Addiction Severity Index Handouts

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ADDICTION SEVERITY INDEX

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

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

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

There are two time periods we will discuss:

1. The past 30 days
2. Lifetime

CLIENT RATING SCALE

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

The scale is:

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

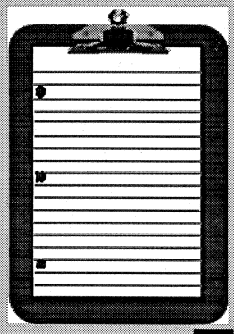
* *Please remind the client to not give inaccurate information and that this is an interview, not a test.*

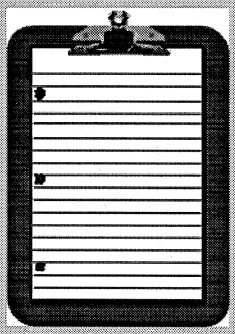
Interviewer Rating Scale: Patient Rating Scale

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

A SHORT GUIDE TO THE ASI

(VERSION 5 UPDATE)





INFORMATION ON:

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

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

FROM

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

With support from NIDA, NIAAA and the Veterans Administration

POINTS TO INCLUDE WHEN INTRODUCING THE A S I

- 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 client rating scale is:

0	not at all
1	slightly
2	moderately
3	considerably
4	extremely

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

The interviewer should mention each of these points.

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

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

PLACEMENT OF THE "N" ON THE ASI

General Information:

If #Gl9 is coded "1" for "no", then #G20 is an "N".

Medical Section:

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

Employment/Support:

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

Drug/Alcohol Section:

If #Dl5 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 Section:

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 "O" for "no", then #L25 is coded "N".

Family/Social Section:

Items #Fl2-#Fl 7 and Items #F18-#F26 are the only items in this section where an "N" may be used. To understand when to use an "N" think in terms of the client's 01mortunity to have a relationship with the person/people referred to in each item. For Items #F12-#Fl 7 an "N" would be coded only if the relative didn't exist (as in the case of a client who has no children). For items #F18-#F26, the rule of thumb is that if there was no opportunity to experience the relationship in question (e.g. if someone in a particular category is deceased or if there has been no contact), then an "N" is coded. If the client reports that there has never been a relationship in a particular category (like no children, never any friends, never a relationship with father, etc.), then an "N" would be coded in both the "Lifetime and "Past 30 Days" boxes.

If #Fl 1 in the F/S section is coded "O", then #F24 in the "Past 30 Days" column is coded "N". In such cases, the interviewer probes to see whether there had ever been any close friends to determine if an "N" is also be coded under "Lifetime" in #F24.

If #El 1in the E/S Section is coded "00" or if the client is self-employed with no employees or co- workers, then #E26 in the F/S section is coded "N" for the past 30 days.

Psychiatric Section:

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

Close ASI Section:

If the interview has been completed, code Gl2 as "N".

LIST OF COMMONLY USED DRUGS:

Alcohol: Beer, wine, liquor
Methadone: Dolophine, LAAM
Opiates: Pain killers: Morphine, Dilaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Syrups, Robitussin, Fentanyl
Barbiturates: Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol
Sed/Hyp/Tranq: Benzodiazepines: Valium, Xanax, Librium, Ativan, Serax, Quaaludes Tranxene, Dalmane, Halcion, Miltown,
Cocaine: Cocaine Crystal, Free-Base Cocaine or "Crack" and "Rock"
Amphetamines: Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis: Marijuana, Hashish, Pot
Hallucinogens: LSD (Acid), Mescaline, Mushrooms (Psilocybin), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstasy
Inhalants: Nitrous Oxide, Amyl Nitrate, Whippits, Poppers, Glue, Solvents, Gasoline, Toluene, Etc.

HOLLINGSHEAD CATEGORIES:

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

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

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

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

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

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

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

8. Homemaker.

9. Student, disabled, no occupation.

SEVERITY RATINGS

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

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

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

2 - Step Method:

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

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

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

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

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

CRITICAL OBJECTIVE ITEMS BY SECTION

SECTION	ITEM	DESCRIPTION
Medical	Ml	Lifetime Hospitalizations
	M3	Chronic problems
Employment / Support	El & E2	Education and Training
	E3	Skills
	E6	Longest Full-time Job
	ElO	Recent Employment Pattern
Drug / Alcohol	Dl - D13	Abuse History
	D15 & D16	Abstinence
	D17 & D18	OD's and DT's
	D19 & D20	Lifetime Treatment
Legal	L3 - Ll6	Major Charges
	Ll7	Convictions
	L24 & L25	Current Charges
	L27	Current Criminal Involvement
Family / Social	F2 & F3	Stability / Satisfaction - Marital
	F5 & F6	Stability / Satisfaction - Living
	FlO	Satisfaction with Free Time
	Fl2 - Fl7	Lifetime Problems
	F30 & F31	Serious Conflicts
Psychiatric	Pl	Lifetime Hospitalizations
	P4 - 11	Present and Lifetime Symptoms

COMPOSITE SCORES

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

An example is the composite score for the Alcohol Section:

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

These items are combined using a mathematical procedure that insures equal weighting of each variable in the total composite score. There is a manual for the derivation of Composite Scores from the ASI (MacGahan et AL, 1985), which details the items from each area to be used and the mathematical procedure to produce the composite scores.

RECOMMENDED ITEMS FOR CROSS CHECKING INTERVIEWER ACCURACY OF THE ASI INTERVIEW

1. If the patient tells you IN THE General Information section, item #Gl9 that he/she has been in a controlled environment in the last 30 days, make sure this information is reflected in the appropriate area of the ASI (e.g. if the patient was in jail, this would be reflected under the Legal section; if in the hospital - under the medical section, etc.).

2. If the patient tells you in the Medical section (item #M4) that he/she is taking prescribed medication, check to see that you have noted this medication under the *DI*A section. Also, where appropriate add the medication under the grid.

3. If the patient tells you in the Medical section (item #MS) that he/she gets a pension, check to make sure you have entered the amount of money he gets under the E/S section (item #ElS).

4. If a patient tells you that s/he spent a lot of money on drugs/alcohol (D/A section, items #D23 - #D24) check the *EIS* section (items #E12 - #El 7) to see if the patient reported enough income to cover the amount spent. EXPLAIN Sometimes a patient may be living off his/her savings - but not very often.

5. Sometimes patients will inform you in the *DIA* section (item #D18) of an O.D. that required hospitalization, which they forgot to tell you about under the Medical section. Go back and clarify items #Ml and #M2 under the Medical section.

6. If the patient admits to engaging in illegal activities for monetary benefit (cash) in the Legal section (item #L27) check the E/S section (item #El7) 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 *FIS* section (item #F4), however they may not have informed you of this under the *EIS* section. Some probes you may want to ask are, "Does this person work?", "Does this person help out with the bills?", pertaining to *EIS* section items #ES & #E9.).

8. If the patient tells you of a psychiatric pension in the Psychological section (item #P3), check the *EIS* section (item #E15) to make sure you entered the amount of money received in the past month for the disability.

9. Check the patient's age, against the number of years he/she has been using drugs and alcohol regularly, and with the number of years he/she has been incarcerated. Compare the total years of regular substance use reported *(DIA* items #Dl - # D13) and the total number of years of incarceration (Legal item #L21) to see if the patient is old enough to have used the substances as long as was reported. If this seems unlikely, an extra probe may be, "Did you use drugs/alcohol regularly while you were incarcerated?"

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

FOLLOW-UP INTERVIEWS

They differ from initial evaluations in a number of ways:

Only a subset of items is applicable and therefore used.

Thus follow up interviews are briefer - 15 to 20 minutes.

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

Interviewer Rating Scales are not used at follow up interviews.

Circled items are used at follow up interview.

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

Lifetime questions are not asked in *DIA* items #Dl-#13, *FIS* items #F18-#F26, or Psych items #P4-Pll.

How to achieve high follow-up rates:

1. Inform patient at initial interview that f7u evaluation will be conducted X-months later.

2. Get names, addresses and phone numbers of more than one family members and/or friends. Be sure that they are different addresses and numbers. Check these numbers and addresses immediately, while the patient is in treatment

3. Get information about other people patient is involved with, like Probation Officer, other Treatment Agencies, etc.

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

5. Insure patient confidentiality - let patient know that the references will not be questioned concerning patient's status but would only be used in locating the patient. Have a story handy to explain curious relatives the reason for the call to the patient.

6. Keep detailed records of all follow-up attempts including times attempted and the results. This helps to reduce overlap of attempts and aids in spreading out efforts.

7. Can also mail a non-revealing but personalized letter stating times a patient can call you or for him to mail back information when you can contact him.

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

ASAM
Handouts

ASAM Assessment Dimensions

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

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

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

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

Dimension 1, Acute Intoxication and/or Withdrawal (Management) Potential: Is acute intoxication and/or withdrawal potential contributing to, or complicating the patient's condition? What risk is associated with the patient's current level of acute intoxication? Is there serious risk of severe withdrawal symptoms or seizures based on the patient's previous withdrawal history, amount, frequency, and frequency of discontinuation or significant reduction of alcohol or other drug use? Are there current signs of withdrawal? Does the patient have supports to assist in ambulatory detoxification if medically safe?

Dimension 2, Biomedical Conditions and Complications: Are there current physical illnesses other than withdrawal that are contributing to or complicating the patient's condition that needs to be addressed? e.g., pregnancy, bleeding, cancer, heart disease etc. Are there chronic conditions that affect treatment? e.g., wheel chair bound; chronic pain with narcotic analgesics.

Dimension 3, Emotional/Behavioral/Cognitive Conditions and Complications: Are there one or more psychiatric disorders contributing to, or complicating the patient's condition? Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed? Are there chronic conditions that affect treatment because of continued symptoms or disability? e.g., stable, but chronic schizophrenic, affective or personality disorder problems. Do any emotional, behavioral or cognitive problems appear to be an expected part of addiction illness or do they appear to be separate? Even if connected to addiction, are they severe enough to warrant specific mental health treatment?

Dimension 4, Readiness to Change: Does the patient feel coerced into treatment or actively object to receiving treatment? How ready is the patient to change? If willing to accept treatment, how strongly does the patient disagree with others' perception that s/he has a mental health or a substance problem? Is the patient compliant to avoid a negative consequence, or internally distressed in a self-motivated way about his/her mental health or alcohol or other drug use problems? Is the patient at a different stage of change for the substance abuse problem versus the mental health problem?

Dimension 5, Relapse/ Continued Use or Continued Problem Potential: Is the patient in immediate danger of continued severe distress and/or drinking/drugging behavior? Does the patient have any recognition and understanding of, and skills for how to cope with his/her mental health and/or addiction problems and prevent relapse or continued problems and/or continued use? What severity of problems and further distress will potentially continue or reappear, if the patient is not successfully engaged into treatment at this time? How aware is the patient of relapse dangers, triggers, and ways to cope with reappearance of psychiatric symptoms and/or cravings to use and skills to control impulses harmful to self or others and/or prevent continued alcohol/drug use?

Dimension 6, Recovery Environment: Are there any dangerous family, significant others, living or school/working situations threatening treatment engagement and success? Does the patient have supportive friendship, financial or educational/vocational resources to improve the likelihood of successful treatment? Are there·1egal, educational, vocational, social service agency or criminal justice mandates that may enhance motivation for engagement into treatment?

General Overview of ASAM Levels of Care:

ASAM PPC Levels of Care: (Detoxification Services for Adults)	**Level:**	**Placement Criteria: (Note: There are not separate Detox. Services for Adolescents)**
Ambulatory Detoxifications without Extended Onsite Monitoring	I-D	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete detox. and to continue treatment or recovery
Ambulatory	II-D	Moderate withdrawal with all day detox.

Detoxifications with Extended Onsite Monitoring		Support and supervision at night, has supportive family or living situation; likely to complete detox.
Clinically-Managed Residential Detoxification	III.2-D	Moderate withdrawal, but needs 24-hr. support to complete detox. and complete increase likelihood of continuing treatment or recovery
Medically-Monitored Inpatient Detoxification	III.7-D	Severe withdrawal and needs 24-hr. nursing care and physician visits as necessary; unlikely to complete detox. without medical or nursing monitoring
Medically-Managed Inpatient Detoxification	IV-D	Severe unstable withdrawal and needs 24-hr. nursing care and daily physician visits to modify detox. regimen and mange medical instability

ASAM PPC Levels of Care:	**Level:**	**Placement Criteria: (Same levels of care for adolescents except level III.3)**
Early Intervention	0.5	Assessment and education for at risk individuals who do not meet diagnostic criteria for substance-related disorder
Outpatient Services	I	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies
Intensive Outpatient	II.1	9 or more hours of service/week for multidimensional, instability, not requiring 24-hour care
Partial Hospitalization	II.5	20 or more hours of service/week for multidimensional, instability, not requiring 24-hour care

Clinically-Managed Low-Intensity Residential	III.1	24-hour structure with available trained personnel; at least 5 hours of clinical service/week
Clinically-Managed Med.-Intensity Residential	III.3	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community
Clinically-Managed High-Intensity Residential	III.5	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community
Medically-Monitored Intensive Inpatient	III.7	24 hour nursing care with physician availability for significant problems in dimensions 1, 2, or 3. Sixteen hours'/day counselor ability
Medically-Managed Intensive Inpatient	IV	24 hour nursing care and daily physician care for severe, unstable problems in dimensions 1, 2, or 3. Counseling available to engage patient in treatment
Opioid Maintenance Therapy	OMT	Daily or several times weekly opioid medication and counseling available to maintain multidimensional stability for those with opioid dependence

Transtheoretical Model of Behavior Change

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

Authors of the Transtheoretical Model: James 0. Prochaska, Ph.D. & Carlo C. DiClemente, Ph.D.

James 0. Prochaska, Ph.D. is the Director of the Cancer Prevention Research Consortium and Professor of Clinical and Health Psychology at the University of Rhode Island. He received his Ph.D. in Clinical Psychology in 1969 at Wayne State University. He has published more than 100 papers on behavioral change for health promotion and disease prevention. A recent study conducted by the Institute for Scientific Information and the American Psychological Society listed him among the 10 most influential authors in Psychology. He has been Principal Investigator on over $40M in research grants on prevention of cancer and other chronic

diseases. He is also a Consultant to the American Cancer Society, the Centers for Disease Control & Prevention, numerous health maintenance organizations, corporations, research journals and universities & research centers. He has been an invited speaker at many regional, national & international meetings & conferences.

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

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

Stages of Change

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

Precontemplation

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

Contemplation

- **Intends to take action within the next 6 months.**

Preparation

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

Action

- **Has changed overt behavior for less than 6 months.**

Maintenance

- **Has changed overt behavior for more than 6 months.**

Healthy and Wise does not overtly categorize activities in the curriculum as precontemplation, contemplation, preparation, action, and maintenance.

However, the activities fall into the five stages and are useful for teachers to assign to students that are in a specific health stage. Below are the cognitive behavioral processes within each stage with suggested Healthy and Wise activities and strategies.

During a Healthy and Wise training session, teachers are trained to use the Transtheoretical Model of Behavior Change and select appropriate activities and lessons in Healthy and Wise for students in each stage of this model to initiate a process of change or to support existing behaviors in a specific stage.

Strategies for Students in the Precontemplation Stage

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

Strategies for Students in the Contemplation Stage

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

Strategies for Students in the Preparation Stage

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

Strategies for Students in the Action Stage

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

Strategies for Students in the Maintenance Stage

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