Addiction Severity Index

Manual And Question by Question Guide

From
The University of Pennsylvania/Veterans Administration Center for Studies of Addiction
Supported by Grants from the National Institute of Drug Abuse and the Veterans Administration

Treatment Research Institute
600 Public Ledger Building, 150 S. Independence Mall West
Philadelphia, PA 19106-3475
(800) 238-2433

This document was printed by:
Oklahoma Department of Mental Health and Substance Abuse Services
Printing Facility

Updated May 2016

ASI BASIC TRAINING

The Correct Administration and Application of the Addiction Severity Index

Resources

- Download ASI and order ASAM instructional material
  - www.tresearch.org
  - www.inflexxion.com
  - www.asam.org
- Search for client information
  - www.oscn.net
  - www.doc.state.ok.us
  - www.odcr.com

Introductions

Name

Agency

Experience with ASI

Hopes & Expectations

Goals

To develop and/or enhance interviewer competencies in ***correctly*** utilizing the Addiction Severity Index.

To better understand the crucial considerations for patient placement.

To understand the relationship of the ASI and the ASAM to correct development of individualized, assessment driven treatment plans and continuing progress monitoring.

Objectives

- Identify the specific intention of each question asked in the ASI.
- Phrase each question in the most efficient way while remaining flexible enough to adapt the instrument to specific clients.
- Verify information through cross checking and collateral information.
- Help identify information not specific to the ASI that must be included to fulfill requirements of a complete "biopsychsocial" structured interview.

Objectives (cont'd)

- Understand the importance of the use of additional probes to augment information provided by the client.
- Consistently apply the correct numerical codes in response to client answers.
- Properly utilize and understand the severity rating procedure.
- Using ASI-Lite for discharge and continuing care updates.

Objectives (cont'd)

What this class will NOT do

- Teach you how to be a better "paper-work filler-outer".
- Convince you that the ASI is the only or even the best assessment tool.
- Change your interviewing style or technique.
- Answer all questions in a black/white, true/false, right/wrong manner.

ASI Platforms

- Paper and Pencil
- Computer/Self-Administered (ex. ASI-MV)

History of the ASI

- Developed in 1980 (yep, that's over 30 years ago)
- Created to enable clinical researchers to evaluate treatment outcomes.
- As it was meant to measure outcomes, questions had to cover different time frames and was suitable for follow-up.
- Widely used, translated into nine languages

Purpose/Function of the ASI

- The ASI is a standardized, semi-structured, multi-focus screening and assessment tool.
- It is NOT a test.
- Designed for use primarily with substance involved clients.
- Used to collect information in all life areas that are most often impacted by substance abuse.
- Has clinical, evaluation and research applicability when administered in follow-up settings.

Quick Review Definitions

- SCREENING: the process of determining through use of specific instruments, the possible presence of a condition (for our purposes, mental health, substance abuse or trauma issues).
- ASSESSMENT: the process of determining the severity of a condition.
- PATIENT PLACEMENT: a protocol for determining the best, safest and least intrusive venue to receive treatment.

Screening

SCREENING: the process of determining through use of specific instruments, the possible presence of a condition (for our purposes, mental health, substance abuse or trauma issues).

- Screening tools establish the presence or absence of a problem or condition.
- Indicates need for more comprehensive evaluation.
- Screening instruments are **NOT** diagnostic tools.
- Examples of single focus screening tools are SASSI, Beck Depression Index and MAST.

ti-focused screening (and
l.

Assessment

ASSESSMENT: the process of determining the severity of a condition.

- Assessment initiates and guides the continuum of care throughout treatment.
- Often indicate the need for more in-depth evaluation.
- Must be continuous throughout treatment, to determine client progress (or lack thereof).
- Assessment must include client input.
- Provide an objective measurement device to chart progress (or lack thereof) through treatment.

Patient Placement

PATIENT PLACEMENT: a protocol for determining the best, safest and least intrusive venue to receive treatment.

- How we use of ASAM PPC criteria to consistently make patient placement decisions based on the presenting problems (symptoms) and their severity
  - ODASL
  - LOCI

Why Use Standardized Instruments?

- Facilitates the collection of accurate information in a reliable and consistent manner.
- Helps to develop broader recovery plans including all aspect of clients' life.
- Identify change (or lack of) throughout treatment process.
- Provides clinicians and treatment agencies with increased accountability (by measuring outcomes).

Strengths and Benefits of the ASI

- Has been shown to be both reliable and valid.
- Reasonably short administration time (45-90 minutes)
- Can (and should) be used throughout treatment to identify progress (ASI-Lite/ASI).
- Helps to identify inconsistencies in client responses.
- Widely accepted nationally (and internationally)
- Flexible to accommodate different counseling and interviewing styles.

Limitations

- Age, did I mention that the ASI is over 30 years old and has not been revised in many years.
- Does not address issues such as culture, trauma, military service, gender specific issues, etc.
- Confusing regarding treatment episodes (alcohol or drug only, detox only).
- Does not include information regarding quantity of drugs or alcohol consumed (only frequency).

Key Points: Coding and Rating

- **Know the intent of each section and the specific questions.**
- Re-phrase or explain questions as needed.
- ***ALWAYS probe*** **for additional information.**
- **Avoid making assumptions. (Why did I rate this section as I did?)**
- **Be aware of personal biases, beliefs and values limit their influence in scoring.**
- **Interviewer Severity Rating is completely independent of client rating. Your clinical judgment trumps clients' lack of insight or motivation.**

The Three C's

- **Coding**: check for completeness leaving no blanks and checking for simple coding errors.
- **Consistency**: Look for inconsistencies in client answers. If found should be addressed. ("Help me understand. You said this and now you're saying that. Which is closer to correct?")
- **Completeness**: Make sure to make copious notes and ask many follow-ups. **AN ASI WITH NO COMMENTS IS INCOMPLETE.**

Coding and Rating

- Leave no blanks spaces
- Only one character/number per box

- Question not answered: X
- Question does not apply: N

- Two distinct time periods
  - **Past 30 days**
  - **Life time (prior to/independent from 30 days ago)**

Client Rating Scale

In the past 30 days how trouble or bothered have you been by these problems?

Speaks to client insight

How important to you know is treatment, counseling or referral for these problems?

Speaks to client readiness to change

Client Rating Scale

- O Not at all
- 1 Slightly bothered (or slightly willing)
- 2 Moderately
- 3 Considerably
- 4 Extremely

Interviewer Severity Rating (ISR)

- Interviewer severity rating primarily to determine met or unmet needs in that life area.
  - 0-1 No problem (treatment or services not indicated)
  - 2-3 Slight problem (problems need to be monitored but services probably not necessary)
  - 4-5 Moderate problem (services indicated and problem needs to be addressed)
  - 6-7 Considerable problems (services indicated and should be addressed as a treatment issue-on treatment plan)
  - 8-9 Extreme problem (immediate danger/services absolutely necessary and needed immediately)

Interviewer Severity Rating and Treatment Planning

- ISR of 0-3 indicates no unmet needs that require being addressed in treatment.
- ISR of 4 or greater indicates some unmet needs that need to be addressed (either as treatment plan goal or in Summary of Assessments).
  - **Oklahoma Healthcare Authority sets "4" or more in alcohol or drug section as indicative of needed treatment.**

Introducing the ASI

- ASI is a standardized semi-structured interview that all clients receive.
- It will take approximately one hour.
- All information is confidential (discuss limits of confidentiality).
- THE ASI IS NOT A TEST.
- Client is free not to answer any question you choose not to answer.
- The purpose of the interview is to help clinician (me) identify presenting problems/unmet needs to plan a course of treatment suitable to you.

Introducing the ASI

Seven distinct life areas covered

- Medical
- Employment/Support
- Alcohol
- Drug
- Legal
- Family/Social
- Psychiatric

Medical Section

- The intent of this section is to determine to what extent physical health problems are caused by or exacerbated by substance use.
- Question M1 does not include ER visits if not admitted or problem free child birth. (If there are multiple ER visits it is important to capture that information as additional.
- Question M4 list all medications currently taken or prescribed and regular use of OTC meds. Need to determine a) prescribing MD, b) how long have been taking (or should have been taking), c) dosage and frequency, d) as directed or not.
- List "psychiatric meds but if possible list separately from other meds.

Corresponds to ASAM domains 1, 2 & 4

Employment and Support

- Intent of section is to determine the employability of the client and see if the clients history indicates the ability to adequately care for self and/or family.
- This section may very well indicate necessity of case management to handle areas such as vocational rehab, job, skills, finding a job, GED classes, need for TANF/food stamps, etc.

Corresponds to ASAM Dimensions 6

Interviewer Severity Rating Simplified Version*

- 0 (replaces both 0 and 1) and indicates no problems.
- 3 (replaces 2 and 3) and indicates slight problem for which treatment is not necessary. "Watchful Waiting".
- 5 (replaces 4 and 5) indicates slight to moderate problem and must be addressed.
- 7 (replaces 6 and 7) indicates serious problems for which treatment is necessary.
- 9 (replaces 8 and 9) and indicates extreme problem for which treatment is mandatory and essential immediately.

*Interviewer may use all numbers in scale if so desired.

Drug and Alcohol Sections

- These are distinct sections with similar questions to be asked about alcohol and/or drugs (medications).
- Intent of sections is to determine lifetime and recent problematic use, consequences, prior treatment experience, periods of abstinence.

Definitions:

- "extended periods"-6 months or more
- "regular use"- 3days per week or more, problematic irregular use, or binge usage
- "alcohol to intoxication"- 3 or more drinks in a sitting or 5 or more drinks in a day.

Corresponds to ASAM dimensions 1, 4, & 5

Interviewer Severity Rating Simplified Version*

- 0 (replaces both 0 and 1) and indicates no problems.
- 3 (replaces 2 and 3) and indicates slight problem for which treatment is not necessary. "Watchful Waiting".
- 5 (replaces 4 and 5) indicates slight to moderate problem and must be addressed.
- 7 (replaces 6 and 7) indicates serious problems for which treatment is necessary.
- 9 (replaces 8 and 9) and indicates extreme problem for which treatment is mandatory and essential immediately.

*Interviewer may use all numbers in scale if so desired.

Legal Status

- This section covers only "criminal" legal problems. However, if client is experiencing other legal issues (e.g. child custody, divorce, lawsuits, IRS problems, etc) this should be noted in the comment section.
- To determine if criminal problems preceded substance abuse or became more intense as a result of substance use.

Corresponds to ASAM dimensions 4 & 6.

Interviewer Severity Rating Simplified Version*

- 0 (replaces both 0 and 1) and indicates no problems.
- 3 (replaces 2 and 3) and indicates slight problem for which treatment is not necessary. "Watchful Waiting".
- 5 (replaces 4 and 5) indicates slight to moderate problem and must be addressed.
- 7 (replaces 6 and 7) indicates serious problems for which treatment is necessary.
- 9 (replaces 8 and 9) and indicates extreme problem for which treatment is mandatory and essential immediately.

*Interviewer may use all numbers in scale if so desired.

Family and Social Status

- Includes family history section. This only applies to genetically related family members.
- Information about family of origin (if different from biological family) needs to be captured as part of a comprehensive extra questioning).
- Section will help determine how much of the client's life is filled socially with other users.
- To help determine and identify others who may be supportive of recovery efforts.

s to ASAM domains 5 and 6

Interviewer Severity Rating Simplified Version*

- 0 (replaces both 0 and 1) and indicates no problems.
- 3 (replaces 2 and 3) and indicates slight problem for which treatment is not necessary. "Watchful Waiting".
- 5 (replaces 4 and 5) indicates slight to moderate problem and must be addressed.
- 7 (replaces 6 and 7) indicates serious problems for which treatment is necessary.
- 9 (replaces 8 and 9) and indicates extreme problem for which treatment is mandatory and essential immediately.

*Interviewer may use all numbers in scale if so desired.

Psychiatric Status Section

- The main purpose of this entire section is to determine if there is the existence of co-occurring or mental health (only) issues.
- Helps to determine extent to which psychiatric difficulties have impacted client's life and if they may interfere with treatment efforts.
- To determine if psychiatric issues are a part of or is independent of substance use.

Corresponds to ASAM dimensions 4, 5 & 6

Interviewer Severity Rating Simplified Version*

- 0 (replaces both 0 and 1) and indicates no problems.
- 3 (replaces 2 and 3) and indicates slight problem for which treatment is not necessary. "Watchful Waiting".
- 5 (replaces 4 and 5) indicates slight to moderate problem and must be addressed.
- 7 (replaces 6 and 7) indicates serious problems for which treatment is necessary.
- 9 (replaces 8 and 9) and indicates extreme problem for which treatment is mandatory and essential immediately.

*Interviewer may use all numbers in scale if so desired.

Concluding the Interview

- Thank the client for their time and honesty.
- Let them know that this information will be used to help determine a course of treatment (along with their input)
- Short Review of all sections of the ASI, especially those with an ISR of 4 or greater to develop "master problem list".

ASAM

The American Society of Addiction Medicine is an organization of over 5000 physicians board certified in the recognition and treatment of those individuals with substance use or co-occurring issues.

The Patient Placement Criteria was developed to better coordinate treatment across multiple levels of care and to identify the intensity of treatment needed.

Criticisms of ASAM

- Some service venues not available (at all or in a timely manner).
- Too complicated (no specific form or format).
- Too complicated (cont'd) The manual is 379 pages to instruct how to follow protocol for patient placement.

Using the ASAM Criteria

- The ASAM PPC-2r is NOT an assessment instrument.
- All information necessary to properly determine placement decisions is based on screening and assessment that PRECEDES patient placement.
- One of the primary determinants of level of care placement is the potential lethality of the clients' current condition.

ASAM Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications.
4. Readiness to Change.
5. Relapse, Continued Use or Continued Problem Potential.
6. Recovery Environment.

ASAM Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications.
4. Readiness to Change.
5. Relapse, Continued Use or Continued Problem Potential.
6. Recovery Environment.

ASAM Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications.
4. Readiness to Change.
5. Relapse, Continued Use or Continued Problem Potential.
6. Recovery Environment.

ASAM Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications.
4. Readiness to Change.
5. Relapse, Continued Use or Continued Problem Potential.
6. Recovery Environment.

ASAM Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications.
4. Readiness to Change.
5. Relapse, Continued Use or Continued Problem Potential.
6. Recovery Environment.

ASAM Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications.
4. Readiness to Change.
5. Relapse, Continued Use or Continued Problem Potential.
6. Recovery Environment.

ASAM Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications.
4. Readiness to Change.
5. Relapse, Continued Use or Continued Problem Potential.
6. Recovery Environment.

Determining Patient Placement from Assessment

- 1. Acute intoxication and/or withdrawal potential
- 2. Biomedical conditions or complications
- 3. Emotional, behavioral or cognitive conditions orcomplications.
- 4. Readiness tochange.
- 5. Continued use or relapse potential.
- 6. Recoveryenvironment.

Lethality

Lethality (cont'd)

2) <u>Biomedical Conditions and Complications</u>

This information comes from the medical section of assessment. The question to answer is "Do medical conditions interfere with the clients' ability to engage in treatment?"
and/or
"Does this condition have the possibility of death if medical treatment is not provided?"

Lethality (cont'd)

3) Emotional, Behavioral or Cognitive Conditions or Complications.

"Does this client represent a threat to himself or someone else?"

and/or

"Does this client have sufficient cognitive capability to participate in and benefit from treatment (at a sub-acute level of care)?"

Withdrawal Management Services for Dimension 1

- I-D – Ambulatory Withdrawal Management without Extended On-Site Monitoring
- II-D – Ambulatory Withdrawal Management with Extended On-Site Monitoring

Withdrawal Management Services for Dimension 1 (con't.)

- III.2-D – Clinically-Managed Residential Withdrawal Management
- III.7-D – Medically-Monitored Inpatient Withdrawal Management
- IV-D – Medically-Managed Inpatient Withdrawal Management

Treatment Levels of Service

Level 0.5 and OMT

- **Level 0.5: Early Intervention Services** – Individuals with problems or risk factors related to substance use, but for whom an immediate Substance –Related Disorder cannot be confirmed
- **Opioid Maintenance Therapy (OMT)** – Criteria for Level I Outpatient OMT, but OMT in all levels

Level I and II Services

- Level I Outpatient Treatment
- Level II.1 Intensive Outpatient Treatment
- Level II.5 Partial Hospitalization

Level III Residential/Inpatient

- Level III.1 Clinically-Managed, Low Intensity Residential Treatment
- Level III.3 Clinically-Managed, Medium Intensity Residential Treatment (Adult Level only)

Level III Residential/IP (Con't.)

- Level III.5 Clinically-Managed, Medium/High IntensityResidential Treatment
- Level III.7 Medically-Monitored Intensive Inpatient Treatment

Level IV Services

- Level IV Medically-Managed Intensive Inpatient Treatment

PREFACE TO THE FIFTH EDITION OF THE ASI WORKBOOK
April - 1990

At this writing the Addiction Severity Index (ASI) is ten years old. The ASI was created for the special purpose of enabling a group of clinical researchers to evaluate treatment outcome in a six-program, substance abuse treatment network. Since the programs were quite different the ASI had to be fairly generic. Since the budget for the project was small, the data had to be collected by technicians rather than health-care professionals. Since the data had to be collected as part of the clinical process in a relatively short period of time the instrument had to focus on a minimum number of questions and they had to be relevant to the treatment plan that was to be provided. Finally, since a major purpose of the project was to measure outcome (an issue that still remains open to various definitions) the questions had to cover a broad range of potential areas that could be affected by substance abuse treatment and the format of these questions had to be suitable for repeat administration at follow-up contacts. Perhaps this set of initial requirements more than any other rationale explains the resulting orientation and construction of the ASI.

There are three purposes to this fifth edition of the ASI workbook. The first is to provide additional information regarding the intent of the questions in the ASI, special circumstances that affect the overall administration of the ASI as well as exceptions and amplifications to instructions for specific questions within the interview. A second purpose of the present edition is to discuss the shortcomings of the instrument and specific areas that have proven problematic over the past ten years of clinical and research use of the ASI. These issues will be discussed here generally by topic area and are treated in much greater detail in the specific sections of the workbook. A final purpose for this edition of the workbook is to introduce a series of new items that have been added to the ASI. These items have been selected from the work of researchers in the substance abuse area over the past ten years and reflect additional areas that have been shown to be importantly related to the development of treatment plans and to patient prognosis following treatment. These items and the instructions for asking them are discussed generally at the conclusion of this preface (See Additional Questions for the ASI) and in more detail in each of the specific sections of the workbook. Since the Family/Social problem area has been particularly revamped there is a separate section of this workbook devoted to the rationale behind the specific modifications suggested for that area (See page 25).

COMMONLY ASKED QUESTIONS ABOUT THE ASI

The Interview Format - Does It Have to be an Interview? This is perhaps the most often asked question regarding the ASI. In the search for faster and easier methods of collecting data many clinicians and researchers have asked for a self-administered (either by computer or paper and pencil) version of the instrument. We have not sanctioned the use of a self-administered version for several reasons. First, we have tested the reliability and validity of the severity ratings by having raters use just the information that has been collected on the form - without the interview. This has resulted in very poor estimates of problem severity and essentially no concurrent reliability. Second, we have been sensitive to problems of illiteracy among segments of the substance abusing population. Even among the literate there are problems of attention, interest and comprehension that are especially relevant to this population. Finally, since the instrument is often used as part of the initial clinical evaluation, it has been our philosophy that it is important to have interpersonal contact for at least one part of that initial evaluation. We see this as simply being polite and supportive to a patient with problems.

We have seen no convincing demonstration that the interview format produces worse (less reliable or valid) information than other methods of administration and we have found that particularly among some segments of the substance abusing population (e.g. the psychiatrically ill, elderly, confused and physically sick) the interview format may be the only viable method for insuring understanding of the questions asked. Particularly in the clinical situation, the general demeanor or "feel" of a patient is poorly captured without person-to-person contact and this can be an important additional source of information for clinical staff.

There are of course many useful, valid and reliable self-administered instruments appropriate for the substance abuse population. For example, we have routinely used self-administered questionnaires and other instruments with very satisfactory results (e.g. Beck Depression Inventory, MAST, SCL-90, etc.) but these are usually very focused instruments that have achieved validity and consistency by asking numerous questions related to a single theme (e.g. depression, alcohol abuse, etc.). The ASI is purposely broadly focused for the purposes

outlined above, and we have not been successful in creating a viable self-administered instrument that can efficiently collect the range of information sought by the ASI. Thus, it should be clear that at this writing there is no reliable or valid version of the ASI that is self-administered and there is currently no plan for developing this format for the instrument. We would of course be persuaded by comparative data from a reliable, valid and useful self-administered version of the ASI and this is an open invitation to interested parties.

Role of the Interviewer - What are the qualifications needed for an ASI interviewer? Having indicated the importance of the interview process it follows that the most important part of the ASI is the interviewer who collects the information. **The interviewer is not simply the recorder of a series of subjective statements.** *The interviewer is responsible for the integrity of the information collected and must be willing to repeat, paraphrase and probe until he/she is satisfied that the patient understands the question and that the answer reflects the best judgment of the patient, consistent with the intent of the question.* It must be emphasized that the interviewer must understand the intent of each question. This is very important since despite the range of situations and unusual answers that we have described in the manual, a new exception or previously unheard of situation occurs virtually each week. *Thus, ASI interviewers should not expect to find answers in the workbook to all of the unusual situations that they will encounter in using the ASI. Instead it will be critical for the interviewer to understand the intent of the question, to probe for the most complete information available from the patient and then to record the most appropriate answer, including a comment.*

There is a very basic set of personal qualities necessary for becoming a proficient interviewer. First, the prospective interviewer must be personable and supportive - capable of forming good rapport with a range of patients who may be difficult. It is no secret that many individuals have negative feelings about substance abusers and these feelings are revealed to the patients very quickly, thereby compromising any form of rapport. Second, the interviewer must be able to help the patient separate the problem areas and to examine them individually using the questions provided. Equally important qualities in the prospective interviewer are the basic intelligence to understand the intent of the questions in the interview and the commitment to collecting the information in a responsible manner.

There are no clear-cut educational or background characteristics that have been reliably associated with the ability to perform a proficient ASI interview. We have trained a wide range of people to administer the ASI, including receptionists, college students, police/probation officers, physicians, professional interviewers and even a research psychologist!! There have been people from each of these groups who were simply unsuited to performing interviews and were excluded during training (perhaps 10% of all those trained) or on subsequent reliability checks. Reasons for exclusion were usually because they simply couldn't form reasonable rapport with the patients, they were not sensitive to lack of understanding or distrust in the patient, they were not able to effectively probe initially confused answers with supplemental clarifying questions or they simply didn't agree with the approach of the ASI (examining problems individually rather than as a function of substance abuse). With regard to assisting the interviewer in checking for understanding and consistency during the interview, there are many reliability checks built into the ASI. They are discussed in some detail in the workbook and they have been used effectively to insure the quality and consistency of the collected data.

Severity Ratings - How important and useful are they? It is noteworthy that the severity ratings were historically the last items to be included on the ASI. They were considered to be interesting but non-essential items that were a summary convenience for people who wished a quick general profile of a patient's problem status. They were only provided for clinical convenience and never intended for research use. It was surprising and interesting for us to find that when interviewers were trained comparably and appropriately, these severity estimates were reliable and valid across a range of patient types and interviewer types. Further, they remain a useful clinical summary that we continue to use regularly - but only for initial treatment planning and referral.

A Note on "Severity" - It should be noted that much of the reason for the reliability and validity of these severity ratings is the structured interview format and the strict (some would say arbitrary) definition of severity that we have adopted: ie."need for additional treatment." Many users of the ASI have selected the instrument exclusively for research purposes and these ratings have never been used for this purpose - especially as outcome measures. Other users do not agree with our definition of severity. Still others do not have the time or inclination to check and recheck severity estimates among their various interviewers. For all of these potential users the severity ratings would not be useful or worth the investment of man-hours required to train reliability. Even for those with

primary clinical uses, **these ratings are not essential** and are perhaps the most vulnerable of all the ASI items to the influences of poor interviewing skills, patient misrepresentation or lack of comprehension and even the surroundings under which the interview is conducted. *Therefore, it is entirely acceptable to train ASI interviewers and to use the ASI without referral to the severity ratings.*

Composite Scores - What are they for, why were they constructed this way and what are the norms? Users familiar with earlier editions of the ASI know there is a separate manual designed to describe their use and to show how to calculate them (See Composite Scores from the Addiction Severity Index - McGahan et al. 1986). The composite scores have been developed from combinations of items in each problem area that are capable of showing change (ie. based on the prior thirty day period, not lifetime) and that offer the most internally consistent estimate of problem status. The complicated formulas used in the calculation of these composites are necessary to insure equal weighting of all items in the composite.

These composites have been very useful to researchers as *mathematically sound measures of **change** in problem status but have had almost no value to clinicians as indications of **current status** in a problem area.* This is due to the failure on our part to develop and publish normative values for representative groups of substance abuse patients (e.g. methadone maintained males, cocaine dependent females in drug free treatment, etc.). At the risk of being defensive, our primary interest was measuring change among our local patients and not comparing the current problem status of various patient groups across the country. Further, we simply did not foresee the range of interest that has been shown in the instrument.

A Note on "Norms" for the Composite Scores - At this writing, we are collecting ASI data from a variety of patient samples across the country. These samples will be used to convert the composite raw scores into T-scores with a mean of 50 and a standard deviation of 10 (as MMPI and SCL-90 scores are presented). Our intention is to publish these "normative data" and to circulate copies of the tables to all individuals who have sent to us for ASI packets. We will also provide programs written in Basic, Lotus 123® or excel to calculate these composite scores and to convert existing composite scores into T-scores. In this way we hope to make up for the lack of standardization that has been a problem with the composite scores to this time.

Appropriate Populations - Can I use the ASI with samples of Substance Abusing Prisoners or Psychiatrically Ill Substance Abusers? Because the ASI has been shown to be reliable and valid among substance abusers *applying for treatment*, many workers in related fields have used the ASI with substance abusing samples from their populations. For example, the ASI has been used at the time of incarceration and/or parole/probation to evaluate substance abuse and other problems in criminal populations. In addition, because of the widespread substance abuse among mentally ill and homeless populations, the ASI has also been used among these groups. While we have collaborated with many workers on the use of the instrument with these populations; it should be clear that there are no reliability or validity studies of the instrument in these populations.

This of course does not mean that the ASI is necessarily invalid with these groups, only that its test parameters have not been established. In fact, workers from these fields have turned to the ASI because they felt that no other suitable instrument was available. In cases where this is true, it is likely that the ASI would be a better choice than creating a totally new instrument. However, it is important to note circumstances that are likely to reduce the value of data from the ASI among these groups. For example, when used with a treatment seeking sample and an independent, trained interviewer, there is less reason for a potential substance abuser to misrepresent (even under these circumstances it still happens). In circumstances where individuals are being "evaluated for probation/parole or jail" there is obviously much more likelihood of misrepresentation. Similarly, when the ASI is used with psychiatrically ill substance abusers who are not necessarily seeking (and possibly avoiding) treatment, there is often reason to suspect denial, confusion and misrepresentation. Again, there is currently no suitable alternative instrument or procedure available that will insure valid, accurate responses under these conditions. The consistency checks built into the ASI may even be of some benefit in these circumstances. However, it is important to realize the limits of the instrument. Regardless, systematic tests of the reliability and validity of the ASI in populations of substance abusers within the criminal justice system and within the mental health system are necessary but have not been done and this is an open invitation to interested parties.

A Special Note on Adolescent Populations - Despite the fact that we have repeatedly published warnings for potential users of the ASI regarding the lack of reliability, validity and utility of the instrument with adolescent populations there remain instances where the ASI has been used in this inappropriate manner. Again, the ASI is not

appropriate for adolescents due to its underlying assumptions regarding self-sufficiency and because it simply does not address issues (e.g. school, peer relations, family problems from the perspective of the adolescent, etc.) that are critical to an evaluation of adolescent problems. At this writing, there are two versions of the ASI that have been developed for adolescent populations and have shown at least initial evidence of reliability and validity in this population. A third instrument is not in the same format as the ASI but has shown excellent reliability and validity. Interested readers may contact these individuals directly for more information about these instruments.

Kathy Meyers, Treatment Research Institute, 2005 Market Street, Suite 1020, Phila, PA 19103
"Comprehensive Addiction Severity Index-C"

or

Yifrah Kaminer, Adolescent Chemical Dependency Program, Department of Psychiatry, University of Pittsburgh, Pittsburgh, Pa.
"Teen - Addiction Severity Index"

or

Al Friedman, Adolescent Substance Abuse Program, Department of Psychiatry, Philadelphia Psychiatric Center, Phila., Pa.
"Adolescent Drug and Alcohol Diagnostic Assessment"

ADDITIONAL QUESTIONS FOR THE ASI

Can I ask additional questions and/or delete some of the current items? As indicated above, the ASI was designed to capture *the minimum information* necessary to evaluate the nature and severity of patients' treatment problems at treatment admission and at follow-up. For this reason, we have always encouraged the addition of particular questions and/or additional instruments in the course of evaluating patients. In our own work we have routinely used the MAST, an AIDS questionnaire, additional family background questions and some self-administered psychological tests.

We do not endorse the elimination or substitution of items currently on the ASI. Again, the ASI items (regardless of whether they are good or bad for particular individual needs) have been tested for reliability and validity as individual items and as part of the composite and/or severity scores. The elimination or substitution of existing items could significantly reduce the reliability and comparability of these ASI scores. It is possible to eliminate whole sections (problem areas) of the ASI if particular problems are not applicable for specific populations or the focus of specific treatment interventions.

In the current version of the ASI and in this workbook, we have included a set of additional items and instruments that have been developed by us and others over the past ten years, to add information in areas that are now inadequately covered by the existing ASI questions. The items themselves are presented on the latest version of the form (See Appendix 1) and the specific instructions for asking these questions and for interpreting the answers are discussed in each of the problem areas in the Specific Instructions part of the workbook. ***It should be clear that we have not used these items in the calculation of the composite scores or in the determination of severity estimates.*** Obviously, the use of additional information for these purposes would alter the reliability and validity of the ASI and reduce the comparability of the resulting scores across sites and time points. Thus it is important to stress that the use of earlier ASI versions will still provide comparable data on the composite scores and on the majority of items, since they have not been changed or eliminated, only supplemented in the current version.

In addition to these items, there has also been significant work over the past ten years in the development of general and specialized information collection interviews and questionnaires for substance abusers. Some of these instruments bear special note in that they can be used instead of or in addition to the ASI to provide enhanced or specialized information. Some of the more widely used and better validated instruments are presented below but the interested reader is advised to consult the tests and measurements literature for additional information.

ADDITIONAL INSTRUMENTS THAT MAY SUPPLEMENT OR REPLACE ASI PROBLEM SECTIONS

GENERAL DATA COLLECTION FORMS (These forms cover a range of treatment problem areas and are well suited to use research and in some clinical applications)

Instruments - Forms from the Treatment Outcome Prospective Study (TOPS)
Contact Dr. Robert Hubbard, Research Triangle Inst., Research Triangle Park, N.C.

Forms from the Drug Abuse Treatment for Aids Risk(DATAR)
Contact Dr. Dwayne Simpson, Texas Christian University, Fort Worth, TX.

INSTRUMENTS FOR PARTICULAR PROBLEM AREAS

MEDICAL

Instruments - The Risk for AIDS Behavior Inventory (RABI) (Metzger et al., 1990)
Adjustment to Environment section from the Uniform Client Data Instrument (UDCI), Somatic Interference With Function Section (Human Services Research Institute, Boston Mass.

EMPLOYMENT

Instruments - None known.

ALCOHOL USE

Instruments - Quantity/Frequency Index (QFI) (Stinnett & Hayashida, 1980)
Alcohol Dependence Scale (ADS) (Skinner et al., 1984)
Michigan Alcoholism Screening Test (MAST) (Selzer), 1975)

DRUG USE

Instruments - None known.

ILLEGAL ACTIVITY

Instruments - None known.

FAMILY/SOCIAL

Instruments - Adjustment to Environment section from the Uniform Client Data Instrument (UDCI) (Human Services Research Institute, Boston Mass.

Client's Quality of Life Instrument (CQLI) (Human Services Research Institute, Boston Mass.

PSYCHIATRIC

Instruments - Beck Depression Inventory (Beck & Ward, 1962)

Symptom Check List - 90 Item (Derogatis)
Anti-Social Personality Items from DSMIII, DSMIII-R. or DSM-IV

We hope the information provided in this Preface and in the Workbook itself will be helpful in the use of the interview and in understanding its strengths and limitations. We have made every effort to provide a comprehensive addition to the original instrument and to share our thinking on those points where obviously more than one method could have been used. We have also tried to make using the workbook easier by developing an abbreviated manual (See Bragg et al., 1990; A Short Reference Guide to the ASI) that has a series of tables that offer handy reference material regarding ASI definitions, conventions and related information. Finally, we have also developed an additional training aid (See Fureman et al., 1990; Common Questions and Errors from the ASI) that contains most of the commonly asked questions about the ASI and many of the common errors. While these reference guides are by themselves, no substitute for a training course and a complete reading of the full workbook, they should help the occasional user to answer questions without wading through the full workbook.

Good luck with the instrument and please write regarding any of your suggestions and or criticisms C/O A. Thomas McLellan, Bld. #7, PVAMC, University Ave., Phila. Pa. 19104.

ADDICTION SEVERITY INDEX

GENERAL INSTRUCTIONS

I. INTRODUCTION

The Addiction Severity Index is a relatively brief, semi-structured interview designed to provide important information about aspects of a patient's life which may contribute to his/her substance abuse syndrome. It is the first step in the development of a patient profile for subsequent use by research and clinical staff. Thus, it is particularly important that the patient perceive the purpose of the interview. If it is to be used solely as a clinical interview it should be described as the first step in understanding the full range of problems for which the patient is seeking help and the basis for the initial treatment plan. If the ASI is to be used solely for research purposes, then the interviewer should explain that the interview will help to provide a description of his/her condition before and after the intervention or procedure that he/she will undergo. The interviewer should also take this opportunity to describe any potential benefits that the patient may expect from participating in the research project.

The interviewer should introduce himself and briefly state that he wishes to ask the patient some questions regarding the plan for treatment. The interviewer should add that these questions are asked **of all applicants** for treatment/research, that the interview will be completely confidential, and that the information will not leave the treatment/research setting. **NOTE:** This should be reemphasized throughout the interview.

The interviewer should then describe the design of the interview, stressing the seven potential problem areas. These areas are: **Medical, Employment/Support, Alcohol, Drug, Legal, Family/Social, and Psychiatric.** It is important that the interviewer stress the nature of the patient's contribution. For example, the interviewer should state:

"We have noticed that while all of our patients have alcohol/drug problems, many also have significant problems in other areas such as medical, employment, family, etc. In each of these areas, I will ask you if you feel you have problems in these areas, how much you have been bothered by these problems, and how important you feel treatment for those problems is to you. This is an opportunity for you to describe your most important problems; the ones you feel you need the most help with."

The final step of the introduction is the explanation of the patient rating scale (see Section II for specific instructions). This 5-point scale will be used by the patient to answer subjective questions in each problem area and will be presented for reference at this point in the interview. The interviewer should describe the use of the scale and offer an example to test for understanding by the patient.

As the focus of the interview proceeds from one area to the next, it is very important for the interviewer to introduce each new section and to change the patient's focus form the previous area. For example:

"Well I've talked with you about your medical problems, now I'm going to ask you some questions about any employment or support problems you may have."

Thereby the patient will be prepared to concentrate on each of the areas independently. In this regard it is important that the patient not confuse problems in a particular area with difficulties experienced in another area, such as confusing psychiatric problems with those due directly to the physiological effects of alcohol or drug intoxication.

Follow - Up Interviews

If a follow-up interview is to be done at some later point, this also should be included in the introduction. For example:

"With your permission, we would like to get back in touch with you in about six months to ask you some similar questions. In that way, we hope to evaluate our program, to see how helpful it has been."

It is expected that by introducing the interview in a clear, descriptive manner, by clarifying any uncertainties, and by developing and maintaining continued rapport with the patient, the admission interview will produce useful, valid information. Note: The specific instructions for performing follow-up interviews are discussed later in this part of the workbook

II. PATIENT'S RATING SCALE

It is especially important that the patient develop the ability to communicate the extent to which he/she has experienced problems in each of the selected areas, and the extent to which he/she feels treatment for these problems is important. These subjective estimates are central to the patient's participation in the assessment of his/her condition.

In order to standardize these assessments, we have employed a 5 point (0-4) scale for patients to rate the severity of their problems and the extent to which they feel treatment for them is important.

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

For some patients it is adequate to simply describe the scale and its values at the introduction to the interview and occasionally thereafter. For other patients, it may be necessary to arrive at an appropriate response in a different fashion. The interviewer's overriding concern on these items is to get the patient's opinion. Getting the patient to use his/her own language to express an opinion is more appropriate than forcing a choice from the scale.

Several problems with regard to these ratings can occur. For example, the patient's rating of the extent of his/her problems in one area should not be based upon his/her perception of any other problems. The interviewer should attempt to clarify each rating as a separate problem area, and focus the time period on the previous 30 days. Thus, the rating should be made on the basis of current, actual problems, not potential problems. If a patient has reported no problems during the previous 30 days, then the extent to which he/she has been bothered by those problems must be 0 and the interviewer should ask a confirmatory question as a check on the previous information. "Since you say you have had no medical problems in the past 30 days, can I assume that, at this point you don't feel the need for any medical treatment?" Note: If the patient is not able to understand the nature of the rating procedure, then insert an "X" for those items.

III. ESTIMATES

Several questions require the patient to estimate the amount of time he/she experienced a particular problem in the past 30 days. These items can be difficult for the patient, and it may be necessary to suggest time structuring mechanisms; e.g., fractional periods (one-half the time, etc.) or anchor points (weekends, weekdays, etc.). Finally, it is important that the interviewer refrain from imposing his/her responses on the patient (e.g. "Sounds like you have an extremely serious medical problem there!"). The interviewer should help the patient select an appropriate estimate without forcing specific responses.

IV. CLARIFICATION

During the administration of the ASI there is ample opportunity for clarification of questions and responses and this is considered essential for a valid interview. To insure the quality of the information, be certain the intent of each question is clear to the patient. Each question need not be asked exactly as stated, use paraphrasing and synonyms appropriate to the particular patient and record any additional information in the "Comments" sections.

NOTE: When it is firmly established that the patient cannot understand a particular question, that response should not be recorded. Enter an **"X"** in the first block of that item in these cases. In a case where the patient appears to have trouble understanding many questions, it may be advantageous to discontinue the interview. In this regard it is far better to wait a day or more for a patient to recover from the initial confusing, disorienting effects of recent alcohol/drug abuse than to record confused responses.

V. INTERVIEWER SEVERITY RATINGS

GENERAL NOTE REGARDING SEVERITY RATINGS: Much has been made of these severity ratings because they have been shown to be reliable, valid and clinically useful. It should be understood however that these ratings are only estimates of problem status, derived at a single point in time and subject to change with alterations in the immediate context of the patient's life. Further, these ratings cannot take the place of the more detailed information supplied by the patient in each of the problem areas. Finally, since these are ultimately just ratings, it is recommended that they not be used as measures of outcome in research or program evaluation studies. More objective, mathematically based composite scores in each problem area have been developed for research purposes. (See McGahan, et. al. 1986).

The severity ratings derived by the interviewer on each of the individual problem areas can be useful clinically. *Ratings in each problem area are based solely on responses to the objective and subjective questions within that area and not on extra information obtained outside the interview*. Although it is recognized that the interviewer's opinions will affect the severity ratings, and are often important, they introduce a non- systematic source of variation, lowering the overall utility of the scale. In order to reduce variation and increase reliability of the estimates, all interviewers must develop a common, systematic method for estimating severity of each problem.

We have established a two-step method for estimating severity. In the first step, the interviewer considers only the objective data from the problem area with particular attention to those critical items (see Appendix I) in each problem area which our experience has shown to be most relevant to a valid estimate of severity. Using the "objective" data the interviewer makes a preliminary rating of the patient's problem severity (need for treatment) based only upon this objective data. In the second step, the patient's subjective reports are considered and the interviewer can modify the preliminary rating accordingly. However, if a particularly pertinent bit of information, that is not systematically collected, figures into the derivation of a severity rating, it must be recorded in the "Comments" section. If the patient suggests that he/she feels a particular problem is especially severe, and that treatment is "extremely important" to him/her, then the interviewer may increase his final rating of severity. Similarly, in situations where the patient convincingly presents evidence that decreases the apparent severity of a problem area, the interviewer may reduce the final rating.

For the purpose of this interview, **severity** will be defined as need for treatment where there currently is none; **or** for an **additional** form or type of treatment where the patient is currently receiving some form of treatment. These ratings should be based upon reports of amount, duration, and intensity of symptoms within a problem area. The following is a general guideline for the ratings:

0-1 No real problem, treatment not indicated
2-3 Slight problem, treatment probably not necessary
4-5 Moderate problem, some treatment indicated
6-7 Considerable problem, treatment necessary
8-9 Extreme problem, treatment absolutely necessary

It is important to note that these ratings are not intended as estimates of the patient's **potential** benefit from treatment, but rather the extent to which some form of effective intervention is needed, regardless of whether that treatment is available or even in existence. For example, a patient with terminal cancer would warrant a medical severity rating of 9, indicating that treatment is absolutely necessary for this life-threatening condition. A high severity rating is recorded in this case even though no effective treatment is currently available. Patients presenting few problem symptoms or controlled symptom levels should be assigned a low level of problem severity. As amount, duration, and/or intensity of symptoms increase, so should the severity rating. Very high severity ratings should indicate dangerously (to the patient or others) high levels of problem symptoms and a correspondingly high need for treatment.

SEVERITY RATING DERIVATION PROCEDURES

STEP 1: Derive a range of scores (2 or 3 points) which best describes the patient's need for treatment at the present time based on the "objective" data alone.

1. Develop a picture of the patient's condition based on the "objective" items and the critical items (Appendix I).
2. Formulate an approximate range.

STEP 2: Select a point within the range above, using only the subjective data in that section.

1. If the patient considers the problem to be considerable and feels treatment is important, select the higher point within the range.
2. If the patient considers the problem to be less serious and considers the need for treatment less important, select the middle or lower rating.

While it is recognized that the criteria for establishing the degree of severity for any problem varies from situation to situation, we have found the above derivation procedures to produce reliable and valid ratings (See McLellan et. al., 1985).

Exceptions: In cases where the patient obviously needs treatment and reports no such need, the interviewer's rating should reflect the obvious need for treatment. E.g., patient reports 30 days of family arguments leading to physical abuse in some cases, but reports no need for family counseling. The *obvious* nature of this need must be stressed. Avoid inferences, hunches or clinical assumptions regarding this problem in the absence of clear indication. Beware of over interpreting "Alcoholic Denial". Clarify through probes where necessary.

If the patient has reported no recent or current problems, but does report a need for treatment, clarify the basis of his rating. E.g., patient reports no use of drugs or alcohol in past 30 days and no urges or cravings for drugs, but claims treatment in the form of continued AA meetings is "extremely important" with a rating of 4. Here the patient is currently receiving adequate treatment and does not need any new, different or additional treatment.

IMPORTANT: Using the method described, there is ample evidence that the severity ratings can be both reliable and valid estimates of patient status in each problem area. However, we do not recommend that the severity ratings be used as outcome measures. It is important to remember that these ratings are ultimately subjective and have been shown to be useful only under conditions where all data are available and the interview is conducted in person. This is not always the case in a follow-up evaluation. We have created composite scores in each of the problem areas, composed of objective items that have been mathematically constructed to provide more reliable estimates of patient status at follow-up. We have used the severity estimates clinically and as predictors of outcome but we have used the composite scores as outcome measures. See McGahan et al., 1986; Composite Scores from the Addiction Severity Index for a description of these measures and their general use.

VI. CONFIDENCE RATINGS

Confidence ratings are the last two items in each section and appear as follows:

Is the above information significantly distorted by:

Patient's misrepresentation?	**0 - NO 1 - YES**
Patient's inability to understand?	**0- NO 1 - YES**

Whenever a "yes" response is coded, the interviewer should record a brief explanation in the "Comments" section.

The judgment of the interviewer is important in deciding the veracity of the patient's statements and his/her ability to understand the nature and intent of the interview. This does not mean a simple "gut hunch" on the part of the interviewer, but rather this determination should be based on observations of the patient's responses following probing and inquiry when contradictory information has been presented (e.g. no income reported but $1000.00 in drug use). The clearest examples are when there are discrepancies or conflicting reports that the patient cannot justify, then the interviewer should indicate a lack of confidence in the information. It is much less clear when the

patient's demeanor suggests that he/she may not be responding truthfully and in situations where the patient will not make eye contact, or rapid, casual denial of all problems. This should not be over interpreted since these behaviors can also result from embarrassment or anxiety. It is important for the interviewer to use supportive probes to ascertain the level of confidence.

NOTE: It is the responsibility of the interviewer to monitor the consistency of information provided by the patient throughout the interview. It is not acceptable to simply record what is reported. Where inconsistency is noted (e.g., no income reported but claims of $500 per day spent on drugs) the interviewer must probe for further information (stressing confidentiality of the information) and attempt to reconcile conflicting reports. Where this is not possible, information should not be recorded and X's should be entered with a written note for the exclusion of information.

VII. DIFFICULT OR INAPPROPRIATE SITUATIONS

Previous Incarceration or Inpatient Treatment - Several questions within the ASI require judgments regarding the previous 30 days or the previous year. In situations where the patient has been incarcerated or treated in an inpatient setting for those periods it becomes difficult to develop a representative profile for the patient. That is, it may not give a fully representative account of his/her general or most severe pattern of behavior. However, it has been our policy to restrict the time period of evaluation for these items to the 30 days prior to the interview regardless of the patient's status during that time. This procedure does represent the patient accurately at the time of treatment or at follow-up.

Even with this general understanding there are still individual items that are particularly difficult to answer for patients who have been incarcerated or in some controlled environment. Perhaps the most common example is found in the employment section. Here we have defined "days of problems" as counting only when a patient has actually attempted to find work or when there are problems on the job. In a situation where the patient has not had the **opportunity** to work it is, by definition, not possible for him/her to have had employment problems. In situations like this where the patient has not had the opportunity to meet the definition of a problem day, the appropriate answer is an "N" and the patient ratings that follow should also be "N's" since they depend on the problem days question.

Patient Misrepresentation - We have found that some patients will respond in order to present a particular image to the interviewer. This generally results in inconsistent or inappropriate responses which become apparent during the course of the interview. As these responses become apparent, the interviewer should attempt to assure the patient of the confidentiality of the data, re-explain the purpose of the interview, probe for more representative answers and clarify previous responses of questionable validity. If the nature of the responses does not improve, the interviewer should simply discard all data which seems questionable by entering "X" where appropriate and record this on the form. In the extreme case, the interview should be terminated.

Poor Understanding - Interviewers may find patients who are simply unable to grasp the basic concepts of the interview or to concentrate on the specific questions, usually because of the effects of drug/alcohol withdrawal or due to extreme states of emotion. When this becomes apparent, the interview should be terminated and another session rescheduled.

VIII. FOLLOW-UP INTERVIEWS

Follow-up interviews may be performed no earlier than one month from the previous interview since the evaluation period is the previous 30 days. The interview may be conducted reliably and validly over the telephone as long as the interview is conducted in a context where the respondent may feel free to answer honestly and the interviewer has given an appropriate introduction to the interview, stressing confidentiality of information (See McLellan et al, 1980; 1985). It should be noted that only those questions that are circled should be asked at the follow-up point since these are the items that are capable of showing patient change. Certain items in the interview are asterisked and special instructions apply. These questions require that the answer reflect the cumulation of

experience since the previous interview. For example, in the employment section, questions on the amount of formal school or training are asked and intended to reflect the addition of schooling since the prior interview. Because of this need for additional information the interviewer is advised to have the original or last copy of the previous interview available for reference. When this is not possible, the interviewer is advised to simply note the additional information (e.g. two more months of school, two additional treatments for alcohol abuse, etc.) near the answer box and to add this number to the answer from the previous interview when it is possible to refer to this form.

SPECIFIC INSTRUCTIONS

Page 1

HEADINGS - On the top of Page 1 we have supplied general guidelines on the procedures used in filling out the form. A brief description of severity ratings, and a summary of the Patient's Rating Scale are also included.

NOTE: It is important to differentiate items which are not applicable to the patient (which should be coded as "N"), from items that the patient cannot understand or will not answer (which should be coded as "X"). **Please leave no items uncoded.**

NOTE: Be sure to answer all circled items on follow-up ASI interviews, utilizing the procedures outlined in the Introduction (see Follow-up Procedure, Page 6) and in the special publication on follow-up procedures (see Erdlen et al., 1987; Doing Follow-ups with the ASI).

LEFT COLUMN - This series of items was designed to provide administrative information . Many facilities may wish to change this section to conform to locally important information regarding insurance coverage, particular program codes, referral arrangements, case manager assignments, etc. This is entirely appropriate and even completely different face sheets may be used. Additions or changes to these items should be made freely as needed to reflect the administrative needs of your facility.

CENTER COLUMN - These questions are generally demographic in nature and, require little clarification. The one specific instruction given here pertains to Item 6.

Geographic Code: This is used to help determine the socioeconomic status of patients admitted to treatment. It is not necessary and may not pertain to your facility.

Item 6 - Controlled Environment: A controlled environment will refer to a living situation in which the subject was restricted in his freedom of movement and his access to alcohol and drugs. This usually means residential status in a treatment setting or penal institution. A halfway house is generally NOT a controlled environment. If the subject was in two types of controlled environments, enter the number corresponding to the environment in which he/she spent the majority of time. In these cases, time spent in a controlled environment will reflect the total time in all settings. If response to Item 6 is "1", enter "N" for Item 7.

RIGHT COLUMN - Test Data: Space is provided for recording a battery of suggested psychological test data. These may be changed freely to reflect the tests administered at your facility.

Severity Profile: The graph is provided as a summary of the patient's problem severity profile. Upon completion of the interview, the interviewer should mark the appropriate ratings on the grid.

How to use this manual...

This user's guide provides in depth instructions on asking each question on the ASI. We consider the ASI a guide to a conversation. It is quite simply a set of questions that you may find useful in gathering information about your patients. We hope that you use this information to create an individual treatment plan for each patient. The following information about each item on the ASI is provided foryou:

Intent/Key points: The information contained in this section describes why the question was originally included on the ASI. Sometimes, the reasons are easy to understand. Regardless, understanding the original intent can help you to use the appropriate judgment about how to code a response. We have based the conventions that we have adopted and recorded in the **Coding Issues** section on the original intent of the question.

Suggested Interviewing Techniques: We recognize that for many patients entering treatment, answering many seemingly meaningless questions can be tiresome. In this section, we offer what we feel are the most efficient ways to phrase each question. It has been our experience that patients are more open to answering questions if they are posed in a direct, non-confrontational manner. In many cases, we recommend that the interviewer simply read the question off the page as written. In other cases, we offer examples of effective ways to paraphrase. We hope that the information in this section helps you to help the patient give you the information you want.

Additional Probes: A probe is a question that does not appear on the ASI. The probe may provide information that helps you to understand the patient's problems more fully. The ASI has been recognized by its creators as the minimum number of questions one would need to begin a treatment plan. Within this section, we offer some additional probes that you may want to ask following each question. Sometimes, asking many probes in the first part of the problem section helps the interview to flow more naturally.

Coding Issues: Coding is the term used to describe the act of recording the information you receive from the patient, into the boxes provided for you, with a numerical "code." Although we have been doing ASI interviews for over ten years, nearly every day we encounter a new situation that is difficult to code, given the choices listed on the ASI. For each question or set of questions, we offer some solutions for coding issues that have arisen at our facility. This should **not** be considered a complete list of all the potential coding issues that could arise in other populations.

Cross-check item with: Similar bits of information are gathered in several sections of the ASI. An alert interviewer can use these internal cross-checks to verify information with the patient throughout the interview. For some items on the ASI, we provide a list of a few other items that are related to it within the interview.

General Instructions

HEADINGS - On the top of Page 1 we have supplied general guidelines on the procedures used in filling out the form. A brief description of severity ratings, and a summary of the Patient's Rating Scale is also included.

NOTE: It is important to differentiate items that are not applicable to the patient (which should be coded as "N"), from items that the patient cannot understand or will not answer (which should be coded as "X.") **Please code all items.**

LEFT COLUMN - This series of items was designed to provide administrative information. Many facilities may wish to change this section to conform to locally important information regarding insurance coverage, particular program codes, referral arrangements, case manager assignments, etc. This is entirely appropriate and even completely different face sheets may be used. Additions or changes to these items should be made freely as needed to reflect the administrative needs of your facility.

CENTER COLUMN - These questions are generally demographic in nature and require little clarification. The one specific instruction given here pertains to Item 6.

Geographic Code: This is used to help determine the socioeconomic status of patients admitted to treatment. It is not necessary and may not pertain to your facility.

General Information

19. Have you been in a controlled environment in the past 30 days?
20. How many days?

Intent/Key Points: To record whether or not the patient has had restricted access to drugs or alcohol in the past 30 days. A controlled environment will refer to a living situation in which the subject was restricted in his freedom of movement and his access to alcohol and drugs. This usually means residential status in a treatment setting or penal institution. A halfway house is generally NOT a controlled environment.

Suggested Interviewing Technique: Read the question as written. Providing the patient with examples can help them to understand what you mean by the term "controlled environment."

"Mr. Smith, in the past 30 days, have you spent any time in a controlled environment...a lock-up situation like a jail...or a detox program...or a medical hospital...any place where you may not have been able to get drugs and alcohol as easily as in your neighborhood?"

Additional Probes:
The name of the institution from which the patient was released.
The reason the patient was in the controlled environment (medical problem, criminal charge).

Coding Issues:
If the subject was in two types of controlled environments, enter the number corresponding to the environment in which he/she spent the majority of time. In these cases, time spent in a controlled environment (Item 7) will reflect the total time in all settings.

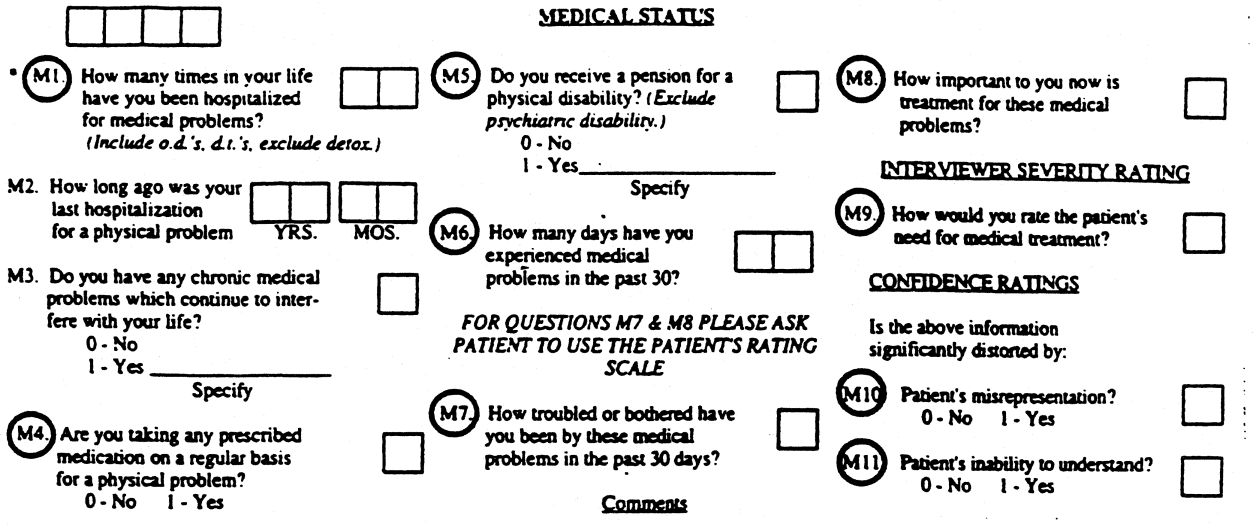
If response to Item 6 is "1," enter "N" for Item 7.

Cross-check this item with:
1. all the items that include information about the past 30 days. For example, if the patient has been in a controlled environment for twenty-five days out of the last thirty, one would assume that the patient hasn't used substances (Drug/Alcohol Questions 1-13) on more than five days. If the patient reports using on days in which he or she was in a controlled environment, record a comment that explains the details.

2. all the items within the instrument that refer to the specific controlled environment. For example, if the patient reports that he or she has been incarcerated for the last six months, the same information should appear in the legal section.

Medical Status

Introduction: The medical status section of the ASI helps you to gather some basic information about your patient's medical history. It addresses information about lifetime hospitalizations, long term medical problems and recent physical ailments. We recommend that you add questions that you consider relevant to your patient's treatment plan.



MEDICAL STATUS

M1. How many times in your life have you been hospitalized for medical problems? *(Include o.d.'s, d.t.'s, exclude detox.)*

M2. How long ago was your last hospitalization for a physical problem YRS. MOS.

M3. Do you have any chronic medical problems which continue to interfere with your life?
0 - No
1 - Yes _____
Specify

M4. Are you taking any prescribed medication on a regular basis for a physical problem?
0 - No 1 - Yes

M5. Do you receive a pension for a physical disability? *(Exclude psychiatric disability.)*
0 - No
1 - Yes_____
Specify

M6. How many days have you experienced medical problems in the past 30?

FOR QUESTIONS M7 & M8 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

M7. How troubled or bothered have you been by these medical problems in the past 30 days?

Comments

M8. How important to you now is treatment for these medical problems?

INTERVIEWER SEVERITY RATING

M9. How would you rate the patient's need for medical treatment?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

M10 Patient's misrepresentation?
0 - No 1 - Yes

M11 Patient's inability to understand?
0 - No 1 - Yes

M1. How many times in your life have you been hospitalized for medical problems?

Intent/Key Points: To record basic information about medical history. Enter the number of overnight hospitalizations for medical problems. Also, include hospitalizations for OD's and DT's but exclude detoxification or other forms of alcohol, drug or psychiatric treatment.

Suggested Interviewing Techniques: Because this is the first section of the interview, the patient may be prepared to tell you about psychiatric hospitalizations or treatments for drug detoxification, rather than hospitalizations for medical problems. If this happens, we recommend that you support his eagerness to tell you about drug-related problems, suggest that he remind you about those problems when you get to the drug/alcohol section, and direct him back to the medical status section. It may help you to reinforce that you are interested in medical hospitalizations by providing examples of physical problems.

"Mr. Smith, I understand that you may want to tell me about drug detoxes. I appreciate that. Remind me about those when we get to the drug/alcohol section. Right now, however, I need to record a little bit of information about your medical history. How many times in your life have you been hospitalized overnight for physical medical problems, like to mend a broken bone or to get your tonsils out...?"

Note: Don't record a patient's estimate that seems to be offered without much thought, like "I've been in the hospital probably about five or six times." Instead, ask for some of the details (year in which the hospitalization occurred, other events in the patient's life at the time) surrounding each hospitalization. By gathering much information early, through probing, you will more fully understand the patient's situation. This additional information may help you to move through the interview in a more conversational fashion.

Additional Probes:
The approximate age of the patient at each hospitalization
The name of each hospital
The types of medications they received for serious injuries

Coding Issues:
Normal childbirth would NOT be counted since it is not a medical problem resulting from sickness or injury. Complications resulting from childbirth would be counted and noted in the comments section.

Recognize that patients may get treatment for fairly serious medical problems through an emergency room. Do not include treatment received through emergency room visits unless the patient was kept overnight.

Cross-check items with:
Medical Status item # 2 (possibly)

M2. How long ago was your last hospitalization for a physical problems?

Intent/Key Points: To record basic information about medical history. Enter the number of years and months since the patient was last hospitalized for a medical problem.

Suggested Interviewing Techniques: Ask as written unless you can tell from the previous question exactly how long ago his last hospitalization occurred.

"Mr. Smith how **long ago** was your last hospitalization?"

Note: This question is occasionally misread. "How **long** was your last hospitalization?" You want to know how **long ago** was his last hospitalization.

Additional Probes:
The name of each hospital
The types of medications the patient received for serious injuries

Coding Issues:
If the last medical hospitalization occurred within the previous month, code the blocks "00 01."

If the patient was never hospitalized for a medical problem, enter "N."

Cross-check item with:
Medical Status item # 1 (possibly)

M3. Do you have any chronic medical problems which continue to interfere with your life?

Intent/Key Points: A chronic condition is a serious or potentially serious physical or medical condition that requires continuous or regular care on the part of the patient (e.g., medication, dietary restrictions, inability to take part in or perform normal activities). Some examples of chronic conditions are hypertension, diabetes, epilepsy, and physical handicaps. Focus on and record the presence of a chronic medical problem if the patient needs continued care, *even if the patient has grown accustomed to the care.* For example, a diabetic patient may report that injecting insulin daily doesn't interfere with his or her life because it has become routine. Regardless, you would count the diabetes as a chronic medical problem.

Suggested Interviewing Techniques: Provide examples and emphasize the chronic aspect of the problem. It may help to de-emphasize the problem's "interference with the patient's life" in cases where the patient has accepted the continued care as less of an interference than a daily routine.

"Do you have a chronic medical problem Mr. Smith...like diabetes or high blood pressure or chronic back pain?"

Additional Probes:
Medical doctor's recognition of the problem as chronic
Year that the problem was diagnosed
HIV test status

Coding Issues:
If a patient states his/her need for reading glasses or minor allergies is a chronic problem, this is a misunderstanding of the question. If the patient does report a valid, chronic problem, comment on the nature of that problem in the space provided.

Cross-check item with:
Medical Status item # 4 (possibly)

M4. Are you taking any prescribed medications on a regular basis for a physical problem?

Intent/Key Points: The purpose of this question is to validate the severity of the disorder by the independent decision to medicate the problem by a physician. Therefore if the medication was prescribed by a legitimate medical professional, for a medical (not psychiatric or substance abuse) condition, it should be counted -- regardless of whether the patient actually took the medication. Medications prescribed for only short periods of time, or for specific temporary conditions (i.e., colds, detoxification) should not be counted. Only the continued need for medication should be counted (e.g., high blood pressure, epilepsy, diabetes, etc.). Do not include medication for psychiatric disorders, this will be recorded later.

Suggested Interviewing Techniques: Ask as written, including the name of the chronic problem from the previous question, if appropriate.

"Mr. Smith, Are you taking any prescribed medication on a regular basis for any medical problem? For example, you mentioned that you have high blood pressure. Are you taking any prescribed medication on a regular basis for the high blood pressure or any other medical problem."

Additional Probes:
Dosage of medication
Source of the medication (Name of physician, pharmacy)
Compliance

Coding Issues:
Medications for sleep problems are usually temporary and generally fall under the psychiatric section.

Cross-check item with:
Drug /Alcohol grid, Items # 1-13 (possibly)
Medical Status, Item #3, (possibly)

M5. Do you receive a pension for a physical disability?

Intent/Key Points: The pension must be for a physical (not psychiatric) disability.

Suggested Interviewing Techniques: Ask as written, with examples

"Mr. Smith, are you receiving a pension for any physical disability from any source such as the VA, social security, or workman's compensation?"

Additional Probes:
Details of the pension
Details of the medical problem that warranted the pension.

Cross-check item with:
Employment/Support item #15

M6. How many days have you experienced medical problems in the past 30 days?

Intent/Key Points: Ask the patient how many days in the past 30 he/she experienced physical/medical problems. Do not include problems directly caused only by alcohol or drugs. This means problems such as hangovers, vomiting, or lack of sleep that would be removed if the patient were abstinent. However, if the patient has developed a continuing medical problem through substance abuse that would not be eliminated simply by abstinence, include the days on which he/she experienced these problems such as cirrhosis, phlebitis, or pancreatitis. **Include** symptoms of minor ailments such as a cold or the flu.

Suggested Interviewing Technique: Ask as written, with examples

Help the patient to understand that you need to record the exact number of days that he or she experienced medical problems. For example, if the patient says that he felt short of breath "some of the time," ask him to tell you the exact number of days that he felt short of breath. Finally, make sure that the shortness of breath was a medical problem unrelated to drug or alcohol use.

"Mr. Smith, how many days have you experienced any medical problems...anything from a cold to the flu to the back pain (or other symptom of a chronic medical problem) which you described earlier?"

Additional Probes:
Exact number of days...not a guess

Cross-check item with:
Medical Status items #7 and #8

M7. How troubled or bothered have you been by these medical problems in the past 30 days?
M8. How important to you now is treatment for these medical problems?

Intent/Key Points: To record the patient's feelings about how bothersome the previously mentioned physical ailments have been in the last month and how interested they would be in receiving (additional) treatment. Be sure to have the patient restrict his/her response to those problems counted in Item 6.

Suggested Interviewing Techniques: When asking the patient to rate the problem, use the name of it, rather than the term "problems." For example, if the patient reports having trouble with chest pains in the last thirty days, ask the patient question 7 in the following way:

"Mr. Smith, how troubled or bothered have you been in the past thirty days by the chest pains that you mentioned...or by any other medical problems?"

Ask the patient question 8 in the following way:

"Mr. Smith, how important would it be for you to get (additional) treatment for the chest pains that you mentioned, or for any other medical problems?"

If 6=0, we suggest that you ask questions 7 and 8 in the following way, to double-check that the patient really hasn't had problems.

"So, Mr. Smith, it sounds like you haven't had any medical problems in the past thirty days...may I assume that you haven't been bothered by any medical problems...?"

Coding Issues:
For item 8, emphasize that you mean additional medical treatment for those problems specified in Item 6.

Cross-check item with:
Medical status, number 6. If Medical Status, number 6 equals 0, then item 7 and 8 must equal 0 also. You can't rate the extent to which a non-existent problem is bothersome.

M9. How would you rate the patients need for medical treatment?

Remember the two step derivation method for severity ratings:

Step 1: Reduce the ten point scale (0-9) to two or three points, using only the objective items (Items 1-6 in the Medical Status section).

0-1 No problem, treatment not necessary
2-3 Slight problem, treatment probably not necessary
4-5 Moderate problem, treatment probably necessary
6-7 Considerable problem, treatment necessary
8-9 Extreme problem, treatment absolutely necessary

Consider adjusting the range based on the critical objective items of the section.

Critical Objective Items of the Medical Section

ITEM	DESCRIPTION
1	Lifetime Hospitalizations
3	Chronic problems

Step 2: Factor in the patient's rating scale. Pick the score that represents the patient's rating scale. For example, if the interviewer's three-point range is 4-5-6, and the patient reports that he has been *extremely* (rates it a "4") bothered and he would be *extremely* (rates it a "4") interested in treatment for medical problems, then select the highest point of the three-point range (in this case, a "6") for the severity rating in this section.

The meaning of the "6" severity rating is that treatment is necessary for the medical section. The severity rating for this section should have no effect on any other sections.

In many cases patients suffer from conditions that may only be arrested and at least for now, cannot be cured (diabetes, hypertension, epilepsy, etc.). If the patient seems to be taking appropriate care of his/her condition (medication, proper diet, etc.) and it is under control, there may be no need for an additional form or type of treatment beyond the regimen he/she is currently receiving. This patient's severity rating may be low since additional treatment is probably not necessary.

If the condition is serious and problematic it should be rated as severe even if there is currently no effective treatment for that condition.

Employment/Support Status

Introduction: The employment/support status section of the ASI was designed to help you to gather some basic information about the resources your patient can record on a job application, as well as his or her current sources of income. Clients may be hesitant to disclose information about illegally receiving money from two sources. For example, a patient may be working while receiving unemployment benefits. They might feel unsure about whether or not they can trust you to keep information confidential. For this reason, we recommend that before you list the possible sources of income (questions 12-17), you **reinforce that the information that they give you during this section will remain within the program**.

E/S1. Education completed?

Intent/Key points: To record basic information about the patient's formal education. Enter the number of years and months of completed formal education. A Graduate Equivalence Diploma (GED) will be entered as "12," but should be noted. Correspondence school will not be entered here.

Suggested Interviewing Techniques: Ask as written, however don't forget to ask if the patient received their GED. Sometimes, patients earn their GED while incarcerated.

"Mr. Smith, how many years of education have you completed?"

Additional Probes:
College major if applicable)
Name of high school or college

Coding Issues:
If a patient received an associate's degree, record 14 00; a bachelor's degree 16 00; a master's degree 18 00; or a doctorate 20 00.

E/S2. Training or technical education completed
E/S3. Do you have a profession, trade or skill?

Intent/Key points: For item #2, record basic information about the patient's formal technical education or training that could be listed on a job application. Enter the number of months of formal or organized training that the patient has completed. Try to determine if this is valid training, such as a legitimate training program or an apprenticeship through a recognized on-the-job training program. If the patient answers "Yes" to item #3, note what his/her trade is. Generally, a trade will be counted as any employable, transferable skill that was acquired through specialized training or education.

Suggested Interviewing Techniques: It may be helpful to ask three separate questions. The first question identifies whether the patient has ever received any formal technical training.

"Mr. Smith, have you ever received any job training through a formal on-the-job training program or a training school like (name of local training school)."

The second question addresses the length of the course.

"How long did that course take to complete?"

Finally, the third question (item #3) identifies the patient's profession, trade or skill. The response to item #3 will not always coincide with the response to item #2 (for example, a school teacher who has been trained in carpentry).

"Do you have a profession, trade or skill?"

Additional Probes:
The name of the training institute
Information about programs that the patient started, but didn't finish
Information about the patient's skills that were acquired without a formal training program

Coding Issues:
Judgment should be used in recording training during military service. Count this training only if it has potential use in civilian life and is designed to give the patient a marketable skill or trade. That is, cook, heavy equipment operation, equipment repair will be counted; infantry training or demolition training generally will not be counted.

E/S4. Do you have a valid driver's license?
E/S5. Do you have an automobile available for your use?

Intent/Key points: This item (and item #5) provides an indication of the patient's opportunity to become employed, since many jobs require driving while at work or at least the ability to get to work in places where public transportation is not available. A valid driver's license is a license that has not expired or been suspended or revoked. Item #5 does not necessarily require ownership but availability on a regular basis for personal transportation. Item #s 4 and 5 are to be used as indicators of the patient's ability to get to and from work.

Suggested Interviewing Techniques: Ask as written. It has been our experience that some patients have a difficult time answering this question in a direct way. They may attempt to qualify their answer. For example, they may say, "My license should be valid, but I just have to take care of some tickets." Record that the patient has no license and code item #5 with a "0" also.

"Mr. Smith, do you have a valid driver's license?"

"Do you have an automobile available for your use, if you needed it to get to work every day?"

Additional Probes:
Reason for the license being invalid

Coding Issues:
If the patient has no valid driver's license, please code item #5 with a "0," rather than an "N."

Cross-check item with:
Legal Status, item # 17, 18 (possibly)

E/S6. How long was your longest full-time job?

Intent/Key points: To record basic information about the patient's work history. Stress that you are interested in the full time job the subject held for the longest time, not a part-time job.

Suggested Interviewing Techniques: Ask as written. Emphasize "full-time."

"Mr. Smith, how long was your longest full-time job?"

It may be helpful, if the patient has a difficult time answering this question as stated, to gather information about the patient's current job status, and work backwards in time, recording information about all of his or her full-time jobs. Although it may seem as if you are doing extra work, the information will help you answer Item #10 (usual employment pattern, past 3 years).

"So, Mr. Smith are you currently working? How long have you been working at this job?
What were you doing before this job? How long were you working at that job?" and so on...

Additional Probes:
Names of places where the patient worked
Job position title
Reasons for leaving jobs
Years that the patient worked at each job
Information about part-time jobs

Coding Issues:
Employment while in military service will be counted only when it is beyond the subject's original enlistment period.

Cross-check item with:
Employment/Support status, item #10 (possibly)

E/S7. Usual (or last) occupation

Intent/Key points: To record information about the patient's job, in addition to the level of skill the job demands as defined by the Hollingshead scale. Record the name of the patient's usual occupation. Record the usual occupation, even if the patient has recently been working in a different capacity. If the patient does not have a usual occupation, then record the most recent job.

Suggested Interviewing Techniques: Ask about the patient's usual job. If the patient reports doing "whatever comes along," ask about his last occupation.

"Mr. Smith, what do you usually do for a living?"
If Mr. Smith does many different things...
"Mr. Smith what is the last job that you've held?"

Additional Probes:
Names of places where the patient has worked

Coding Issues:
Code as "N" only when the patient has never worked at all.

Be sure to specify within general classes of work (i.e., if salesman, then computer sales, used car sales, etc.).

Cross-check item with:
Employment/Support item #s 2,3,6 (possibly)

E/S8. Does someone contribute to your support in any way?
E/S9. Does this constitute the majority if your support?

Intent/Key points: To record information about additional sources of financial support. Ascertain whether the patient is receiving any regular support in the form of cash, housing or food from a friend or family member, not an institution. A spouse's contribution to the household is included.

Suggested Interviewing Techniques: Ask as written, with examples. Stress that you mean financial support. Help the patient to understand that financial support can mean housing and food, as well as cash.

"Mr. Smith, is anyone currently contributing to your support? For example, is anyone allowing you to stay with them? Is anyone putting money toward your bills? Does your wife work?"

"Is the support that you are receiving the majority of your support?"

Note: Clients who are living with their parents may get defensive if you ask them directly about whether their parents are helping them financially. There is no need to press them to admit that their parents are helping them. You already have information about their current address (see "Current Address" on front page). If they report that they aren't paying any room and board, you may code item #8 with a "1." You might consider asking, "Are you receiving money from any source other than your parents?" If the answer is no, you may code Item #9 with a "1," also.

Coding Issues:
If the information from Item #s 12 to 17 does not confirm the initial response from item #s 8 and 9, then clarify any discrepancy.

Code item 9 with an "N" if answer to Item 8 was "No."

Record information only about financial support from individuals...not institutions, such as the Department of Public Assistance.

Cross-check item with:
Employment/Support item #s 12-17 (support)

E/S10. Usual employment pattern, past 3 years

Intent/Key points: The interviewer should determine which choice is most representative of the past 3 years, not simply the most recent. Full time work (including under-the-table jobs) is regular and greater than 35 hours per week. Regular part-time work is a job in which the patient has a work schedule less than 35 hours per week but it is regular and sustained. Irregular part-time work refers to jobs in which the patient works on a part-time basis but not work on a reliable schedule. When there are equal times for more than one category, record that which best represents the current situation.

Suggested Interviewing Techniques: It may take a series of questions to get the correct response to this item. Depending on the patient, you might consider beginning by asking about their current work situation, and working backwards in time. Other patients find it easier to think back to what they were doing three years ago, and work forwards.

If you know he is employed:
"Is your current job full-time? How long have you held this job?
What kind of work did you do before this job? Was that job full-time?"

If you know he is unemployed:
"How long have you been unemployed? What were you doing in your previous job?
How long did you hold that job? Was it a full-time or part-time job?"

Regardless, the information that you finally record will represent the patient's employment pattern during *most* of the past three years.

Additional Probes:
Names of work places
Amount of overtime

Coding Issues:
Record the code that corresponds to the pattern that the patient held during the greatest part of the past three years. For example, you would code this item, "1" for a patient who worked full-time for two of the last three years, even if the patient had not worked for the past year.

If the patient has been employed for the past year and a half after being unemployed for a year and a half, record that the patient was "usually" employed (the periods of employment and unemployment were equal, however the period of employment was the most recent).

Cross-check item with:
Employment/Support # 6 (possibly)

E/S11. How many days were you paid for working in the past 30?

Intent/Key points: To record basic information about current work situation. Record number of days in which the patient was paid (or will be paid) for working. Jobs held in a prison or in a hospital are not counted. "Under-the-table" jobs are included. Paid sick days and vacation days are included here.

Suggested Interviewing Techniques: Ask as written. Emphasize that you're interested in "under the table" work also. Often patients report that they were paid for working "every day." The interviewer must clarify whether the patient worked a five-day week (20), or a six-day week (24). Ask for the exact number of days worked this month.

"Mr. Smith, how many days were you paid for working, including under the table work, in the past 30?"

Additional Probes:
Name of employer
Explanation for days of work missed
Days of overtime

Coding Issues:
A five-day work week will be coded "20"

Cross-check item with:
Employment/Support #10 (possibly)

E/S12-17. How much money did you receive from the following sources in the past 30 days?

Intent/Key points:

12. Employment: This is net or take-home pay. Also include pay for under-the-table work.

13. Unemployment Compensation: Self-explanatory.

14. Welfare: This refers to public assistance or welfare. Include dollar amount of food stamps here as well as transportation money provided by an agency to assist the patient in getting to and from treatments.

15. Pension, Benefits or Social Security: This includes pensions for disability or retirement, veteran's benefits, "SSI", and workman's compensation.

16. Mate, Family or Friends: The purpose of this question is to determine how much additional pocket money the patient had during the past 30 days -- not to determine whether he/she was supported with food, clothing and shelter. Record only money borrowed or received from one's mate, family or friends. These refer only to cash payments given to the patient and not to an estimated value of housing and food provided. (This was assessed in items 8 & 9.) Do not simply record the earnings of a spouse in this item -- just the dollars actually given to the patient to spend.

17. Illegal: This includes any money obtained illegally from drug dealing, stealing, "fencing" stolen goods, illicit gambling, etc. If patient has received drugs in exchange for illegal activity do not attempt to convert this to a dollar value. Simply note this in the comment sections here and in the legal section. Again, the focus in on money available to the patient, not an estimate of the patient's net worth.

Suggested Interviewing Techniques: Read as written, with examples for each item.

" Mr. Smith how much money did you receive from employment in the past 30 days?"

Additional Probes:

Information about bartering.

Coding Issues:

Include under "Mate, family or friends" any coincidental or windfall income from licit gambling, loans, inheritance, tax returns, etc., or any other unreliable source of income.

Cross-check item with:

Employment/Support status, items 8 and 9

Drug/Alcohol #20

E/S18. How many people depend ... for the majority of their food, shelter, etc.?

Intent/Key points: Stress that these people must regularly depend upon the patient for financial support. These are not simply people to whom the patient has occasionally given money. Do not include the patient himself or a spouse who is self-supporting. Do include dependents who are normally supported by the patient but due to unusual circumstances, have not received support recently. Alimony and child support payments are included as indications of persons depending on the patient, if appropriate.

Suggested Interviewing Techniques: Read as written, with examples.

"Mr. Smith, how many people depend on you for the majority of their food or shelter? For example, are any children living with you who depend on you to buy their food for them?"

Additional Probes:
Is the money taken out of your check?

Cross-check item with:
Other items that refer to children or other dependents.

E/S19. How many days ... experienced employment problems in the past 30?

Intent/Key points: Include inability to find work (only if patient has tried), or problems with present employment (if employment is in jeopardy or unsatisfactory, etc.).

Suggested Interviewing Techniques: The way you ask this question depends on the information that you have about the patient so far. If the patient is working, it is appropriate to ask as written, with examples.

"Mr. Smith, how many days have you had employment problems in the past 30? For example, have you been put on probation at work for any reason?"

If the patient *has not* worked in the past 30 days, you should ask a preliminary question, which is not coded.

"Have you actively looked for work in the past 30 days?"

If the answer is "yes," ask how many days the patient actively looked for work.
Record that response in item #19 and ask items #20 and #21. Refer to the number of days the patient couldn't find work as employment problems.

Additional Probes:
Nature of employment problems

Coding Issues:
It is important to distinguish if the problems reported here are simply interpersonal problems on the job (e.g., can't get along with certain members of the work force), or if the problems are entirely due to alcohol/drug use. Problems such as these would most likely be counted under the Family/Social or the Alcohol/Drug section, rather than this section.

Do not include problems in "finding a job" that are directly related only to the patient's substance abuse such as withdrawal or hangover.

Do not include bad feelings about employment prospects, or the wish to make more money or change jobs unless the patient has actively attempted these changes and has been frustrated.

In a situation where the patient has not had the **opportunity** to work, due to incarceration or other controlled environment, it is, by definition, not possible for him/her to have had employment problems. In situations such as this where the patient has not had the opportunity to meet the definition of a problem day, the appropriate answer is an "N" and the patient ratings that follow should also be "N's" since they depend on the problem days' question.

E/S20. How troubled or bothered...employment problems in the past 30 days?

E/S21. How important is it for you to get employment counseling?

Intent/Key points: These ratings are restricted to those problems identified by Item 19. For Item 21, stress that you mean help finding or preparing for a job -- not giving them a job.

Suggested Interviewing Techniques: The way you ask this question depends on the information that you have about the patient so far.

In Item #19, if the patient identified either a problem on the job, or a problem finding a job after actively looking for one, ask the questions as written:

"Mr. Smith, how troubled or bothered have you been by the employment problems that you had in the past 30 days, such as the time you spent on work probation?"

If the patient reported in Item #19 that he or she has not worked in the past 30 days, you should code #20, "0" without asking it. We assume that if the patient has not actively looked for work in the past month, he or she has not been bothered by employment problems. The interviewer should still ask #21 in the following way:

"Mr. Smith, how important would it be for you to get employment counseling?"

Additional Probes:
Job Sources contacted by the patient

Coding Issues:
In a situation where the patient has not had the **opportunity** to work , due to incarceration or other controlled environment, it is, by definition, not possible for him/her to have had employment problems. In situations such as this where the patient has not had the opportunity to meet the definition of a problem day, the appropriate answer is an "N" and the patient ratings that follow should also be "N's" since they depend on the problem days question.

Cross-check item with:
Employment/Support item #19

E/S22. Employment/Support Severity rating

Remember the two step derivation method for severity ratings:

Step 1: Reduce the ten-point scale (0-9) to two or three points, using only the objective items (Items 1-19 in the Employment/Support Status).

0-1 No problem, treatment not necessary
2-3 Slight problem, treatment probably not necessary
4-5 Moderate problem, treatment probably necessary
6-7 Considerable problem, treatment necessary
8-9 Extreme problem, treatment absolutely necessary

Consider adjusting the range based on the critical objective items of the section.

Critical Objective Items of the Employment/Support Section

ITEM	**DESCRIPTION**
1 & 2	Education and Training
3	Skills
6	Longest Full-time Job
10	Recent Employment Pattern

Step 2: Factor in the patient's rating scale. Pick the score that represents the patient's rating scale. For example, if the interviewer's three point range is 4-5-6, and the patient reports that he has been *extremely* (rates it a "4") bothered and he would be *extremely* (rates it a "4") interested in treatment for medical problems, then select the highest point of the three point range (in this case, a "6") for the severity rating in this section.

The meaning of the "6" severity rating is that treatment is necessary for problems related to employment or financial support. The severity rating for this section should have no effect on any other sections.

Drug and Alcohol Use

Introduction: The Drug/Alcohol use section of the ASI helps you to gather some basic information about the patient's substance abuse history. It addresses information about current and lifetime substance abuse, consequences of abuse, periods of abstinence, treatment episodes, and financial burden of substance abuse. We recommend that you add extra questions as you deem necessary, to complete your treatment plan. The manual addresses the "Drug Grid," Drug and Alcohol items 1-12 in three separate sections: the patient's use in the past 30 days, lifetime use, and the route of administration boxes. We recommend that for each substance, you ask the questions pertaining to the last thirty days before you ask about lifetime use.

D/A1-12: Drug and Alcohol Use Past 30 Days.

Intent/Key points: To record information about recent substance use. Record the number of days in the last thirty that the patient reported any use at all of a particular substance. **Note:** *It is important to ask **all** substance abuse history questions regardless of the presenting problem* (e.g., an alcoholic may be combining drugs with drinking; a cocaine user may be unaware of a drinking problem).

Suggested Interviewing Techniques: Be sure to prompt the patient with examples (using slang and brand names) of drugs for each specific category. We recommend that you ask this question as written below.

"Mr. Smith, how many days in the past thirty have you used_____?"

NOT How many times in the past thirty days.
There may be a big difference between the number of days and the number of times.
NOT...How many drinks or "lines" or "rocks" in the past thirty days.
There may be a big difference between the number of days and the number of drinks.

Note: Item #2 -- Alcohol to Intoxication -- does not necessarily mean getting drunk. In fact, it is not advisable to use the phrase "to intoxication" in asking the question since patients' interpretations of this phrase vary so widely. Instead ask the number of days the patient felt the "effects" of alcohol, e.g., got "a buzz," "high," or drunk. If the patient gives evidence of considerable drinking yet denies feeling the effects of the alcohol, get an estimate from the patient of how much he/she has been drinking. (He/she may be denying the effects or manifesting tolerance.). In such cases, as a rule, the equivalent of 3 or more drinks in one sitting or within a brief period of approximately one to two hours, can be considered "Alcohol to Intoxication" for Item 02.

Additional Probes:
Quantity of use per day
Estimated amount of money spent on the substance per day
Usage patterns (only on week-ends, for example)

Coding Issues:

1. Prescribed medication is counted under the appropriate generic category.

2. LAAM should be recorded under "Methadone." Antagonists, such as Antabuse and Naltrexone are not recorded under the substance history section but should be noted as comments at the bottom of the page.

3. Cocaine is used in many forms and these often have different names. "Crack" or "rock" cocaine is simply the "freebased" (smokable) form of cocaine. All different forms of cocaine
(e.g., crystal cocaine - snorted, freebase cocaine - smoked, crystal cocaine - injected) should be counted under the cocaine category.

Cross-check Drug/Alcohol Use items 1-12 with:
Drug/Alcohol Use, Item 13
Drug/Alcohol Use, Item 20
Drug/Alcohol Use, Item 22 (possibly)

D/A1-12: Drug and Alcohol Use, Lifetime Use

Intent/Key points: To record information about extended periods of **regular use**. The "rule of thumb" for regular use is a frequency of 3 or more times per week. However, it is true that cocaine, alcohol and even some other drugs can be regularly and severely abused in **two-day binges**. Therefore, the interviewer should probe for evidence of regular problematic use, usually to the point of intoxication and to the point where it compromises other normal activities such as work, school or family life. Problematic use here will generally be obvious and it should be counted even if it is less than 3 times per week. If there is substantial but irregular use of any drug (less than 3 times per week for a month or longer), please record this under "Comments" but do not include under Items 1-12.

Suggested Interviewing Techniques: Generally, you will need to ask a number of questions to get the information that you will eventually code in the boxes in the grid. With many patients, it is possible to get a valid response by asking the question the following way:

"Mr. Smith, How many years of your life have you regularly used_____?
By regularly, I mean three or more times per week."

However, when interviewing patients with complicated substance use histories, it may be helpful to ask them the year that they began to use the substance regularly, and work forward in time from there.

"Mr. Smith, when did you start using alcohol regularly?"
"Since you started, have you ever abstained for over a month?"
"When did you pick up again?"

After you have recorded the periods of time that the patient has used each substance, you know what to record in the lifetime section of the drug grid. You may consider summarizing it for the patient like this:

"So Mr. Smith, it sounds like you started using cocaine regularly while you were in high school in 1978. You continued to use it regularly until 1981, when you got into treatment. You stayed clean until three months ago, when your brother died. You have been using regularly since then. So, in your lifetime, you have used it regularly for three years and three months (code three years).

Additional Probes:
Events that occurred at the same time that the patient was using (or abstaining from) a substance.
Differences in route of administration over time
Substance combinations

Coding Issues:
1. Six months or more of regular or problematic use will be considered one year; less than six months of problematic use should be noted in the comments section but not counted as a year.

2. See **Coding Issues, Drug and Alcohol Use Past 30 Days** for other relevant coding issues.

Cross-check items with:

Drug/Alcohol Use, Item #s 13, 20, 22

D/A1-12: Drug and Alcohol Use, Route of Administration

Intent/Key points: To record information about the patient's usual or most recent route of administration for each substance listed. The code for the administration is listed below the drug grid as follows: **1 - oral 2 - nasal 3 - smoking 4 - non IV injection 5 - IV injection**

Suggested Interviewing Techniques: Use the name of the specific drug. Provide examples.

"Mr. Smith, how are you using the cocaine? For example, are you snorting it...or are you freebasing it...are you injecting it?"

Additional Probes:
Use of drug combinations

Coding Issues:
1. In cases where two or more routes are routinely used, the most serious route should be coded. (the routes of administration are numbered in order of their severity.)

D/A13. Multiple Substances:

Intent/Key points: To record information about drug combinations. Under **"Past 30 Days"** ask the patient how many days he took more than one (ASI category) substance including alcohol. Under **"Lifetime Use"** ask the patient how long he regularly (generally 3 times per week for a month or more) took more than one substance per day including alcohol.

Suggested Interviewing Techniques: By reviewing the information in the drug grid, you should be able to estimate the number of days that the patient used more than one drug in the past 30, as well as the number of years he regularly used more than one substance. To insure that you are getting accurate information, ask the following:

"How many days in the past 30 have you used more than one substance per day?"
and
"How many years have you regularly used more than one substance per day?"

Additional Probes:
The substances which the patient used together.
Substances which the patient used within the same day, but did *not* use together.
The names of drugs that were prescribed.

Cross-check items with:
Drug/Alcohol Item #s 1-12

D/A14. Which substance is the major problem?

Intent/Key points: To record the patient's current major substance of abuse. *The interviewer should determine the major drug of abuse* based upon the years of use, number of treatments, number of DT's/overdoses. If the information provides no clear indication of his drug problem, then ask the patient what he/she thinks is the major substance problem. Enter one of the following codes:

1 - ALCOHOL
3 - HEROIN
4 - METHADONE
5 - OTHER OPIATES/ANALGESICS.
6 - BARBITURATES
7 - OTHER SED/HYP/TRANQ
8 - COCAINE
9 - AMPHETAMINES
10 - CANNABIS
11 - HALLUCINOGENS
12 - INHALANTS
15 - ALCOHOL/DRUG
16 - POLYDRUG

NOTE: Record a "16" if the patient has major problems with more than one drug; or a "15" if the patient abuses alcohol **and one or more** drugs.

Suggested Interviewing Techniques: If you have to ask the question, ask it as it appears on the ASI. Allow the patient to report more than one substance as his major problem.

"Mr. Smith, which substance is your major problem?"

Coding Issues:
1. Some patients may report that legal methadone is their primary drug problem, as in the case of patients who are seeking detoxification and drug-free treatment. This can be used as the major problem in Item 14 and problems associated with the legal methadone may be recorded in Item 22.

2. For follow-up interviews record what the patient thinks is the major substance abuse problem. If at follow-up the patient maintains he/she has no drug or alcohol problem but reports experiencing drug or alcohol problems on Item 22, then clarify Item 14 by asking if he/she considers that substance the current major problem.

Cross-check item with:
Drug/Alcohol Items #1-12

D/A15. How long was your last period of voluntary abstinence from this major substance?
D/A16. How many months ago did this abstinence end?

Intent/Key points: To record details about the patient's successful attempts at abstaining from the current problem substance. Ask the patient how long he/she was able to remain abstinent from the major drug(s) of abuse (Item 14). Stress that this was the **last** attempt (of at least one month) at abstinence, not necessarily the longest.

Suggested Interviewing Techniques: You may need to ask a series of questions to get accurate responses to these items.

For example, for Item #15, you may need to ask:
"Have you ever stopped using_____for over a month?"
"When was the last time you stopped using_____for over a month?"
"Did you stay clean on your own, or were you in some sort of a controlled environment at the time?"
"How long did that period of abstinence last?"

For Item #16, you should ask:
"How many months ago did this abstinence end?"

Additional Probes:
Circumstances surrounding the periods of abstinence
Circumstances surrounding the end of the abstinence period

Coding Issues:
Periods of hospitalization or incarceration are not counted. Periods of abstinence during which the patient was taking Methadone, Antabuse or Naltrexone as an outpatient are included.

If the code for item 14 was **"00-No problem,"** enter "N" for item #s 15 and 16.

If the code for item 14 was **"15-Alcohol and Drug"** then abstinence will refer to **both** alcohol and the major drug(s).

If the code for item 14 was **"16-Polydrug"** then abstinence will refer to all abused drugs. Enter "99" if the number of months equals 99 or more.

If the patient has not been abstinent for one month, enter "00" for Item #15 and "N" for item 16.

If the period of abstinence is current, enter "00" for item #16.

Cross-check item with:
Drug/Alcohol Items #1-12

D/A17 & 18. How many times have you had alcohol D.T.ís/overdosed on drugs?

Intent/Key points: To record information about consequences of using too much of a substance. If in doubt about a reported "OD," ask what was done to the patient to revive him/her. Simply letting the patient "sleep if off" does not constitute an OD. If the patient describes any incident in which intervention by someone was needed to recover, do count this as an OD. The nature of overdose will differ with the type of drug used. While opiates and barbiturates produce coma-like effects, amphetamine overdoses ("overamps") frequently result in toxic psychoses.

Suggested Interviewing Techniques: Ask as written. Follow-up with additional questions which will determine how you will code the response.

"Mr. Smith, how many times have you had alcohol D.T.ís?"
"How many times have you overdosed on drugs?"

"Did someone have to help to revive you?"
"Did someone have to calm you down?"

Additional Probes:
Whether or not the patient was hospitalized
Whether or not the OD was intentional

Coding Issues:

1. Include suicide attempts if they were attempted by drug overdose (Remember this in the Psychiatric section and be sure to check the Medical section to note hospitalization).

2. **Definition of Delirium Tremens (DT's):**
DT's occur 24 to 48 hours after a person's last drink. They consist of tremors (shaking) and delirium (severe disorientation). They are often accompanied by a fever. There are sometimes, but not always, hallucinations. True DT's are usually so serious that they require some type of medical care or outside intervention. Impending DT's as diagnosed by a professional would also be considered serious enough to count as DT's.

Problems sometimes mistaken for DT's:
DT's are not to be confused with "the shakes" which occur about 6 hours after alcohol has been withdrawn and do not include delirium.

Cross-check item with:
1. Medical Status Item #1 (possibly)

D/A19 & 20. How many times in your life have you been treated for alcohol abuse/drug abuse?
D/A21 & 22. How many of the were detox only?

Intent/Key points: To record the number of times the patient has received help for their drug or alcohol problems. The purpose of item #19 is to determine the extent to which the patient has sought extended rehabilitation versus minimal stabilization or acute crisis care. Therefore, record the number of treatments in #19 that were detoxification only and did not include any follow-up treatment.

Suggested Interviewing Techniques: Ask as written.

"Mr. Smith, how many times in your life have you been treated for alcohol or drug abuse?"

"How many of those treatments involved a detox with no follow-up?"

Additional Probes:
The names of programs
Reasons for leaving programs

Coding Issues:
1. Count any type of alcohol or drug treatment, including detoxification, halfway houses, inpatient, outpatient counseling, and AA or NA (if 3 or more sessions) within a one-month period.

2. If the patient was treated for **both** alcohol and drug problems simultaneously, count the treatment under both categories. Note that the treatment was for both.

3. Exclude "Driver's School" for D.W.I. violations. Ask questions separately for alcohol and drugs. In the case of dual problems try to get the number of treatments in each category.

4. Code as a single episode treatment experiences that occur in different facilities immediately following one another. For example, a patient who spends two months in a residential program followed immediately by a six-month outpatient program has been involved in one treatment episode, *not* two treatment episodes. However, if the patient returns home before being admitted to the outpatient program, the outpatient program should be counted as a separate treatment episode.

Cross-check item with:
Drug/Alcohol Use, Items 1-13

D/A23 & 24. How much would you say you spent during the past 30 days on alcohol/drugs?

Intent/Key points: This is primarily a measure of financial burden, not amount of use. Therefore, *enter only the money spent, not the street value of what was used* (e.g., dealer who uses but does not buy; bartender who drinks heavily but does not buy, etc.).

Suggested Interviewing Techniques: If you probed sufficiently during the Drug/Alcohol grid, you should have information about the amount of money that the patient spends daily on each substance. By multiplying the daily dollar amount by the number of days the patient says he or she used, you will get a good estimate of the amount of money the patient spent in the last month, without even asking the question. Regardless, ask the question as written. If a patient responds that he cannot possibly estimate the amount of money he spent in the past month, remind him what he told you in the drug grid.

"How much have you spent on alcohol and drugs in the past 30 days?"
"You told me that you spent about $20 a day on coke...and you used coke on sixteen days...so it sounds as if you spent at least three hundred twenty dollars on coke."

Sometimes, the patient will argue about the amount of money he spent. He may explain that although he used $320.00 worth, he only spent $200 worth because he knows people who provide him with cheap drugs. **Code only what the patient reports he spent on drugs.**

Additional Probes:
As described above, information that explains differences between the reported amount of money spent and amount of drugs used.

Coding Issues:

1. Enter "X" only if patient cannot make a reasonable determination.
2. Don't include the dollar amount of drugs for which the patient provided services (sex for drugs, acting as a "middle man" for drug deals). Just include the amount of cash the patient put out for the drugs.

Cross-check item with:
Employment/Support item #s 12-17

D/A25. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 (Include NA, AA)?

Intent/Key points: Treatment refers to any type of outpatient substance abuse therapy. This does not include psychological counseling or other therapy for non-abuse problems.

Suggested Interviewing Techniques: Ask as written below.

"Mr. Smith, how many days in the past 30 have you been treated in an outpatient setting or attended self-help groups like AA or NA?"

Additional Probes:
Names of programs
Types of meetings

Coding Issues:

1. Do include methadone maintenance, Antabuse, etc.
The fact that the patient was "officially enrolled" in a program does not count if he/she has not attended.

2. Include AA, NA, or CA meetings if client has attended 3 or more in the past month.

3. Treatment requires personal (or at least telephone) contact with the treatment program.

D/A26 & 27. How many days in the past 30 have you experienced alcohol problems/drug problems?

Intent/Key points: Be sure to stress that you are interested in the number of days the patient had problems directly related to alcohol or drug use. Include craving for alcohol or drugs, withdrawal symptoms, disturbing effects of drug or alcohol intoxication, or wanting to stop and not being able to do so.

Suggested Interviewing Techniques: Ask as written, with plenty of examples based on what the patient has already told you. Client's "denial" of problems may hinder the interviewer's ability to record accurate information. The interviewer should focus the question on symptoms or situations already described by the patient as problematic. For example, a patient may say, "I can handle my alcohol use. My lawyer said that I should get into treatment because it will help my DUI case." The interviewer might say, "How many days in the past 30 have you had problems related to alcohol use...such as worrying about your DUI case?" Another example follows:

"Mr. Smith, how many days in the past 30 have you experienced alcohol problems...such as the fact that you've been getting in trouble at work because of your drinking, or the fact that you have been spending all of your money on alcohol.

Additional Probes:
Thinking about using (craving)
Inability to stop using after starting
Consequences of using
Experiencing physical withdrawal symptoms

Coding Issues:
Do not include the patient's inability to find drugs or alcohol as a problem.

Cross-check item with:

Drug/Alcohol section, Items 23 and 24. If 22=0, then 23 and 24 must equal "0" also.
One can't rate nonexistent problems.

D/A28 & 29. How troubled or bothered ... past 30 days by alcohol or drug problems?
D/A30 & 31. How important ... get treatment for alcohol or drug problems?

Intent/Key points: To record the patient's feelings about how bothersome the previously mentioned drug or alcohol problems have been in the last month, and how interested they would be in receiving (additional) treatment. Be sure to have the patient restrict his/her response to those problems counted in Item 22.

Suggested Interviewing Techniques: When asking the patient to rate the problem, provide concrete examples of them, rather than the term "problems." For example, if the patient reports that besides worrying about a DUI case, he has had physical problems from alcohol, such as hangovers, the interviewer should ask Item #23 in the following way:

"Mr. Smith, how troubled or bothered have you been in the past thirty days by alcohol problems such as the hangovers that you mentioned...or the worry over your upcoming case?"

Ask Item #24 in the following way:

"Mr. Smith, important would it be for you to talk to someone about your alcohol problems...such as the hangovers that you mentioned...or the worry over your upcoming case?"

Cross-check item with:

Drug/Alcohol section, Item 22. If 22=0, then 23 and 24 must equal "0" also.
One can't rate nonexistent problems.

D/A 32 & 33.
Drug Severity Rating
Alcohol Severity Rating

Remember the two step derivation method for severity ratings:

Step 1: Reduce the ten-point scale (0-9) to two or three points, using only the objective items (Items 1-22, Drug/Alcohol Section).

0-1 No problem, treatment not necessary
2-3 Slight problem, treatment probably not necessary
4-5 Moderate problem, treatment probably necessary
6-7 Considerable problem, treatment necessary
8-9 Extreme problem, treatment absolutely necessary

Consider adjusting the range based on the critical objective items of the section.

Critical Objective Items of the Drug and Alcohol Sections

ITEM	**DESCRIPTION**
1 - 13	Abuse History
15 - 16	Abstinence
17	ODs and DTs
18	Lifetime Treatment

Step 2: Factor in the patient's rating scale. Pick the score that represents the patient's rating scale. For example, if the interviewer's three point range is 4-5-6, and the patient reports that he has been *extremely* (rates it a "4") bothered and he would be *extremely* (rates it a "4") interested in treatment for medical problems, then select the highest point of the three point range (in this case, a "6") for the severity rating in this section.

The meaning of the "6" severity rating is that treatment is necessary for problems related to drugs or alcohol use. The severity rating for this section should have no effect on any other sections.

Legal Status

Introduction: The legal status section of the ASI helps you to gather some basic information about your patient's legal history. It addresses information about probation or parole, charges, convictions, incarcerations or detainments, and illegal activities. We recommend that you add questions that you consider relevant to your patient's treatment plan. An interviewer can most efficiently gather accurate information from this section by doing a lot of probing in the first part of the section. For example, if a patient reports that he or she was charged with a criminal offense, the interviewer should ask whether he or she was convicted, and if so, whether any time was spent in prison. By addressing and recording these details in the early part of the section, the interviewer can move more quickly through the latter parts of the section.

L1. Was this admission prompted or suggested by the criminal justice system?
L2. Are you on probation or parole?

Intent/Key points: To record information about the relationship between the patient's treatment status and legal status. For item #1, enter "1" if any member of the criminal justice system was responsible for the patient's current admission or generally, if the patient will suffer undesirable legal consequences as a result of refusing or not completing treatment. For item #2, enter "1" if the patient is currently on probation or parole.

Suggested Interviewing Techniques: Ask both questions as written. Provide examples of referral sources that are related to the criminal justice system to clarify any confusion related to item #1.

"Mr. Smith, was your admission to this treatment program prompted or suggested by the criminal justice system, like a lawyer or probation officer... (or did you decide to come here on your own...or was it your family that persuaded you to seek help here)?"

"Are you on probation or parole?"
If a patient says that he or she is currently on probation or parole, we recommended that you routinely ask for details. For example, you should ask :
"Why are you on probation (With what criminal offense were you charged)?"
"How long have you been on probation? When will your probation period end?"

Additional Probes:
Who referred the patient
Circumstances surrounding the
referral?
Nature of the probation or parole (Federal or State)
Name of probation or parole officer

Cross-check item with:
Legal Status, Item #s 3-14C

L3-16. How many times have you been arrested and charged with the following?

Intent/Key points: This is a record of the number and type of arrest counts with official charges **(not necessarily convictions)** accumulated by the patient during his life. Be sure to include the total number of counts and not just arrests. These include only formal charges not times when the patient was just picked up or questioned. Do not include juvenile (prior to the age of 18) crimes, unless the court tried the patient as an adult, which happens in cases of particularly serious offenses.
NOTE: The inclusion of adult crimes only is a convention adopted for our purposes alone. We have found it is most appropriate for our population. The use of the ASI with different populations may warrant consideration of juvenile legal history.

Suggested Interviewing Techniques: If a patient responds that he or she has been charged with an offense, we recommend that you ask for details (e.g., whether the patient was convicted or not, whether the patient was incarcerated, paid a fine, or spent time on probation). These details will help you to move more quickly through the latter part of the section. If you don't gather information early, your attempts at gathering information from patients with complicated legal histories may be hindered. Therefore, we recommend that you ask the question as written below, with probes similar to the ones listed below asked routinely.

"Mr. Smith, how many times in your life have you been charged with_____?"

If the patient reports that he or she was charged:
"What happened with that charge...for example, was it dropped...were you convicted of it?"

If the patient reports that he or she was convicted:
"What happened when you were convicted...did you spend time in prison...did you pay a fine... were you on probation?"

Additional Probes:
The years in which they was charged with each offense
Details surrounding each criminal act
Significant events occurring at the same time that the patient was charged with each offense

Coding Issues:
1. Do include arrests that occurred during military service but do not include those that have no civilian life counterpart (e.g., AWOL, insubordination) but do record these in the "Comments" section.

2. Code attempts at criminal activity (e.g. attempted robbery, attempted rape) the same way that you code the activity. Therefore, charges of attempted robbery would be coded with robbery.

3. In this state (Pennsylvania) "contempt of court " is the charge levied against someone who has failed to pay support or alimony payments

L17. How many of these charges resulted in convictions?

Intent/Key points: To record basic information about the patient's legal history. Do not include the misdemeanor offenses (16-18) in this item. Note that convictions include fines, probation, suspended sentences as well as sentences requiring incarceration. Convictions also include guilty pleas. Charges for parole and/or probation violations are automatically counted as convictions.

Suggested Interviewing Techniques: If you did not gather information about convictions through probing during item #s 1-14C, ask as written.

"Mr. Smith, how many of these charges resulted in convictions?"

Additional Probes:
Whether or not the patient was incarcerated

Coding Issues:
Code Item #15 with an "N" if Item #s 3-14C are all "00"

Cross-check item with:
Legal Status Item #19 (possibly)

How many times have you been charged with the following?
L18. Disorderly conduct, vagrancy, public intoxication
L19. Driving while intoxicated
L20. Major driving violations

Intent/Key points: Charges in item #16 category may include those which generally relate to being a public annoyance without the commission of a particular crime. Driving violations counted in #18 are moving violations (speeding, reckless driving, leaving the scene of an accident, etc.). This does not include vehicle violations, registration infractions, parking tickets, etc.

Suggested Interviewing Techniques: Ask as written:

"Mr. Smith, how many times have you been charged with the following...(disorderly conduct, vagrancy, or public intoxication)?"

Additional Probes:
Outcomes of the charges

Coding Issues:
Employment/Support Item #4 (possibly)

L21. How many months were you incarcerated in your life?
L22. How long was your last incarceration?
L23. What was it for?

Intent/Key points: For item #19, enter the number of total months spent in jail (whether or not the charge resulted in a conviction), prison, or detention center in the patient's life since the age of 18, unless the patient was detained as an adult while still a juvenile. If the number equals 100 or more, enter "99." Count as one month any period of incarceration two weeks or longer. For item #21, use the number assigned in the first part of the "Legal Section" (03-14 and 16-18) to indicate the charge for which the patient was incarcerated. If the patient was incarcerated for several charges, enter the most serious or the one for which he/she received the most severe sentence.

Suggested Interviewing Techniques: Ask the questions as written:

"How many months have you been incarcerated in your life?"
"How long was your last incarceration?"
"For what charge were you incarcerated?"

Additional Probes:
Details of unusual periods of incarceration (serving time for two convictions concurrently)

Coding Issues:
1. Make sure that you code the total number of months that the patient was incarcerated for large periods of time. DO NOT code large numbers (30+) of overnight incarcerations. For example, a barroom brawler may report getting thrown in jail over thirty times for a couple of nights each time. Do not count those thirty incarcerations

2. If the patient has never been incarcerated for over a month, code item #19 with "00," item #20 with "N," and item #21 with "N."

3. Item #20 should always be smaller than item #19.

Cross-check item with:
1. Make sure that long periods of incarceration are accounted for in other parts of the interview, like the drug/alcohol grid. For example, if a patient reports spending a long time in jail, but never reported abstaining from drug use, you should clarify whether he used drugs in jail. Record the information in the comments section.

L24. Are you presently awaiting charges, trial or sentence?
L25. What for:

Intent/Key points: To record information about the patient's current legal status. For item #23, enter "N" if the patient is not awaiting charges, trial, or sentence. Do not include civil lawsuits unless a criminal offense (contempt of court) is involved.

Suggested Interviewing Techniques: Ask as written

"Are you presently awaiting charges, trial or sentence for any reason?"

Additional Probes:
The date on which the sentencing will take place.

Coding Issues:
Item #22 should never be coded with an "N." It should always be asked.

If Item 22="0," then Item #23 should be coded "N"

For item 23, use the numerical code on the left column which corresponds to the charge.

L26. How many days in the past 30 were you detained or incarcerated?

Intent/Key points: To record information about whether the patient was detained in the last 30 days.

Suggested Interviewing Techniques: Ask as written. If he asks for the difference between an incarceration and a detainment, ("Hey, didn't you ask me that question already?"), give him a few examples of detainments. For example, if the patient was put in jail to sleep off a drunk, or detained and questioned by the police because he looked like someone who had committed a crime, you would code that he has been "detained or incarcerated in the past 30 days."

"Mr. Smith, how many days in the past 30 were you detained or incarcerated?"

Additional Probes:
Reasons for being detained

Coding Issues:
Include being detained but released on the same day.

Cross-check item with:
General information, Items 6, 7 (possibly)

L27. How many days in the past 30 have you engaged in illegal activities for profit?

Intent/Key points: Enter the number of days the patient engaged in crime for profit.
Do not count simple drug possession or drug use. However, do include drug dealing, prostitution, burglary, selling stolen goods, etc.

Suggested Interviewing Techniques: Ask as written

"Mr. Smith, How many days in the past 30 have you engaged in illegal activities for profit?"

Additional Probes:
The type of illegal activity
Whether the patient received cash or drugs

Coding Issues:
Include illegal activity as "for profit" even if the patient received drugs or other goods (rather than cash) in return for the illegal activity.

Cross-check item with:
Employment/Support Status item #17 (possibly)

L28. How serious do you feel your present legal problems are?
L29. How important to you *now* is counseling or referral for these legal problems?

Intent/Key Points: To record the patient's feelings about how serious he feels his the previously mentioned legal problems are, and the importance of getting (additional) counseling or referral. For Item 27, the patient is rating the need for referral to legal counsel so that he can defend himself against criminal charges.

Suggested Interviewing Techniques: When asking the patient to rate the problem, use the name of it, rather than the term "problems." For example, if the patient reports that he is awaiting trial on a criminal charge, ask him the questions in the following way:

"Mr. Smith, how serious are your present legal problems...such as your upcoming burglary trial?"

"How important would it be for you to get counseling or referral for the burglary trial that you mentioned?"

Coding Issues:
Allow the patient to describe their feelings about current legal problems only...not potential legal problems. For example, if a patient reports selling drugs on a few days out of the past thirty, but has not been caught, he does not have any current legal problem. If he gets caught selling drugs then he will have a legal problem.

L30. Legal Status Severity Rating

Remember the two step derivation method for severity ratings:

Step 1: Reduce the ten-point scale (0-9) to two or three points, using only the objective items (Items 1-25 in the Legal Status section).

0-1 No problem, treatment not necessary
2-3 Slight problem, treatment probably not necessary
4-5 Moderate problem, treatment probably necessary
6-7 Considerable problem, treatment necessary
8-9 Extreme problem, treatment absolutely necessary

Consider adjusting the range based on the critical objective items of the section.

Critical Objective Items of the Legal Status Section

ITEM	**DESCRIPTION**
3 -14	Major Charges
15	Convictions
22 - 23	Current Charges
25	Current Criminal Involvement

Step 2: Factor in the patient's rating scale. Pick the score that represents the patient's rating scale. For example, if the interviewer's three-point range is 4-5-6, and the patient reports that he has been *extremely* (rates it a "4") bothered and he would be *extremely* (rates it a "4") interested in treatment for medical problems, then select the highest point of the three point range (in this case, a "6") for the severity rating in this section.

The meaning of the "6" severity rating is that counseling or referral is necessary for the patient's legal problems. The severity rating for this section should have no effect on any other sections.

Family History

Introduction: The Family History grid is designed to summarize the psychiatric, alcohol and drug abuse problems of the patient's relatives in each of the specified categories.

FH: 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?

Intent/Key points: The Family History grid is designed to summarize the psychiatric, alcohol and drug abuse problems of the patient's relatives in each of the specified categories. The information supplied by the patient cannot generally be validated and thus should be coded cautiously using the following guidelines. Determination of "problem" status -- It is not necessary for there to be a medical diagnosis or formal treatment to count as a "problem." Again, the patient is the best source of information here and should be told to count a problem as **"...one that either did or should have led to treatment."** In general, a "**yes**" response should be recorded for any category where at least one member of the relative category meets the criterion. For example, if the patient has two aunts on his mother's side and feels that one of them had a serious drinking problem and the other had a significant psychiatric problem, "yes" codes are recorded under the Aunt category (mother's side) for both alcohol and psych. A "**no**" response should **only** be counted if all relatives in the category fail to meet the criterion.

Suggested Interviewing Techniques: A preliminary question can help to determine whether any biological relatives exist in that category.

"Mr. Smith, did your mom have any sisters?"

Then, focus the question on whether *any* individual in the category has had a problem.

"Mr. Smith. did *any* of your aunts have an alcohol problem that should have led to treatment?"
"Mr. Smith. did *any* of your aunts have a drug problem that should have led to treatment?"
"Mr. Smith. did *any* of your aunts have a psychiatric problem that should have led to treatment?"

Additional Probes:
The names of individual family members with multiple problems.
The birth order of individual family members with multiple problems.

Coding Issues:
Code information about biological family, only.

It is particularly important for interviewers to make judicious use of the "N" and "X" responses to these questions.

An "**N**" should be coded for all categories where there is no relative for the category.

An "**X**" code should be used for any situation where the patient simply can't recall or is not sure for any reason. **It is better to use an "X" than to record possibly inaccurate information.**

Cross-check item with:
Since the information gathered within this section refers only to biological family, the information gathered in the family/social section may refer to a different set of relatives. Therefore, information within this section may not be consistent with information in other sections.

Family/Social Relationships

Introduction: In this section more than any other, there is difficulty in determining if a relationship problem is due to intrinsic problems or to the effects of alcohol and drugs. In general, the patient should be asked whether he/she feels that "if the alcohol or drug problem were absent," would there still be a relationship problem. This is often a matter of some question but the intent of the items is to assess inherent relationship problems rather than the extent to which alcohol/drugs have affected relationships.

F/S1. Marital Status:
F/S2. How long have you been in this marital status?
F/S3. Are you satisfied with this situation?

Intent/Key points: To record information about the patient's marital status, duration of marital status and satisfaction with marital status. For item #1, enter the code for present legal marital status. For item #2, enter number of years and months patient has been in the current marital status. For item #3, a "satisfied" response must indicate that the patient generally likes the situation, not that he/she is merely resigned to it.

Suggested Interviewing Techniques: Ask as written, with examples.

"Mr. Smith, what is your marital status. are you married, remarried, single?"
"How long have you been_____?"
"Are you satisfied with your marital status?"

Additional Probes:
Reasons for dissatisfaction or separation (if applicable)

Coding Issues:
1. Consider common law marriage (seven years in Pennsylvania) as married (1).

2. Individuals who consider themselves married because of a commitment ceremony or significant period of cohabitation should be coded as married and considered married for the remainder of the questions pertaining to marriage or spousal relations.

3. For patients who were never married enter the number of years since age 18 (an indication of their adult status) in item #2.

F/S4. Usual living arrangements?
F/S5. How long have you lived in these arrangements?
F/S6. Are you satisfied with these living arrangements?

Intent/Key points: To record information about the patient's usual living arrangements during the past three years. For item #4, code the arrangement in which the patient spent most of the last three years, even if it is different from his or her most recent living arrangement. If the patient lived in several arrangements, choose the most representative of the three-year period. If the amounts of time are evenly split, choose the most recent situation. For patients who usually live with parents, enter the number of years residing there since age 18 in item #5. A "satisfied" response in item #6 must indicate that the patient generally likes the situation, not that he/she is merely resigned to it.

Suggested Interviewing Techniques: You may have to ask a number of additional questions to get accurate responses to these items. For example, you may have to provide a frame of reference (the last three years). You may consider asking the patient for information about his current living arrangements, and all previous arrangements for the past three years, as follows:

"Mr. Smith, you mentioned that you are currently living with your mother. For how many years (or months) have you been living with her?"
"With whom were you living before you moved in with your mom?"
"How long were you living with those folks?"
and so on...

By recording this information, you can figure out not only which living arrangement was the most representative, but the length of each arrangement, as well.

Additional Probes:
Reasons for leaving each arrangement

Coding Issues:
1. Ask the patient to describe the amount of time spent living in prisons, hospitals, or other institutions where access to drugs and alcohol are restricted. If this amount of time is the most significant, enter an "8."

Cross-check item with:
General information, item #1
All information related to recent controlled environments on the rest of the interview (if the response to #4 is "8")

F/S7 & 8. Do you live with anyone who has a current alcohol problem/uses non-prescribed drugs?

Intent/Key points: Items 7 & 8 address whether the patient will return to a drug and alcohol free living situation. This is intended as a measure of the integrity and support of the home environment and **does not** refer to the neighborhood in which the patient lives. The home environment in question is the one in which the patient either currently lives (in the case of most outpatient treatment settings) or the environment to which the patient expects to return following treatment. This situation does not have to correspond to the environment discussed in items 4 through 6.

Suggested Interviewing Techniques: Since you should already have information about the patient's current living situation, you can tailor the question to the patient. For example, if the patient reports living only with his mother, you may ask this series of questions:

"Mr. Smith, Does your mother drink?"
"Do you think she has a problem with alcohol?"
"Does she use non-prescribed drugs, or prescribed drugs in a non-prescribed fashion?"

Additional Probes:
Client's relationship to people who use substances (father/daughter, husband/wife)
Number of people who use substances

Coding Issues:
1. For the alcohol question (6A), code yes **only** if there is an individual with an active alcohol problem (i.e., a drinking alcoholic) in the living situation, regardless of whether the patient has an alcohol problem.

2. For the drug use question (6B), code yes if there is **any form of drug use** in the living situation, regardless of whether that drug using individual has a problem or whether the patient has a drug problem.

F/S9. With whom do you spend most of your free time?
F/S10. Are you satisfied with spending your free time this way?

Intent/Key points: The response to item #7 is usually easy to interpret. Immediate and extended family as well as in-laws are to be included under "Family" for all items that refer to "Family." "Friends" can be considered any of the patient's associates other than family members, and related problems should be considered "Social."

Suggested Interviewing Techniques: Ask as written, with examples.

"Mr. Smith, with whom do you spend most of your free time...your family, friends or alone...?"
Are you satisfied with spending your free time this way?"

Additional Probes:
Details about free time (going to movies, using drugs)

Coding Issues:

A "satisfied" response to item #8 must indicate that the patient generally likes the situation, not that he/she is merely resigned to it.

IMPORTANT: Some patients may consider a girlfriend/boyfriend with whom they have had a long standing relationship, as a "family member." In such cases he/she can be considered a family member. If you have coded this person as a "family member" here, also consider him/her as a family member in questions 19a, 20 and 22 and as a "spouse" in question 9a. Don't consider him a close friend for item #9.

Cross-check item with:
Family/Social status #9 (possibly)

F/S11. How many close friends do you have?

Intent/Key points: Stress that you mean close. Do not include family members or a girlfriend/boyfriend who is considered to be a family member/spouse.

Suggested Interviewing Techniques:

"Mr. Smith, how many close friends do you have...by that I mean people outside of your family that you can trust ?"

Additional Probes:
Names of close friends
Amount of contact with close friends

Cross-check item with:
Other items in the interview that address close relationships, such as
Family/Social #16

F/S12-17 Would you say you have had close, long lasting personal relationships with any of the following people in your life?

Intent/Key points: Item 9A assesses the extent to which the patient has a history of being able to establish and maintain close, warm and mutually supportive relationships with any of the people listed. A simple yes response is not adequate for these questions and some probing will be needed to determine specifically if there has been the ability to feel closeness and mutual responsibility in the relationship. Does the patient feel a sense of value for the person (beyond simple self-benefit)? Is the patient willing to work to retain/maintain these relationships?

Suggested Interviewing Techniques: You will have to ask a number of questions to get accurate responses to these items.

"Mr. Smith, have you had a long-lasting personal relationship with your mother? For example, would you go out of your way to do things for her? Would you loan her money if she needed it? Have you seen her recently? Do you miss her when you don't see her?"

Coding Issues:
It is particularly important for interviewers to make judicious use of the "N" and "X" responses to these questions. In general, a "yes" response should be recorded for any category where at least one member of the relative category meets the criterion. For example, if the patient has two brothers and has had serious problems with one of them and has developed a warm, close relationship with the other, then items 9A (Brothers/Sisters) and 12 would both be counted as "yes." In contrast, a "**no**" response should **only** be counted if all relatives in the category fail to meet the criterion. An "N" should be coded for all categories where there is no relative for the category.

Cross-check item with:
Family/Social status #10-18 (possibly)

F/S18-26. Have you had significant periods in which you have experienced serious problems getting along with...?

Intent/Key points: To record information about extended periods of relationship problems. These items refer to serious problems of sufficient duration and intensity to jeopardize the relationship. They include extremely poor communication, complete lack of trust or understanding, animosity, constant arguments. If the patient has not been in contact with the person in the past 30 days, it should be recorded as "N." An "N" should also be entered in categories that are not applicable, e.g., in the case of a patient with no siblings.

Suggested Interviewing Techniques: It is recommended that the interviewer ask the lifetime question from each pair, first. For example,
"Have you ever had a significant period in your past which you experienced serious problems with your father?" Regardless of the answer the interviewer should inquire about the past 30 days. However, the interviewer should first inquire about whether there has been recent contact.
"Have you had any personal or telephone contact with your father in the past 30 days?"
(If "No", record an "N" in the "Past 30 Days" column) If "Yes", ask:
How have things been going with your father recently? Have you had any serious problems with him in the past 30 days?"

Additional Probes:
Nature of the problem
Facts about relationships (Number of siblings, children)

Coding Issues:
1. It is possible that a patient could have had serious problems with a father in the past but because of death, not have a problem in the past month. The correct coding in this case would be "yes" under lifetime and "N" under past 30 days. An "X" code should be used for any situation where the patient simply can't recall or is not sure for any reason. It is better to use an "X" than to record possibly inaccurate information.

2. Item 13 may include any regular, important sexual relationship.

3. IMPORTANT: Understand that the "Past 30 Days" and the "Lifetime" intervals in items 10 to 18C are designed to be considered separately. The past 30 days will provide information on recent problems while lifetime will indicate problems or a history of problems before the past 30 days.

4. It is particularly important for interviewers to make judicious use of the "N" and "X" responses to these questions. In general, a "yes" response should be recorded for any category where at least one member of the relative category meets the criterion. In contrast, a "**no**" response should **only** be counted if all relatives in the category fail to meet the criterion. An "N" should be coded for all categories where there is either no relative for the category or no contact with the relative.

F/S27-29. Has anyone ever abused you:

Intent/Key points: These items have been added to assess what may be important aspects of the early home life for these patients (lifetime answers) and to assess dangers in the recent and possibly future environment (past 30 days' answers). It will be important to address these questions in a supportive manner, stressing the confidentiality of the information and the opportunities for the patient to raise this in subsequent treatment sessions with an appropriate provider.

Emotional abuse will generally be coded entirely by what the patient reports and it is understood that it will be difficult to judge whether the "actual" abuse reported (or lack of it) would be considered abuse to another person. No attempt should be made to do this since the intent here is to record the patient's judgment.

Physical abuse should follow the same guidelines as emotional abuse, with one caution. Simple spankings or other punishments should not be counted as abuse unless they were (in the eyes of the patient) extreme and unnecessary.

Sexual abuse is not confined to intercourse but should be counted if the patient reports any type of unwanted advances of a sexual nature by a member of either sex.

Suggested Interviewing Techniques: Ask as written, with examples as written.

"Mr. Smith, have any of the people that I just mentioned ever abused you emotionally? For example, has anyone ever humiliated you or made you feel ashamed by calling you names?"

Additional Probes:
Others' knowledge of the abuse

Cross-check item with:
Family/Social item #s 9A (possibly), 10-18 (possibly)

F/S30 & 31. How many days in the past 30 have you had serious conflicts with your family/with other people (excluding family)?

Intent/Key points: Conflicts require personal (or at least telephone) contact. Stress that you mean serious conflicts (e.g., serious arguments; verbal abuse, etc.) not simply routine differences of opinion. These conflicts should be of such a magnitude that they jeopardize the patient's relationship with the person involved.

Suggested Interviewing Techniques: Ask as written, with examples.

"Mr. Smith, how many days in the past 30 have you had serious conflicts...by serious, I mean conflicts which may have put your relationship with someone in your life in jeopardy...for example, a big blow-up...?"

Additional Probes:
The nature of the conflict (what did you fight about?)

Coding Issues:
If a conflict occurred *only* because a patient was under the influence of a substance, you should record the problem days in the drug/alcohol problem section, rather than the family/social section. Problem days recorded in this section should have their origins in interpersonal conflict, not substance abuse. They should be primarily relationship problems, not substance abuse problems.

F/S32. How troubled or bothered ... by family problems in the past 30 days?
F/S34. How important is it for you to get counseling for family problems?
F/S33. How troubled or bothered ...by social problems in the past 30 days?
F/S35. How important is it for you to get counseling for social problems?

Intent/Key Points: To record the patient's feelings about how bothersome any previously mentioned family or social problems have been in the last month, and how interested they would be in receiving (additional) counseling. These refer to any dissatisfaction, conflicts, or other relationship problems reported in the Family/Social section.

Suggested Interviewing Techniques: When asking the patient to rate the problem, mention it specifically, rather than using the term "problems." For example, if the patient reports being troubled by problems with his mother in the last thirty days, ask the patient question 20 in the following way:

"Mr. Smith, how troubled or bothered have you been in the past thirty days by the problems that you have had with your mother?"

Ask the patient question 21 in the following way:

"Mr. Smith, how important is it for you to talk to someone about the problems that you and your mother have been having?"

Additional Probes:
Details of the problems

Coding Issues:
Do not include the patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends.

Do not include problems that would be eliminated if the patient's abuse problems were absent.

For Item 22, be sure that the patient is aware that he/she is **not** rating whether or not his/her family would agree to participate, but how badly he/she needs counseling for family problems in whatever form.

Cross-check item with:
Other items in the section that refer to problems. Problems related to family and social relationships may be recorded in many places throughout the section. For example, dissatisfaction with marital status (item #3) living arrangements (item #6),or free time (item #8) may be reported. In addition, patients may indicate a need for treatment to address serious problems (item #10-18), or serious conflicts (item #s 19A, 19B).

F/S36. Family/Social Section Severity Rating

Remember the two step derivation method for severity ratings:

Step 1: Reduce the ten-point scale (0-9) to two or three points, using only the objective items.

0-1	No problem, treatment not necessary
2-3	Slight problem, treatment probably not necessary
4-5	Moderate problem, treatment probably necessary
6-7	Considerable problem, treatment necessary
8-9	Extreme problem, treatment absolutely necessary

Consider adjusting the range based on the critical objective items of the section.

Critical Objective Items of the Family/Social Section

ITEM	**DESCRIPTION**
2 - 3	Stability / Satisfaction - Marital
5 -6	Stability / Satisfaction - Living
8	Satisfaction with Free Time
11 - 19	Lifetime Problems with Relatives
19A & B	Serious Conflicts

Step 2: Factor in the patient's rating scale. Pick the score that represents the patient's rating scale. For example, if the interviewer's three-point range is 4-5-6, and the patient reports that he has been *extremely* (rates it a "4") bothered and he would be *extremely* (rates it a "4") interested in treatment for medical problems, then select the highest point of the three point range (in this case, a "6") for the severity rating in this section.

The meaning of the "6" severity rating is that treatment is necessary for family and social issues The severity rating for this section should have no effect on any other sections.

Psychiatric Status

Introduction: When administering this section, it is important to remember that the ASI should be considered a screening tool rather than a diagnostic tool. Therefore, a patient need not meet diagnostic criteria for a symptom to have experienced the symptom. Further, the ASI will not provide definitive information on whether drug problems preceded psychiatric problems, or vice versa. All symptoms other than those associated with drug effects should be counted in this section. For example, depression and sluggishness related to detoxification should not be counted, whereas depression and guilt associated with violating a friend's trust or losing a job should be counted.

P1 & 2. How many times have you been treated in a hospital or inpatient setting/outpatient or private patient for any psychological or emotional problems?

Intent/Key points: This includes any type of treatment for any type of psychiatric problem. This does not include substance abuse, employment, or family counseling. The unit of measure is a treatment episode (usually a series of fairly continuous visits or treatment days), not the number of visits or days in treatment per se.

If the patient is aware of his/her diagnosis, enter this in the comments section.

Suggested Interviewing Techniques: Ask as written.

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

Additional Probes:
Names of programs
Reasons for leaving each program

P3. Do you receive a pension for a psychiatric disability?

Intent/Key points: Pensions for physical problems of the nervous system (e.g., epilepsy, etc.) should be counted under Item 5 in Medical Section, not here.

Suggested Interviewing Techniques: Ask as written.
"Mr. Smith, do you receive a pension for a psychiatric disability?"

Additional Probes:
Source of pension
Amount of pension

Cross-check item with:
Employment/Support Status, Item # 15

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

P4. Experienced serious depression suggested by sadness, hopelessness, significant loss of interest, listlessness, difficulty with daily function, guilt, "crying jags," etc.
P5. Experienced serious anxiety or tension suggested by feeling uptight, unable to feel relaxed, unreasonably worried, etc.

Intent/Key points: These lifetime items refer to serious psychiatric symptoms experienced over a significant time (at least 2 weeks). The patient should understand that these periods refer only to times when he/she was not under the direct effects of alcohol, drugs or withdrawal. This means that the behavior or mood is not due to a state of drug or alcohol intoxication, or to withdrawal effects.

Suggested Interviewing Techniques: We recommend that you ask the lifetime questions before you ask the questions pertaining to the last 30 days. Regardless of the answer, the interviewer should inquire about the past 30 days. For example, the interviewer should ask, "How about more recently? Have you experienced severe depression in the past 30 days?" It has been our experience that the patient will usually be able to differentiate a sustained period of emotional problem from a drug or alcohol induced effect. However, to avoid potential confusion, you may want to ask them a general question, first.

"Mr. Smith, have you had a significant period in your life in which you have experienced serious depression?"

If the patient responds positively, then qualify his answer. You may find it helpful to ask him about the circumstances surrounding the time when he was experiencing the symptom:

"What was going on in your life that made you feel that way?"
You may decide to ask him directly.

"During that time, were you doing drugs that made you feel anxious, or was it an anxiety that occurred even when you weren't doing drugs?"

Finally, ask him about the last 30 days:
"Have you experienced any anxiety during the last 30 days?"

Additional Probes:
Circumstances surrounding the time when the patient experienced the symptom

Coding Issues:
Again, understand that the "Past 30 Days" and the "Lifetime" intervals are designed to be considered separately. The past 30 days will provide information on recent problems while lifetime will indicate problems or a history of problems prior to the past 30 days.

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

P6. Experienced hallucinations (saw things or heard voices that were not there) restricted to times when patient was drug free and not suffering from withdrawal.

P7. Experienced trouble understanding, concentrating or remembering Suggested by serious trouble in concentrating, remembering and/or understanding, restricted to times when patient was drug free and not suffering from withdrawal.

Intent/Key Points: Item 6 refers to serious psychiatric symptoms over a significant time (at least 2 weeks). Item 5 is of sufficient importance that even its brief existence warrants that it be recorded. For items 5 and 6, the patient should understand that these periods refer only to times when he/she was not under the direct effects of alcohol, drugs or withdrawal. This means that the behavior or mood is not due to a state of drug or alcohol intoxication, or to withdrawal effects. It has been our experience that the patient will usually be able to differentiate a sustained period of emotional problem from a drug or alcohol induced effect. Therefore, in situations where doubts exist, the patient should generally be asked directly about his/her perception of the symptoms or problems.

Suggested Interviewing Techniques: We recommend that you ask the lifetime questions before you ask the questions pertaining to the last 30 days.

"Mr. Smith, have you had a significant period in your life in which you have experienced hallucinations...when you were not doing drugs or using alcohol?"

Finally, ask him about the last 30 days:

"Have you experienced any hallucinations during the last 30 days?"

Additional Probes:
The nature of the hallucination (what the patient saw or heard)

Coding Issues:
Understand that the "Past 30 Days" and the "Lifetime" intervals are designed to be considered separately. The past 30 days will provide information on recent problems while lifetime will indicate problems or a history of problems prior to the past 30 days.

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

P8. Experienced trouble controlling: violent behavior (or losing control) rage, or violence.

P9. Experienced serious thoughts of suicide: Times when patient seriously considered a plan for taking his/her life.

P10. Attempted suicide: Include discrete suicidal gestures or attempts.

Intent/Key Points: Items 8,9 and 10 are of sufficient importance that even their brief existence warrants that they be recorded. Further, the seriousness of item #s 7, 8, and 9 warrant inclusion even if they were caused by or associated with alcohol or drug use. Reports of recent suicide attempts or thoughts should be brought to the attention of supervisor from the treatment staff as soon as possible, even if this violates normal confidentiality guidelines.

IMPORTANT: For item #8 Ask the patient if he/she has recently considered suicide. If the answer is "Yes" to this question, and/or the patient gives the distinct impression of being depressed to the point where suicide may become a possibility, notify a member of the treatment staff of this situation as soon as possible.

Suggested Interviewing Techniques: We recommend that you ask the lifetime questions before you ask the questions pertaining to the last 30 days.

"Mr. Smith, have you had a significant period in your life in which you have experienced trouble controlling violent behavior?"

Finally, ask him about the last 30 days:

"Have you experienced trouble controlling violent behavior during the last 30 days?"

Additional Probes:
Circumstances surrounding the symptom (What made you get violent?)
Details of their suicide plan (How were you going to do it?)

Coding Issues:
Understand that the "Past 30 Days" and the "Lifetime" intervals are designed to be considered separately. The past 30 days will provide information on recent problems while lifetime will indicate problems or a history of problems prior to the past 30 days.

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

P11. Been prescribed medication for any psychological/emotional problem: The medicine must have been prescribed by a physician for a psychiatric or emotional problem. Record yes if the medication was prescribed, even if it was not taken by the patient.

Intent/Key Points: To record information about whether the patient has had psychiatric problems that warrant medication.

Suggested Interviewing Techniques: It is recommended that the interviewer ask the lifetime question from each pair, first. For example:

"Have you ever taken prescribed medication for any psychological or emotional problem?"

Regardless of the answer, the interviewer should inquire about the past 30 days.

"How about more recently? Have you taken any psychiatric medication in the past 30 days?"

Additional Probes:
The types of medication taken
The patient's perception of the reason for the medication to be taken
Whether or not the patient has been taking it as prescribed

Coding Issues:
Understand that the "Past 30 Days" and the "Lifetime" intervals are designed to be considered separately. The past 30 days will provide information on recent problems while lifetime will indicate problems or a history of problems before the past 30 days.

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

Intent/Key Points: To record the number of days that the patient has experienced the previously mentioned psychological or emotional problems. Be sure to have the patient restricts his/her responses to those problems counted in Items 3 through 9.

Suggested Interviewing Techniques: Although many patients admit experiencing some of the individual symptoms, they may not identify them as "psychological or emotional problems." For example, they may say that although they have had trouble controlling violent behavior in the past 30 days, they have not experienced any emotional problems. ("Hey, I 'm not crazy...People mess with me, I defend myself.") Therefore, we have found it helpful to target the question to the specific symptoms reported in Items #s 3-9. For example:

"Mr. Smith, how many days in the past 30 have you experienced the anxiety (or the depression, or the trouble controlling violent behavior) that you mentioned?"

Additional Probes:
Duration of the symptom
Trigger for the symptom (if applicable)

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

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

Intent/Key Points: To record the patient's feelings about how bothersome the previously mentioned psychological or emotional problems have been in the last month and how interested they would be in receiving (additional) treatment. Be sure to have the patient restrict his/her response to those problems counted in Items 3 through 9.

Suggested Interviewing Techniques: When asking the patient to rate the problem, use the name of it, rather than the term "psychological problems." For example, if the patient reports having trouble with serious anxiety in the last thirty days, ask the patient question 11 in the following way:

"Mr. Smith, how troubled or bothered have you been in the past thirty days by the anxiety that you mentioned?"

Ask Item #13 in the following way:

"Mr. Smith, how important would it be for you to get (additional) treatment for the anxiety that you mentioned?"

Coding Issues:
Referring to item 11, have the patient rate the severity of those problems in the past 30 days. Be sure that patient understands that you do not necessarily mean transfer to a psychiatric ward, or psychotropic medication.

P15 - 20. Patient Symptoms: These are ratings by the **interviewer** based on his/her observations of the patient. The interviewer should use his judgment based upon the patient's behavior and answers during the interview. Do not over interpret; count only the presence of overt symptoms in these categories. (See above for description).

P21. Psychiatric Status Severity Rating:

Remember the two step derivation method for severity ratings:

Step 1: Reduce the ten-point scale (0-9) to two or three points, using only the objective items (Items 1-11 in the Psychiatric Status section).

0-1 No problem, treatment not necessary
2-3 Slight problem, treatment probably not necessary
4-5 Moderate problem, treatment probably necessary
6-7 Considerable problem, treatment necessary
8-9 Extreme problem, treatment absolutely necessary

Consider adjusting the range based on the critical objective items of the section.

Critical Objective Items of the Psychiatric Status Section

ITEM	**DESCRIPTION**
1	Lifetime Hospitalizations
3 - 10	Present and Lifetime Symptoms

Step 2: Factor in the patient's rating scale. Pick the score that represents the patient's rating scale. For example, if the interviewer's three point range is 4-5-6, and the patient reports that he has been *extremely* (rates it a "4") bothered and he would be *extremely* (rates it a "4") interested in treatment for medical problems, then select the highest point of the three point range (in this case, a "6") for the severity rating in this section.

The meaning of the "6" severity rating is that treatment is necessary for the psychiatric section. The severity rating for this section should have no effect on any other sections.

APPENDICES

1. **ASI Introduction**
2. **Critical Objective Items**
3. **Instructions for using "N" on the ASI**
4. **Hollingshead Abbreviated Categories**
5. **List of Commonly Used Substances**
6. **Items for Cross-Checking the ASI**
7. **ASI Follow Up Interview Instructions**
    a. **Generic Follow Up Consent Form**
    b. **Follow Up Tracking Form**

Introducing The ASI

POINTS TO INCLUDE WHEN INTRODUCING THE ASI:

- All patients get this 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 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.

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

Critical Objectives Items by Section

Section Item	Description
Medical	
M1	Lifetime Hospitalizations
M3	Chronic problems
Employment/Support	
E1 & E2	Education & Training
E3	Skills
E6	Longest Full-time job
E10	Recent Employment Pattern
Drug/Alcohol	
D1-13	Abuse History
D15-16	Abstinence
D17-18	OD's and DT's
D19-20	Lifetime Treatment
Legal	
L3-16	Major Charges
L17	Convictions
L24-25	Current Charges
L27	Current Criminal Involvement
Family/Social	
F2-3	Stability/Satisfaction – Marital
F5-6	Stability/Satisfaction – Living
F10	Satisfaction with Free Time
F30-31	(in 5th edition, formerly 10 A&B) Serious Conflicts
F18-26	Lifetime Problems with Relatives
Psychiatric	
P1	Lifetime Hospitalizations
P3-10	Present & Lifetime Symptoms

Placement of the "N" on the ASI

Page 1:

Bottom Left, G12, "SPECIAL", if the interview has been completed code as "N". If G19 is coded "1" for "no", then G20 is an "N".

Medical Section:

If M1 is coded"00", then M is coded "NN".

Employment/Support:

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

Drug/Alcohol:

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".

Legal:

If L3 through L16 are all coded as "00", then L17 is coded "N".

If L21 is coded "00", then L22 and L23 are coded "N".

If L24 is coded "0" for "no", then L25 is coded "N".

Family/Social:

The Family History grid and items F12-26 from the Family/Social section are the only ones where an "N" may be used. To understand when to use an "N" think on terms of the clients' opportunity to have a relationship with the person/people referred to in each item. As a rule of thumb, if there was the 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 F11in the F/S section is coded "00", then F24 in the "Past 30 Days" column is coded "N". In such cases, the interviewer probes to see whether there have ever been any close friends to determine if an "N" is also coded under "Lifetime" in F24.

If E1 in the E/S section is coded "00" or if the client is self-employed with no employees or co-workers, then F26 in the F/S section is coded "N".

Psychiatric:

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

HOLLINGSHEAD CATEGORIES

1. Higher Executives, Major Professionals, Owners of Large Businesses

2. Business Managers (medium sized businesses), Lesser professionals (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, etc.) actor, reporter, travel agent.

4. Clerical and Sales, Technician, Little Businesses
   (Bank teller, bookkeeper, clerk, draftsman, timekeeper, secretary, car salesperson)

5. Skilled Manual – usually having had training
   (baker, barber, brakeman, chef, electrician, fireman, lineman, machinist, mechanic, paperhanger, painter, repairman, tailor, welder, policeman, plumber)

6. Semiskilled
   (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, include unemployed)

LIST OF COMMONLY USED SUBSTANCES

Alcohol: Beer, Wine, Liquor, grain (methyl alcohol)

Methadone: Methadone, Dolophine, LAAM

Other Opiates:

Pain Killers: Morophine, Dilaudid, Demerol, Percocet, Percodan, Pantapon, Dia-Quel, Darvon, Darvocet, Talwin, Codeine, (Tylenol 2,3,4), Syrups (Robitussin, Actifed – C), Fentanyl

Barbiturates: Nembutal, Seconal, Tuinal, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol, Doriden, Placidyl

Sed/Hyp/Tranq:

- Benzodiazepines: Valium, Librium, Ativan, Serax, Tranxene, Dalmane, Halcyon, Xanax
- Phenothiazines (Antipsychotics): Thorazine, Stelazine, Haldol, Navane, Serentil, Mellaril, Prolixin, Compazine, Miltown
- Other: Chloral Hydrate (Noctec), Tofranil, Quaaludes

Cocaine: Cocaine crystal, free-base cocaine or "crack," "rock cocaine"

Amphetamines: Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice (Crystal)

Cannabis: Marijuana, Hashish

Hallucinogens:

LSD (Acid), Mescaline, Mushrooms (Psilocybin), Peyote, Green, PCP (Phencyclidine), Angel Dust

Inhalants: Nitrous Oxide, Amyl Nitrate (Whippets, poppers), glue, solvents

Just Note: Dilatin (an anticonvulsant)
Antabuse, trexan
HBP Meds: Catapres, Hydrachlorathiazide
Asthma Meds: Ventolin Inhaler & Theodur
Antidepressants: Desipramine, Sinequan
Ulcer Meds: Tagamet, Zantac

ITEMS FOR CROSS CHECKING THE ACCURACY OF THE ASI INTERVIEW

1. If the patient tells you on page 1, item G19 that s/he 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 sections, item M4 that s/he 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, M5, that s/he gets a pension, check to make sure you have entered the amount of money he gets per month under the E/S section, E15.

4. If a patient tells you that s/he spent a lot of money on drugs/alcohol (D/A section item D23-24) check the E/S section (E12-17) to see if the patient reported enough income to cover the amount spent. 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 (D18) of an OD 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 profit in the Legal section (L27) check the E/S section (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 (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 E8-9. If the patient does give you his current living arrangements under F/S section (F4), check to make sure the information correlates with item G14 on page 1.

8. If the patient tells you of a psychiatric pension in the Psychiatric section (P2). Check the E/S section (E15) to make sure you entered the amount of money received in the past month for the disability.

9. Check the patients' age, against the number of years s/he has been using drugs and alcohol regularly, and with the number of years s/he has been incarcerated. Compare the total years of regular substance use reported (D/A items D1-13) and the total number of years of incarceration (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 evaluation in a number of ways:

1. Only a subset of items are applicable and therefore used.

2. Thus f/u interviews are briefer – 15 to 20 minutes.

3. You can even get good information doing follow-ups over the phone.

4. Interviewer Rating Scales are **not** used at f/u.

1. Circled items are used at f/u interview.

2. Asterisked items need to be rephrased to record cumulative data since the time of the last interview.

3. Lifetime questions are not asked in D/A items D1-13, F/S items F18-26, or Psych items P3-10.

How to achieve follow-up rates:

1. Inform patient at interview that f/u evaluation will be conducted X-months later.

2. Get the name, address and phone number of more than one family member 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 the patient is involved with, i.e. a Probation Officer, other Treatment agencies, etc.

4. Insure confidentiality – a non-revealing telephone number for the patient to call when you leave a message for the patient.

5. Insure patient confidentiality – let patient know that the references will not be questioned concerning patients' 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 contact him.

****

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

ASI Coding Practice

ADDICTION SEVERITY INDEX

CODING PRACTICE – 2012

1. During an ASI, a patient who you are seeing for a clinical intake asks you why you are asking these questions. You tell him:

   A. It is a standard test we give to all our subjects.
   B. It is a questionnaire which will tell us whether you go inpatient or outpatient.
   C. It is an interview which we conduct to help us to create a treatment plan for you.
   D. It is an interview which helps us to diagnose a variety of problems such as alcohol problems or depressive disorders.

2. A patient comes into your office for an ASI interview. He is clearly inebriated and having difficulty communicating with you. You should:

   A. Stop the interview and reschedule it for another day.
   B. Conduct on the questions that she can understand.
   C. Do your best to get all the information. Complete the interview. Code "1" in the confidence ratings boxes where appropriate.
   D. Try breaking through the obvious denial of the alcohol problem before beginning the ASI.

3. The primary difference between an "N" and an "X" is that:

   A. "N" means not applicable; "X" means unanswered.
   B. "N" means no answer given, "X" means client lying.
   C. "N" means no data available, "X" means wrong answer.
   D. "N" means never; "X" means extra space needed.

4. A patient reports that in the past 30 days, she was in jail for five (5) days and in a medical hospital for two (2) days. How would you code item G19 in the General Information section?

   A. "4" (Medical Treatment)
   B. "2" (Jail)
   C. "6" (Other)
   D. Probe for further information to determine correct answer.

5. A patient reports the following five hospitalizations: a three-day hospital stay in 1974 for injuries sustained in a motorcycle accident, a two week stay in 1983 for an operation on a bleeding ulcer which had been aggravated by drinking, and a 4 day stay in 2000 due to complications with the birth of her child. The patient also had three emergency room visits in 1991 for chest pain. During each emergency room visit, she was treated and released within four hours. How would you code the following Medical status questions?

   A. Question M1="03", Question M2="12 00"
   B. Question M1="02", Question M2="29 00"
   C. Question M1="02", Question M2="12 00"
   D. Question M1="01", Question M2="37 00"

6. A patient reports in item M4 that she has a current prescription for seizure medicine. However, she has not taken the medication for the past few weeks because she has been "bingeing" on cocaine. How should you code item M4 of the Medical section?

   A. "0" (No) because she has not been taking recently.
   B. "0" (No) because is seems she doesn't really need it.
   C. "1" (Yes) because it was prescribed by a physician and she should be taking it.
   D. "X" The information is probably distorted because she isn't taking her medication.

7. A patient moved from Oklahoma to Seattle six days ago. He has a valid Oklahoma driver's license. However, he became so fond of Seattle's public transportation system that he sold his car. Although he doesn't have a car, he can get wherever he needs on METRO. How would you code the following questions in the Employment/Support section?

   A. Question E4="1", Question E5="1"
   B. Question E4="1", Question E5="0"
   C. Question E4="0", Question E5="0"
   D. Question E4="0", Question E5="N"

8. A patient tells you that she has gone to work on eighteen days out of the past thirty (three five day weeks and three other days, all Monday-Friday). She has taken paid sick leave on two additional days, while looking for a drug treatment program. She will receive $1,600 take home for the past month's work. In addition, this month she received $50.00 from a friend for helping him move on a Saturday. Code the following questions in the Employment/Support section.

   A. Question E11="17", Question E12="$1,600"
   B. Question E11="18", Question E12="$1,650"
   C. Question E11="19", Question E12="$1,600"
   D. Question E11="21", Question E12="$1,650"

9. A patient tells you that on 20 of the last 30 days, he has consumed two bottles of beer during his lunch hour. He says that he doesn't feel the effects of the alcohol. How would you code the last 30 days' column of item D2 in the Drug/Alcohol section?

   A. "00"
   B. "20"
   C. "40"
   D. You can't tell from the information provided.

10. A 40-year-old patient tells you that she started using cocaine in 1992. How would you code the "*Yrs/Lifetime*" portion of item D8 in the Drug and Alcohol section?

   A. "00"
   B. "11"
   C. "92"
   D. You can't tell from the information provided.

11. A patient reports that he used marijuana every weekend from Friday to Sunday during nine months of 1980, his senior year of high school. The nine-month period was the only time in his life he used marijuana. The correct coding of the "*Yrs/Lifetime*" column of item D10 of the Drug and Alcohol section is:

   A. "00"
   B. "01"
   C. "09"
   D. "28"

12. A client reports that she was treated only once in her life for drug problems. The treatment involved a five-day detox followed by a 28-day inpatient hospitalization. The proper coding of items D20 & D22 is:

   A. Question D20="02", Question D22="01"
   B. Question D20="02", Question D22="00"
   C. Question D20="01", Question D22="00"
   D. Question D20="01", Question D22="01"

13. In response to Drug/Alcohol Use section item D24, a patient says that he has spent no cash on drugs in the past 30 days. However, he says that on five days he has "turned tricks" in exchange for cocaine that would have cost him $750. The correct coding of item D24 is:

A. "0000"
B. "0500" because he probably inflated the value of the drugs.
C. "0750"
D. "4500" because he could have made this much if he worked more.

14. Given the above situation, if the five days described were the only days in the past 30 in which he engaged in illegal activities, what would be the correct coding for item E17 in the Employment/Support section and item L27 in the Legal section?

A. E17="0750" L27="05"
B. E17="0750" L27="00"
C. E17="0000" L27="05"
D. E17="0000" L27="00"

15. A patient reports that as a juvenile she was charged as an adult for attempted murder. The correct coding for item L13 in the Legal status section would be:

A. "00", because she was a juvenile.
B. "00", because she only attempted murder.
C. "00", for both reasons.
D. "01", with appropriate footnote.

16. A patient says that she has five brothers. The oldest brother is the only sibling with an alcohol problem. Her second oldest brother is the only one with psychiatric problems. Her three youngest brothers have had serious drug problems, with no alcohol or psychiatric history. How would you code the Family History section for these brothers?

		A	D	P
A.	Brother =	“1	0	1”
B.	Brother =	“1	1	1”
C.	Brother =	“1	2	1”
D.	Brother =	“1	3	0”

17. A patient says that he lived alone with his wife for six years before she kicked him out of their house one year ago. During the last year, he has lived in his mother's house with his mother, an adolescent niece, and the niece's infant daughter. How would you code the following items from the Family/Social section?

A. F4="2" (with sexual partner alone) F5="06 00"
B. F4="2" (with sexual partner alone) F5="01 00"
C. F4="4" (with parents) F5="01 00"
D. F4="5" (with family) F5="01 00"

18. In response to item F30 (past 30 days), a patient states that the only conflicts that he has had this month have been with his wife. For the past fifteen days, he and his wife have had daily blow-ups

which primarily involve his drug use. He explains that his wife doesn't trust him at all anymore. How would you code item F30 in the Family/Social section?

A. "00"
B. "01"
C. "15"
D. You can't tell from the information provided.

19. A patient states that she had gotten extremely depressed for three significant periods in her life. All three of these periods of depression began when she thought about how she was messing up her life from drug use. However, she was not using drugs during any of these periods of depression. None occurred in the last 30 days. How should you code the *Lifetime part* of item P4 in the Psychiatric section?

A. "0"
B. "1"
C. "3"
D. You can't tell from the information provided.

20. A patient states that he hadn't experienced any psychiatric problems in the past 30 days. However, he reports that last week he punched a hole in his wall and threw a television across his living room when he was drunk. How would you code the *past 30 days* box in item P8 of the Psychiatric section?

A. "0"
B. "1"
C. "2"
D. You can't tell from the information provided.

21. A patient reports that he attempted suicide once in his life by jumping out of a sixth story window, while he was under the influence of a combination of substances. After a lengthy orthopedic hospitalization, he was transferred to a 28-day inpatient drug treatment program where he participated in daily recovery groups and talked to a psychiatrist weekly about his mood swings. Where would information about this single treatment experience be documented on the ASI?

A. Medical Status - M1
B. Drug/Alcohol Use - D20
C. Psychiatric Status - P1
D. It would be documented all three places
E. Medical Status - M1 and Drug/Alcohol - D20
F. Drug/Alcohol - D20 and Psychiatric Status - P1

22. A patient reports that she took prescribed Valium daily for two years to help her deal with anxiety. Make sure that information about this medication appears in the following places:

A. Medical Status item M4
   D/A Use item D7
   Psychiatric Status item P11
B. D/A Use item D7
   Psychiatric Status item P11
C. Psychiatric Status item P11 only
D. Medical Status item M4
   Psychiatric Status item P11

Substance Abuse Information Web Sites

Websites for Addiction Professionals

NOTE: All sites are preceded by "http.//"

- Addiction Resource Guide: site contains information on treatment facilities nationally and internationally. Also has links to professional and advocacy organizations. www.addictionresourceguide.com

- Addiction Technology Transfer Center (ATTC): This is the homepage to the national center. Regional sites are linked. Information is available on "best practices", recent research and topical information from screening to discharge planning. www.nattc.org

- Addiction Treatment Forum: information, news and research for addiction treatment including national conference schedules on related upcoming events. www.atforum.com

- Alcoholism and Addiction Treatment free resources: This site has multiple links for manuals, textbooks, brochures and articles available for download or order. The site references licensing requirements by state, employment opportunities in the addiction field, and research on many of the behavioral addictions. www.e-help.com/addiction_and_alcoholism_treatment.html

- American Association for Treatment of Opioid Dependence, Inc.: This site is specific to methadone treatment but references sites on infectious diseases, as well as topics of use to treatment professionals in fields not limited to methadone. www.aatod.org

- American Society of Addiction Medicine (ASAM) This is the homepage for the organization that authored "Patient Placement Criteria" which is considered a best practice for determining level of care for new admissions or continued assessment in substance abuse treatment facilities. www.asam.org

- The Anna Institute: This website contains many resources the occurrence of adverse childhood experiences (ACE) and later life social, physical and mental problems. http://www.theannainstitute.org

- Behavioral Health Resource Management: The site is sponsored by Chestnut Health Systems and The University of Chicago Center for Psychiatric Rehabilitation. There is access to many journal publications and will soon have a specific section for co-occurring disorders. They are proponents of "Recovery Management", a broader, more holistic, and long term approach to treatment and recovery. www.bhrm.org

- Center for Substance Abuse Treatment (CSAT): This site is narrower in scope than the SAMHSA site and contains information specific to substance abuse. Many resources are available including TIPS (Treatment Improvement Protocol). All resources are available at no charge and are either downloadable or easily ordered. www.csat.samhsa.gov

- Co-Occurring Center for Excellence (COCE): This SAMHSA site contains research papers on co-occurring disorders and treatment. http://store.samhsa.gov/pages/searchresults/coce

- Culture Vision: This resource compiles short synopses of common characteristics of ethnic, religious/spiritual, cultural, and/or special populations. It is not to be used to stereo-type groups but offers insight as to common practices and beliefs. www.crculturevision.com

- Faces and Voices of Recovery: This is an advocacy site for anyone interested in recovery news and events. Anyone who cares to can enroll to receive daily emails regarding recovery activities. www.facesandvoicesofrecovery.org

- Institute for Behavioral Research, Texas Christian University: This site contains a vast amount of research based material. Treatment manual in all areas of addiction science are available for easy download from this site. The site is updated regularly www.ibr.tcu.edu

- Join Together: This is another advocacy site but contains daily reporting on anything prevention or treatment related. Again, one is able to register to receive daily emails regarding the latest alcohol or other drug abuse prevention or treatment. www.jointogether.org

- National Association of Drug Court Professionals (NADCP): This is the home page for anything regarding drug courts. Listings of trainings available, public policy, and other problem solving courts. www.nadcp.org

- National Council on Alcoholism and Drug Dependence: This is an advocacy organization whose purpose is to disseminate information on prevention, treatment and recovery.
  www.ncadd.org

- National Institute on Alcohol Abuse and Alcoholism (NIAAA): These sites (and the one immediately following, NIDA) are home pages for divisions of the National Institute of Health that contain information specific to alcoholism or drug addiction. Reports, articles, news and FAQ's are all addressed.
  www.niaaa.nih.gov

- National Institute on Drug Abuse (NIDA): See above
  www.nida.nih.gov

- National Institute of Justice: This is an arm of the U.S. Dept. of Justice that compiles research regarding legal and criminal matters. It does, however, contain articles and research pertaining to drug courts, programs within

prisons, and ex-prisoner reintroduction to society after incarceration. www.ojp.usdoj.gov/nij/

- National Registry of Evidenced-Based Practices: This website has listed and links to all clinical practices that have been determined to be "evidence-based". Some of the materials presented are public domain and available for download but much is proprietary and copy write protected. www.nrepp.samhsa.gov/

- Network for the Improvement of Addiction Treatment (NIATx): This site contains a great deal of useful information, including case studies, promising practices, and sample forms for all clinical charting. Virtually everything on the site is available to download as PDF files. www.NIATx.net

- Office of Applied Studies, SAMHSA: This specific SAMHSA site contains listings of studies listed alphabetically by subject matter. Pick a specific drug and linkage will be made to articles on that subject. www.oas.samhsa.gov

- The Quality Forum: homepage of organization with stated mission of "improve American healthcare through endorsement of evidence based practices." Most information is non-addiction healthcare, but scroll to bottom of homepage and click on "Treatment for Substance Abuse Use Disorders Project" for in-depth review of best practice information. www.qualityforum.org

- Substance Abuse and Mental Health Services Administration (SAMHSA): This is the homepage website for SAMHSA. There are many links from this site. Any information regarding federal funding, grants, statistical data and recent news regarding mental health and/or substance abuse is available through this site or its linkages. www.samhsa.gov

- Tips and Topics from David Mee-Lee, M.D. This is a monthly newsletter written by Dr. David Mee-Lee, a Fellow at the American Society for Addiction Medicine (ASAM) He was one of the primary authors of "Patient Placement Criteria Manual IV), which is the "bible" for level of care placement for all consumers entering treatment for AOD treatment. Marcia@davidmeelee.ccsend.com

- Trauma Center Publications: This site has links to multiple articles published in peer reviewed journals on all subjects related to trauma. www.traumacenter.org/products/publications.php

- Treatment Research Institute: Homepage of organization dedicated to disseminating evidence-based scientific methods for treatment of addiction. This is also the site containing valuable information on the ASI. www.tresearch.org

- White Bison: this site list multiple Native American treatment methods and trainings. They also publish and online daily meditation. www.whitebison.org