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 (eg. 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 (eg. Beck Depression Inventory, MAST, SCL-90, etc.) but these are usually very focussed instruments that have achieved validity and consistency by asking numerous questions related to a single theme (eg. depression, alcohol abuse, etc.). The ASI is purposely broadly focussed 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 (eg. 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 (eg. 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.

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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.