ASI HISTORY & OVERVIEW

What is the Addiction Severity Index?

The Addiction Severity Index (ASI) is a semi-structured instrument used in a face-to face interview conducted by a clinician, researcher, or trained technician. It was developed by A. Thomas McLellan, Ph.D. and colleagues at the University of Pennsylvania in 1980. The ASI covers seven (7) important areas of a client's life: medical, employment/support, drug and alcohol use, legal, family/social, and psychiatric. The instrument is designed to obtain lifetime information about problem behaviors as well as focusing specifically on the 30 days prior to assessment. The ASI has high reliability and validity, as confirmed in studies published in leading journals. It is a widely used addiction assessment tool throughout the United States and other countries.

How was the ASI developed?

The ASI was created in 1980 to enable clinical researchers at the University of Pennsylvania to evaluate treatment outcome in a six-program, substance abuse treatment network, with clients at the V.A. Medical Center. Since the programs were quite different, the ASI had to be fairly generic. The budget for the project was small and the data had to be collected by technicians rather than health care professionals. Because the clinical data had to be collected in a relatively short period of time, the instrument had to focus on a minimum number of questions, relevant to treatment planning. Finally, in order to measure outcome, the questions had to cover a broad range of areas that represent problems associated with drug abuse which could also be affected by substance abuse treatment. The format had to be suitable for repeat administration at follow-up contacts.

How can a facility benefit by using the ASI?

Users of the ASI have noted the following benefits:

- provides a comprehensive, standardized psychosocial history in 45 minutes
- assists in developing a treatment plan and in matching clients to treatment services (not necessarily to treatment modality)
- is designed for client follow-ups, allowing programs to monitor treatment effectiveness
- is easily administered once trained correctly
- is easily adapted for special populations

Evidence Based – Proven Effective – Designed for Transfer

How is the information collected and recorded?

The information usually is collected through a face-to-face interview with a client. Responses are recorded on the ASI instrument. While the ASI enables the clinician/researcher to collect important assessment information, it also incorporates the client's evaluation of his/her need for treatment in each of the seven (7) areas of the instrument. The ***objective*** and ***subjective*** data are combined to derive measures of problem severity for each of these areas. A 10-point ***interviewer severity rating scale*** is used for clinical and treatment planning purposes. Key objective items are combined in a ***mathematically computed composite score*** for use as outcome measures in program evaluation and treatment effectiveness studies. (ASI software used for clinical/research purposes can be purchased through an independent vendor.) When good rapport is established with the client, the ASI helps the interviewer by:

- enhancing objectivity
- posing questions the interviewer might not normally ask, thereby uncovering important
- diagnostic information
- identifying problems in major areas of the client's life
- alerting the interviewer to inconsistencies among information obtained in different areas and providing ways to probe areas that are inconsistent, unclear, or incomplete identifying the need for referral to treatment
- assisting the interviewer to develop an initial treatment plan.

The complete ASI instrument is used at assessment (baseline), while an abbreviated version, used in a face-to-face client interview or conducted on the telephone by a trained interviewer, is used for follow-up purposes.

What are the limitations of the ASI?

It is not appropriate for use with adolescents. (A number of other instruments are available for use with adolescents.) Because the ASI focuses on the 30 days prior to assessment, it has decreased value with psychiatric clients or inmates who have been hospitalized / institutionalized for extended periods of time. When used with these populations, the ASI can capture lifetime problems, but it cannot obtain a true baseline and, therefore, cannot be used to measure change over time.

Why is training necessary?

The ASI has good reliability and validity when administered by a trained individual under appropriate conditions. Without standardized training, many of the ASI's potential benefits can be lost.

The ASI developers strongly caution against use of the ASI without adequate training or in ways that are inconsistent with its design (e.g., as a questionnaire). Inappropriate use poses risks to the interpretation of clinical and research findings.

What's the difference between severity ratings and composite scores?

Severity ratings are ***subjective estimates*** of client status. They were developed to allow a trained interviewer to estimate problem severity in each of the ASI areas, using a ten-point scale. These ratings have been shown to produce reliable and valid estimates of client status in each area, and are of great practical value in (1) summarizing the client's overall status at treatment admission; and (2) formulating an initial treatment plan. However, despite their reliability and validity, severity ratings are subjective estimates, are based in part on lifetime data and, as such, are not appropriate as criteria for measuring change over time.

Composite scores are calculated by combining ***selected objective data*** from each ASI problem area (section). The developers used an empirical method of combining those items from each ASI problem area which were capable of showing change and which were well related to each other. These measures are mathematically derived and have shown reliability and validity in several settings. For more complete information, researchers are encouraged to refer to the **ASI Composite Scores Manual.**

In conducting ASI follow-up interviews, should severity ratings be used?

Many programs conducting research studies now employ trained interviewers to conduct ASI follow-up interviews on the phone. The ASI Manual, Fifth Edition and the Follow-up Procedures both describe how to conduct ASI follow-up interviews. Because severity ratings are ultimately subjective estimates; because they incorporate "lifetime" items that do not change; and because they are not valid when done over the phone, **PLEASE DO NOT USE SEVERITY RATINGS AT FOLLOW-UP AS OUTCOME MEASURES.**

What's the best way to add questions to the ASI?

In order to make the ASI more responsive to the needs of special populations, many programs add questions to various ASI problem areas (sections). The ASI developers recommend the following guidelines:

- **DO NOT** omit any of the questions from the ASI.
- **DO NOT** change the original numbering of questions on the ASI.
- Add questions at the end of each section, before the questions that utilize the client rating scales -- OR -- insert questions where they flow best with the existing ASI questions, and number them "3a, 3b, " etc.

Program administrators who are interested in adapting the ASI for their special populations are encouraged to read A Guide to Adapting the Addiction Severity Index for Special Populations, by Deni Carise, Ph.D., and A. Thomas McLellan, Ph.D.