WHY THE ASI IS NOT A CLINICAL ASSESSMENT AND WHY MANDATES FOR ITS USE SHOULD BE ELIMINATED

The ASI (Addiction Severity Index) was initially designed as a program evaluation tool for VA population and subsequently has provided a basis for determining indications of effectiveness of treatment programs and various societal benefits from the effective treatment of substance use disorders in a variety of settings. **As an evaluation instrument, the ASI should be administered following routine initial clinical assessments that cover diagnostic determinations and treatment planning/placement assessments.**

Ironically, **the ASI actually does not measure the severity of addictions in terms of the clinical syndromes**. The primary measure is days of use in the last 30. However, this is an arbitrary metric – one that is reliably measured, scientifically valid, and largely irrelevant to the real world. Someone having one glass of wine with dinner each evening would receive a maximum value while a binge drinker meeting diagnostic criteria for a severe alcohol use disorder would likely receive a lower score.

Mandates by state agencies to use the ASI as an intake instrument to standardize intake are totally inappropriate. Time spent gathering ASI data could be better spent in doing assessments that are actually required for clinical practice. Since reimbursements often are insufficient to cover both the time spent doing the ASI and the clinical assessments necessary for good clinical practice there may be pressure to skimp or take shortcuts in both areas. **Indeed mandating the use of the ASI may have become one of the major impediments to improving the quality of treatment in many states.**

A much more defensible and pragmatic approach to the administrative need states may have to gather information on the nature and extent of problems at intake and in documenting outcomes in a routine way is to mandate the content and format of the information to be collected. This would then allow clinicians and programs to collect data in the most efficient and accurate way possible. For example, one might mandate that the programs document whether clients are abusing or dependent on each of the substance categories of the current diagnostic criteria. One could even have them quantify how many of the diagnostic criteria are positive in a simple data matrix. This would then allow programs to utilize diagnostic tools that are appropriate for their populations to obtain the relevant information from each client. Similarly, programs could be mandated to document certain treatment planning/placement parameters in accordance with criteria in the state, but allow clinicians to determine how that information is to be collected. Outcome information could also be dictated in terms of outcomes of interest, such as abstinence or continued substance use, whether the individual is requiring continuing medical or psychological/psychiatric services, has been arrested, etc. Again, if the parameters of the information to be collected are specified, the specific instrument or procedure required to collect the information vary from program to program, but will still produce the same basic data.

WHY THE ASI IS NOT AN APPROPRIATE INTAKE INSTRUMENT

General deficiencies of the ASI make it not only inadequate for conducting intake assessments, but actually make it a hindrance to good clinical practice. The time spent collecting the ASI data detracts from the limited time clinicians have to identify the nature and extent of the clinical condition(s) and to identify client needs in developing a treatment plan and recommending an appropriate treatment placement.

The ASI has no relevant diagnostic information and cannot adequately address any of the six dimensions of the ASAM Criteria for the development of a defensible treatment plan including

placement. None of seven dependence and four abuse criteria of the DSM-IV-TR are covered by the ASI in a way to support a diagnosis. Thus, one cannot verify whether abuse or dependence indications exist in general or for any specific substance. Placement into a residential program is recommended by the PPC-2R only if a diagnosis of dependence is identified.

The ASI provides virtually no relevant information for the six dimensions of the ASAM PPC-2R despite attempts to infer indications from the ASI data. The deficiencies are outlined by dimension as follows:

Dimension 1: The ASI cannot inform the intake worker whether there is likely to be a detoxification or withdrawal problem or how bad it is likely to be. It does not provide information on how recently a given substance has been ingested or the previous withdrawal history. The only exception would be if the individual acknowledges use during all 30 days in combinations of substances that could be problematic, but this is a stretch.

Dimension 2: The medical section us insufficient to assess whether the person has a medical condition that will interfere with treatment or requires attention at this time.

Dimension 3: The psychiatric section of the ASI cannot definitively identify whether there is a serious emotional problem that requires immediate attention or whether there is a personality disorder that requires attention independent of the addictive disorder. Even the questions about suicide do not adequately provide guidance as to whether the thoughts are current or there is an intent or plan. While some of the questions do address areas of the PPC-2R, they do not provide sufficient information for treatment planning.

Dimension 4: There is virtually nothing on readiness to change other than the patients' ratings of how "important" treatment is to them. There is no indication that the individuals really recognize the nature or extent of their problems or their willingness to take part in treatment or other recovery efforts.

Dimension 5: A number of risk factors based on the existent literature on prognoses can be identified from the ASI, but are not converted into indications of risk levels. Many risk factors noted in the ASAM PPC-2R are not covered. These include, but are not limited to, severity of craving and physiological/psychological response to substances, levels of engagement by self or others in the recovery effort, ability to recognize relapse triggers or risky situations, and impulsivity relevant to substance use.

Dimension 6: The ASI section on family and social relationships covers numerous questions about relationships, but fails to determine whether those individuals are supportive or detrimental to recovery. The only questions that do so pertain to persons the client lives with but not other relatives or friends. In short, there is minimal information on the nature and extent to which the social network and individuals within it are likely to be contusive or detrimental to recovery.

In summary, the ASI requires a considerable period of time to collect information that might be of administrative interest, but provides little if any true contribution to clinical practice. The time spent conducting the ASI interview detracts from the clinical tasks of identifying problems and their severity and assessing client needs. **The ASI is essentially useless unless it is actually used as a program evaluation tool to compare baseline data to outcome data.**