

Measurable Objective (What will patient say or do? Under what conditions or circumstances? How well or how often will he/she do or say this?)	Intervention Codes	Freq & Duration	Target Date	Resolution Date
① Set and keep appointment with Dr. Smith.	RF	1x	8-25	
② Comply with medical recommendations that are established for her.	I	ongoing	Ongoing	
③ Obtain copy of medical report and bring to counselor	I	1x	8-25	

D/C Criteria Codes	Service Codes
R = Required for D/C	I = Individual
O = Optional for D/C	G = Group
	H = Homework
	A = Audiotape
	V = Videotape
	R = Reading
	M = Medication
	RF = Referral
	T = Telephone
	C = Contemplation
	L = Laboratory

Treatment Plan Update Due: 9-16-98

Patient Signature — Date

Therapist Name — Date

Figure 10

Just in Time

It was a good thing that Mary was forced into treatment. If her medical conditions had been allowed to continue to worsen without proper treatment, she may have developed even more serious health problems.

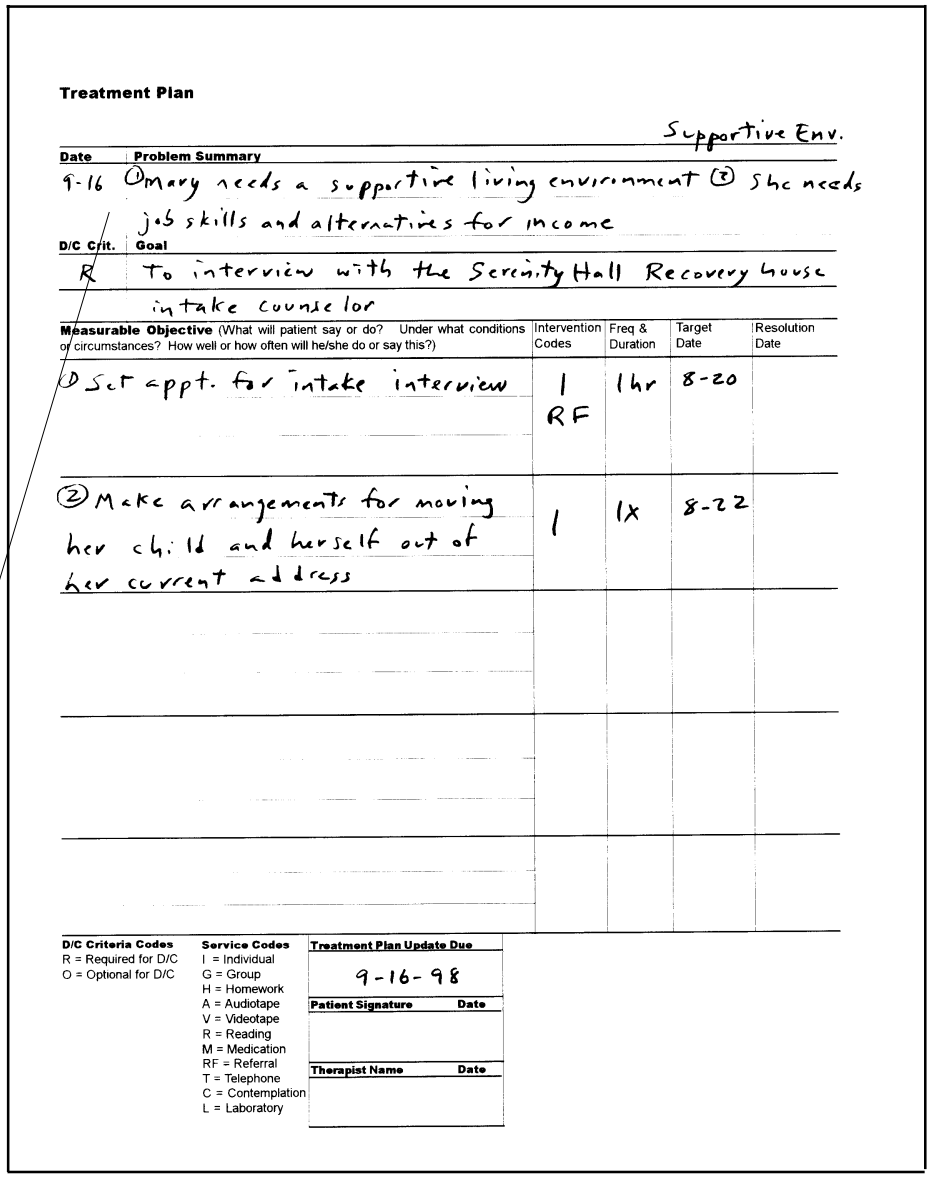
Unfortunately, our discussion with Mary about changing her support system didn't go nearly so well...

Support System

Mary refused to even consider moving out of her current living arrangement. While she was not happy with her current boyfriend, and she realized how his substance use might compromise her recovery, she simply wasn't ready to commit to taking such a big step.

This is Mary's treatment plan, not ours. As counselors our role in the treatment planning process is to offer recommendations and encouragement. Clearly, on this particular part of her plan, we were moving more quickly than Mary was prepared to go.

When it became apparent that Mary was strongly opposed to moving into a recovery house, we put this page of her plan aside, pulled out a blank form, and asked Mary: "What do you want to do about these problems?"



Treatment Plan

Supportive Env.

Date	Problem Summary
9-16	① Mary needs a supportive living environment ② She needs job skills and alternatives for income

D/C Crit.	Goal
R	To interview with the Serenity Hall Recovery House intake counselor

Measurable Objective (What will patient say or do? Under what conditions or circumstances? How well or how often will he/she do or say this?)	Intervention Codes	Freq & Duration	Target Date	Resolution Date
① Set appt. for intake interview	1 RF	1hr	8-20	
② Make arrangements for moving her child and herself out of her current address	1	1x	8-22	

D/C Criteria Codes
R = Required for D/C
O = Optional for D/C

Service Codes
I = Individual
G = Group
H = Homework
A = Audiotape
V = Videotape
R = Reading
M = Medication
RF = Referral
T = Telephone
C = Contemplation
L = Laboratory

Treatment Plan Update Due
9-16-98

Patient Signature **Date**

Therapist Name **Date**

Figure 11

Mary's Choice

Mary did not offer any new solutions to her difficulties except to say, "Don't worry, I can find some other job". Noting her defensiveness, we apologized to Mary for misunderstanding her situation. We asked her to help us get a better understanding of her responses to the items on the ASI that led me to make these recommendations (e.g. items from "Employment/Support", "Family/Social" and "Drug and Alcohol").

By taking a respectful, collaborative approach, Mary became less defensive, and open to suggestion. In the end, Mary agreed to visit our Recovery House.

Follow Up

Mary set and kept her appointment with the Recovery House intake worker--and she seemed to like what she saw. Although she did not immediately enter the program, about a week after her meeting with them, she had a fight with her boyfriend and showed up at the program for an unscheduled admission. Fortunately for her, there was an opening, and after some initial resistance to the House Rules, she eventually agreed to comply with the program, and moved in.

Addiction Treatment

Mary has requested that she be transferred from our drug-free service (where her ASI was completed) to our methadone program.

Based upon her addiction history, the high risk behaviors that she had been engaging in and her relative lack of motivation for becoming drug-free, this seemed like her best choice. Fortunately our center offers methadone as well as drug-free treatment and so we were able to transfer to that division of our program.

Dual Capabilities

In addition, Mary agreed to be evaluated by a psychiatrist who works in our methadone program. Having her psychiatric issues addressed at the methadone clinic increases the likelihood that she will follow through this time. In addition, it will enable her to have her medications periodically re-evaluated without having to go to a different clinic.

Follow Up Report

After a rocky start, Mary eventually became stabilized on 60 milligrams of methadone. She has been coming to the clinic on a regular basis for about a month now, and she has significantly reduced her use of all other illicit substances.

Mary was seen by our psychiatrist who diagnosed her as having PTSD and depression.

Treatment Plan

Addiction Tx

Date	Problem Summary
8-16	① Mary is physically dependent upon opiates, including heroin ② Mary is depressed and anxious ③ Mary wants to enter our methadone program.
D/C Crit.	**Goal**
R	To enroll Mary in our methadone program and schedule her for an assessment of her psychiatric status.

Measurable Objective (What will patient say or do? Under what conditions or circumstances? How well or how often will he/she do or say this?)	Intervention Codes	Freq & Duration	Target Date	Resolution Date
① Schedule an intake appointment at our methadone clinic.	RF	1X	8-16	
② Coordinate psychiatric assessment with our psychiatrist	RF	1X	8-16	

D/C Criteria Codes
R = Required for D/C
O = Optional for D/C

Service Codes
I = Individual
G = Group
H = Homework
A = Audiotape
V = Videotape
R = Reading
M = Medication
RF = Referral
T = Telephone
C = Contemplation
L = Laboratory

Treatment Plan Update Due
9-16-98

Patient Signature **Date**

Therapist Name **Date**

Figure 12

Her anxiety disappeared once she began treatment. She was prescribed an antidepressant, but once again, Mary elected not to take it. She indicated that she preferred to see how she was doing after a month or so off the streets and in her new life. Mary agreed that if, after a couple months, she wasn't feeling better, she would be willing to reconsider her decision.

In the meantime, she would remain in counseling and continue her participation in Narcotics Anonymous and Alcoholics Anonymous, which she had begun attending with some of the other women in the recovery house.

The Treatment Planning Process

Treatment planning is a collaborative process in which a team of professionals and the client develop a written document that:

a. identifies the client's most important treatment goals

b. describes measurable, time-sensitive steps towards achieving those goals

Let's break this process down to it's component parts.

Collaborative Assessment Process

One of the first things that happens to our clients when they enter treatment is that members of a treatment team begin asking lots of questions. Some of these questions are purely administrative in nature (e.g. "what type of insurance do you have") and others are more clinical in nature (e.g. "when did you have your last drink"). All of these questions contribute to the assessment process, and as such, should be considered during the treatment planning process.

In many organizations people with varying credentials collect information from the client. A clerk may obtain demographic and insurance information, a nurse may obtain medical information and a counselor may complete an ASI and interview the client's family. In other organizations, one person single-handedly collects all the information that constitutes the assessment. In either case, a good treatment plan incorporates information from all possible sources.

Many of us work in settings where there are only one or two professional disciplines represented (such as counselors and a physician). For example, the treatment team may include a physician and several counselors. It has been our experience that the best treatment plans are developed when the client and a multi-disciplinary clinical team work together in a collaborative process, sharing ideas and solutions.

Sources of Assessment Information

There are a wide range of possible sources of information all of which may contribute to the assessment process. Some of these information sources include, but are not limited to:

- Intake Interview
- ASI
- Psychosocial History
- Family & Friends Interview
- Medical Assessment
- Psychiatric Assessment
- Nursing Assessment
- Laboratory Studies (e.g. drug screen)
- Probation Officer Report
- Police Report (if client was referred by criminal justice system)
- EAP Referral Information

All of this information, when available, should be considered by the treatment team prior to beginning the treatment planning process.

Preliminary vs. Master Treatment Plans

Many programs develop an initial, or preliminary treatment plan, usually within the first 24 hours after a client has been admitted. This is a requirement of the JCAHO as well as many States. A preliminary treatment plan is designed to get the treatment process started even before a comprehensive assessment has been completed. Preliminary treatment plans need to be followed by a comprehensive treatment plan within a matter of days (on an inpatient unit) or couple weeks (in an outpatient service).

Preliminary treatment plans identify services that are to be provided and the time frames for achieving specific critical tasks such as the completion of the comprehensive assessment. Preliminary treatment plans, by their very nature, have a limited degree of individualization because the assessment process has not yet been implemented. Nonetheless, whatever information is available should be carefully considered when developing a preliminary treatment plan.

For example, if our intake interview revealed that an outpatient client was living in a situation

where drugs were freely available or with other active drug addicts, we would want to immediately begin working with the client to find alternative housing. If we delay this particular intervention too long, there is a significant risk that the client may not remain in treatment long enough to complete a comprehensive assessment!

Master Problem List

Throughout the accumulation of all assessment information, the clinical staff should add items to the client's Master Problem List. Once again, this should be a collaborative process with all members of the clinical staff contributing from their professional perspectives. A sample "Master Problem List" Form is attached.

Quite simply, any problem or area of concern for the client or clinical team should be placed on the Master Problem List. This list should be updated periodically with items dropped as they are resolved and others added as the clinical team becomes aware of them.

Diagnostic Summary

Many states, as well as the JCAHO, require that addiction treatment and mental health programs complete a Diagnostic Summary prior to developing a comprehensive treatment plan. The diagnostic summary pulls together all of the available assessment information into one integrated *interpretation* of the client's current status. A good diagnostic summary attempts to paint a clear picture of the client's personal history, strengths and challenges. Areas covered in a diagnostic summary might include, but not be limited to:

- Mental Status
- Possible Mental Disorders
- Risk Assessments
- Treatment History
- Reasons for Treatment
- Physical Health & Nutrition
- Substance Use History
- Obstacles to Recovery
- Work History
- Family History
- Sexuality & Intimate Relations
- Beliefs and Values
- Education History
- Finances History
- Military History
- Legal Problems
- Freetime
- Special Issues
- Assets
- Liabilities
- Readiness to Learn

When a diagnostic summary is properly written, other clinicians should be able to get a decent understanding of the client from it.

One of the benefits of writing a diagnostic summary is that the author is forced to think about the client in order to develop an interpretation of all the assessment information. The individual writing the diagnostic summary not only reviews all of the assessment information, but also attempts to boil down all of this data into the essential, critical elements.

Upon completing this thoughtful process, the counselor is ready to move forward and begin developing a treatment plan.

Writing a Treatment Plan

Problem Summary

A treatment plan typically begins with a Problem Summary (see our sample Treatment Plan Form). The Problem Summary pulls items from the Master Problem List and whenever possible combines related problems.

For example, in Mary's case, our Master Problem List included the following items (see page 13):

- Needs medical exam
- Needs medications evaluated
- Pain status needs to be assessed

Mary's Problem Summary combined these items into the following statements:

Mary has medical concerns including chronic pain. Mary needs to have her current medications evaluated.

Goal

The next element of a treatment plan is the creation of a treatment goal. A goal describes the desired

outcome to be achieved by the client. Referring back to Mary's case, her medical goal was:

To have a comprehensive medical evaluation.

Goals are usually global in nature and have no time frames associated with them. Nonetheless, they summarize the desired result that we are hoping to achieve if our efforts are successful.

Objectives (or Action Steps)

It is in the Objectives section of a treatment plan that we develop specific, time-sensitive and measurable steps that will be taken in order to achieve the goal. The Objectives section identifies:

- a target date for achieving each objective
- the type of services to be utilized in achieving each objective
- the frequency of that service

Refer back to Mary's Medical treatment plan and review the Objectives section.

Resolution Date

Most addiction treatment counselors discover fairly quickly that it is easy to lose site of the client's treatment objectives. For this reason, the counselors progress notes should routinely refer back to the treatment plan objectives. Progress towards the achievement of these objectives should be noted in the progress notes; similarly modifications and updates to the goals and objectives should be recorded in these notes.

As objectives are achieved, the appropriate date it was resolved should be noted. This way, when new plans are developed it is easy to identify what still needs to be accomplished.

Multiple Problems and Goals

Treatment plans typically include three to five specific goals and each goal has its own set of Objectives. Our client's lives are complex and often require several treatment initiatives across several fronts.

The determination of how many treatment goals to develop begins with a review of the Master Problem List.

To the degree that it is possible, the treatment planning team will want to see which items on the Master Problem List can be combined together and addressed by a single treatment goal.

For example, Mary had nine items on her Master Problem List, but only required three Treatment Goals.

Client Involvement

Everything we have described so far referred to work performed by the counselor and members of his or her clinical team. Once the treatment plan has been written, however, the next step is to sit down with the client to discuss the plan. After all, it *is* the client's treatment plan.

Treatment plans need to be written in clear, jargon-free language so that clients can read it and understand what is being proposed. Similarly, each objective in a treatment plan needs to be specific, referring to only one action or task to be performed. If recovery were a cake, the treatment plan would be the recipe!

Presenting the Treatment Plan

Clients are free to accept or reject any or all elements of a treatment plan. This is a client right. On the other hand, treatment programs are free to end the treatment relationship when a client's reluctance is so extreme that there is no common ground.

Typically, however, if the treatment planning team has accuratedly assessed the client's treatment needs as well as his or her readiness to change, there will be a meeting of minds. Even when there are differences of opinion, the client benefits by getting to see what the treatment team considers to be their best recommendations.

Recovery, after all, is a process, not an event. Clients often need to "try on for size" various aspects of this new life that is being proposed. This is no small matter. Reluctance on the part of a client to embrance his or her treatment team's plan simply means that the team has either:

a. attempted to move the client too quickly

b. failed to help the client see what the treatment team sees.

In both cases, future opportunities will present themselves for revisiting the treatment plan--provided the client has remained in treatment. On of the most common challenges of outpatient treatment programs is client retention. Effective, well-designed treatment plans can increase client retention by timing the introduction of treatment interventions to match a client's readiness to change.

In a sense, the treatment plan is similar to a contract negotiation between the client and counselor and treatment team. The treatment team has taken the time to learn about the recovery process in general, and through a careful assessment process, has uncovered the treatment needs of the client.

A well-crafted treatment plan conveys this knowledge and care in a simple document which serves as the basis of a "negotiation process". Either party can walk away from the negotiation, but both are worse off if this happens.

Conclusion

This ends our discussion of treatment planning in general, and ASI-based treatment planning, in particular. It is hoped that this manual demonstrates how the ASI can be used as a treatment planning tool--and how superior treatment plans will lead to superior treatment outcomes.

Stages of Change
Handouts

Transtheoretical Model of Behavior Change

Healthy and Wise has been developed using the Transtheoretical Model of Behavior Change as the primary model to influence students' health behaviors and, ultimately, to encourage students to use a self-reflection and decision making process to improve and maintain their health.

Authors of the Transtheoretical Model: James O. Prochaska, Ph.D. & Carlo C. DiClemente, Ph.D.

James O. Prochaska, Ph.D. is the Director of the Cancer Prevention Research Consortium and Professor of Clinical and Health Psychology at the University of Rhode Island. He received his Ph.D. in Clinical Psychology in 1969 at Wayne State University. He has published more than 100 papers on behavioral change for health promotion and disease prevention. A recent study conducted by the Institute for Scientific Information and the American psychological Society listed him among the 10 most influential authors in Psychology. He has been Principal Investigator on over $40M in research grants on prevention of cancer and other chronic diseases. He is also a Consultant to the American Cancer Society, the Centers for Disease Control & Prevention, numerous health maintenance organizations, corporations, research journals and universities & research centers. He has been an invited speaker at many regional, national & international meetings & conferences.

Carlo DiClemente, Ph.D. is Chair and Professor of Psychology at the University of Maryland Baltimore County since 8/95. He is the co-developer to the Transtheoretical Model Dr. Prochaska started. He received his Ph.D. in Clinical Psychology from the University of Rhode Island in 1978. He had his Postdoctoral Fellowship in Houston, Texas in 1979. He has been a research specialist, the Chief of Alcoholism Treatment Center, Chief of Addictive Behavior and Psychosocial Research at the Texas Research Institute of Mental Sciences, Associate Professor of the Dept. of Psychiatry and Behavioral Sciences at the Univ. of Texas Medical School, and Professor of the Dept. of Psychology at the Univ. of Houston. Despite moving to Maryland, he is still a Consultant at the Sid W. Richardson Institute for Preventive Medicine of the Methodist Hospital at Houston, and Faculty Associate of School of Public Health at the Univ. of Texas Center for Health Promotion.

The Transtheoretical Model notes the **5 stages of change** (the phases people go through) individuals use to change their troubled behavior: **precontemplation, contemplation, preparation, action, and maintenance.** This model advocates that an appropriate and successful intervention can only be implemented when it is determined which stage an individual is in.

Stages of Change

* **Precontemplation**
* **Contemplation**
* **Preparation**
* **Action**
* **Maintenance**

Precontemplation

* Has no intention to take action within the next 6 months.

Contemplation

* Intends to take action within the next 6 months.

Preparation

* Intends to take action within the next 30 days and has taken some behavioral steps in this direction.

Action

* Has changed overt behavior for less than 6 months.

Maintenance

* Has changed overt behavior for more than 6 months.

Healthy and Wise does not overtly categorize activities in the curriculum as precontemplation, contemplation, preparation, action, and maintenance. However, the activities fall into the five stages and are useful for teachers to assign to students that are in a specific health stage. Below are the cognitive behavioral processes within each stage with suggested healthy and Wise activities and strategies. During a healthy and Wise training session, teachers are trained to use the Transtheoretical Model of Behavior Change and select appropriate activities and lessons in Healthy and Wise for students in each stage of this model to initiate a process of change or to support existing behaviors in a specific stage.

Strategies for Students in the Precontemplation Stage

Cognitive/Behavioral Processes	Strategies and Activities
*Social Support Stay away from stinkin' thinkin' people.	Utilize healthy and Wise learning centers, cooperative group activities, and family activities to build social support. Healthy and Wise encourages good health behaviors and attitudes.
*Consciousness-Raising/ Increasing Awareness	Utilize the up-to-date content in Healthy and Wise to create awareness.
*Increasing Healthy Opportunities	Utilize Healthy and Wise activities that give students opportunities to make healthy choices or use decision-making skills to choose healthy options. Provide plenty of time for physical activity including a daily recess period. Provide healthy food options in the cafeteria and in vending machines. Encourage ongoing support from food service personnel, school nurses, and counselors.
*Seeking and Welcoming Outside Influences	Utilize community guest speakers and give students information on recreational physical activities or sports leagues available in the community.

Strategies for Students in the Contemplation Stage

Cognitive/Behavioral Processes	Strategies and Activities
Social Support	Utilize Healthy and Wise learning centers, cooperative group activities, and family activities to build social support. Healthy and Wise encourages good health behaviors and attitudes.
Consciousness-Raising/ Increasing Awareness	Utilize the up-to –date content in Healthy and Wise to create awareness.
Increasing healthy Opportunities	Utilize healthy and Wise activities that give students opportunities to make healthy choices or use decision-making skills to choose healthy options. Provide healthy food options the cafeteria and in vending machines. Encourage ongoing support from food service personnel, school nurses, and counselors.
Seeking and Welcoming Outside Influences	Utilize community guest speakers and give students information on recreational physical activities and sports leagues available in the community.
*Emotional Arousal/Stirring Up Emotions	Use Healthy and Wise stories and articles that students and families can relate to. Real world experiences.
*Self-Evaluation/Taking Stock	Use Healthy and Wise reflection activities. Use food and exercise journals, healthy and Wise evaluation tools, Elementary Health Index Modules, etc.

Strategies for Students in the Preparation Stage

Cognitive/Behavioral Processes	Strategies and Activities
Social Support Stay away from stinkin' thinkin' people.	Utilize Healthy and Wise learning centers, cooperative group activities, and family activities to build social support. Healthy and Wise encourages good health behaviors and attitudes.
Increasing Healthy Opportunities	Utilize Healthy and Wise activities that give students opportunities to make healthy choices or use decision-making skills to choose healthy options.
Seeking and Welcoming Outside Influences	Utilize community guest speakers and give students information on recreational physical activities and sports leagues available in the community.
Emotional Arousal/Stirring Up Emotions	Using Healthy and Wise stories and articles that students and families can relate to. Real world experiences.
Self-Evaluation/Taking Stock	Use food and exercise journals, Healthy and Wise self-evaluation tools, Elementary Health Index Modules.
* Commitment/Willingness to Act	Use the Healthy and Wise activities that have students make a plan to change.
*Taking Small Steps	Encourage realistic health goals as students develop their Healthy and Wise lifestyle changes. Change is a process, not an event.
*Preparing for Change	Utilize the research activities to help students and families help prepare for change. Evaluate how these changes might affect day-to-day life and plan adjustments.
*Setting a Date for Action	Students should indicate when they will begin the plan.

Strategies for Students in the Action Stage

Cognitive/Behavioral Processes	Strategies and Activities
Social Support Stay away from stinkin' thinkin' people	Utilize healthy and Wise learning centers, cooperative group activities, and family activities to build social support.
Commitment	Monitor progress and commitment. Use monthly Healthy and Wise issues to support ongoing commitment to health and physical activity.
*Rewards Extrinsic/Intrinsic	Use non-food rewards to support good health behaviors. Encourage students to recognize the intrinsic rewards of healthy lifestyle habits. Recognize and praise good health behaviors.
*Countering	Use activities that encourage students to think of or list healthier alternatives. Use fun physical activities to replace junk food reward or snacking habits.
*Environmental Control	Help students learn to develop healthy grocery lists. Select activities that require students to suggest healthier environments or habits. Ask parents to provide healthier food options at parties.
*Helping Relationships/Support	Bring in additional people that can help support or reinforce healthy lifestyle behaviors. Athletic coaches, trainers, registered dieticians, etc. Ask school nurses, counselors, and food service personnel to enhance the monthly Healthy and Wise curriculum. Encourage students to seek helpful relationships at home or in their neighborhood. Use Healthy and Wise content that identifies helpful relationships or people.

Strategies for Students in the Maintenance Stage

Cognitive/Behavioral Processes	Strategies and Activities
Social Support Stay away from stinkin' thinkin' people.	Utilize Healthy and Wise learning centers, cooperative group activities, and family activities to build social support.
Commitment	Monitor progress and commitment. Use monthly Healthy and Wise issues to support ongoing commitment to health and physical activity.
Rewards Extrinsic/Intrinsic	Use non-food rewards to support good health behaviors. Encourage students to recognize the intrinsic rewards of healthy lifestyle habits. Recognize and praise good health behaviors.
Countering	Use activities that encourage students to think of or list healthier alternatives. Use fun physical activities to replace junk food rewards or snacking habits.
Environmental Control	Help students learn to develop healthy grocery lists. Select activities that require students to suggest healthier environments or habits. Ask parents to provide healthier food options at parties.
Helping Relationships/Support	Bring in additional people that can help support or reinforce healthy lifestyle behaviors. Athletic coaches, trainers, registered dieticians, etc. Ask school nurses, counselors, and food service personnel to enhance the monthly healthy and Wise curriculum. Encourage students to seek helpful relationships at home or in their neighborhood.
*Boredom and Potential Relapse	Use Healthy and Wise activities to continuously challenge students throughout the year. Encourage students to set new goals and celebrate their successes.
*Avoiding Injuries or Overconfidence	Healthy and Wise continuously reinforces sports safety concepts. Utilize these concepts and activities on an ongoing basis.
*Helping Others/Mentoring	Encourage students to help or mentor others. Students or families in the maintenance stage should be asked to provide assistance, demonstrations, examples, etc. as much as possible. Use them as role models.