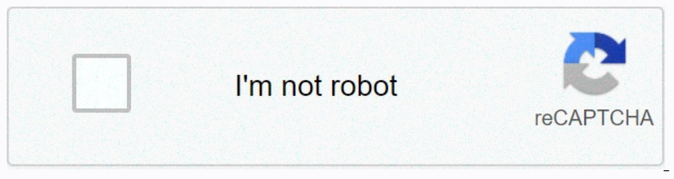

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Addiction severity index scoring manual

Your loved one may be struggling now, but there is hope ahead. You may know your loved one has a problem, but how serious is it? What exactly are you up against? There is an objective way to get an answer to that question. There are 11 symptoms of substance use disorder, according to widely accepted standards published in the Diagnostic and Statistical Manual of Psychosis, 5th Edition (DSM-5). 11 DSM-5 Substance Use Disorder Criteria Read through the following criteria and note how many of them accurately describe your loved one. Use this substance in larger quantities or for longer periods of time than intended Want to cut, but can not Spend more time receiving, using or recovering from appetite and urging the use of substances That can not be done at home, school or workplace due to substances Continue to use , even if it causes relationship problems Abandon each activity interesting or meaningful because of substance use Re-use and again, even if it leads to dangerous situations Continue to use even if it makes a physical or psychological problem worse Need more and more substances to get the same effect Developing withdrawal symptoms, which can be relieved by re-use of Serious Addiction? Add up all the criteria that you think fully describe your loved one. 2-3 symptoms show a mild substance abuse disorder. 4-5 symptoms show a moderate substance abuse disorder 6 or more symptoms that show a serious substance abuse disorder While it is useful to know your loved one's addiction index scores, it does not tell the whole story or predict your loved one's ability to get better. With proper treatment, anyone can live a full and meaningful life, without drug or alcohol chains. A fresh start at The Raleigh House Rehab isn't just about learning to stay away from drugs or alcohol. It's about learning to live—and being happy, tested, and tested—without drugs or alcohol. At The Raleigh House, based in Denver, we offer both inpatient and outpatient treatment to help our residents accomplish their goals. Not sure what suits you or your loved one? Fill out our form or contact us today to learn more about treatment programs at Raleigh House. The Addiction Severity Index (ASI) was developed in 1980 by A. Thomas McLellan, Lester Luborsky, George E. Woody, Charles P. O'Brien available from developers at Building 7, PVAMC, University of Ave, Philadelphia, PA 19104; From: Clinical Male Health, 2008Samuel B. Obembe M.B; B.S., C.A.D.C., in practical skills and clinical management of alcoholism & drug addiction, 2012Addiction Severity Index (ASI) is a widely used assessment tool in evaluating substance abuse treatment. This tool serves as a guiding tool in treatment planning. This tool is an interview process that assesses the history, frequency and consequences of alcohol and drugs indicators commonly associated with drug use: medical status, employment status, alcohol use, drug use, legal status, family relationships, social relationships, and psychological activity are established with questionno questionn questions administered by clinicians, researchers, or technicians. The higher the subject score on ASI, the greater the need for treatment. McLellan et al. (2004) concluded that ASI is a valid evaluation tool. SIMON H. BUDMAN, ... ALBERT J. Villapiano, in evidence-based complementary treatments, 2008The ASI-MV® has proven to be both a cost effective and a time-saving tool for Inflexxion's commercial clients. The average cost to manage, score, and generate a full narrative report of ASI-MV® is about $7. As stated earlier, the cost to have an ASI management staff, including scoring and scoring-ups, is at least $25, with fringe benefits. The use of ASI-MV® shown the ability to save 72% of the cost of evaluation. In the first year of ASI-MV® made out of 30 supplier groups, contracted with a major regional coordination agency in Michigan, the regulator's management reported that suppliers had saved about $45 per rating. They also reported an average employee evaluation time reduced from 2 to 1 hour. Every year, this is saving the area about $225 000 and, as a result, they have increased the number of initially authorized counseling sessions from 10 to 11.Many ASI-MV® sites report similar large savings and realm of resources accordingly. AJ Levine, ... CH Hinkin, in the Comprehensive Handbook on Alcohol-Related Pathology, 2005The ASI (McLellan et al., 1980) is a semi-structured interview that takes about 45-60 minutes. It was developed at Philadelphia Veterans Medical Center to have a diverse tool for evaluating treatment outcomes in alcohol and other substance abuse people. The question of ASI is based on the pre-or-co-substance dependence that occurs with certain life events. The tool focuses on seven areas that are often affected in the lives of substance abuseers: medical status, employment, drug use, alcohol use, legal status, family/social status, and mental status. Information on the frequency, duration, and severity of problems in these seven areas is collected for both lifetime and recent hisses (the last 30 days). ASI offers two types of scores: severity and subjective ratings on the needs of the client's treatment and an overall score on the severity of the problem in the previous 30 days. Specific questions regarding alcohol include the total number of years of lifetime use, the amount spent on alcohol, and the number of days alcohol problems. A recent confirmed study by an ASI management COMPUTER found it to be reliable, with good correlation with the interviewer management version (Butler et al., 2001). An adapted version for adolescents is also available (T-ASI; Kaminer et al., 1991). Ken C. ... Randy Stinchfield, in Innovations in Adolescent Substance Abuse Interventions, 2001 Another ASI was invented by Kaminer, Bukstein & Tarter (1991). T-ASI covers seven areas of content: chemical use, school status, employment support status, family relationships, legal status, peer-to-social relationships, and mental status. Part of the medical condition is not included because it is considered less relevant to people who abuse adolescent drugs. Patient and interviewer severity ratings are elicited on a five-point scale for each content area. Psychological data show that the agreement between the rater is very favorable and the data is valid (Kaminer, Wagner, Plummer & Seifer, 1993). AJ Gordon, ... DA Fiellin, in the Comprehensive Handbook on Alcohol-Related Pathology, 2005M harm when diagnosing AUD is established there are a number of well-validated tools that enhance the ability of patients to measure functional defects and severity of diseases related to alcohol consumption. Their use is outside the scope of this assessment, but the Addiction Severity Index and Commonly Used Drinker's Consequences Inventory (McLellan et al., 1992; Miller et al., 1995; Alterman et al., 2000). There exists a number of tools to assess readiness to change unhealthy alcohol behaviors (Prochaska and DiClemente, 1992). The tools include stages of readiness for change and the scale of treatment eagerness and the Scale of Change Assessment by the University of Rhode Island (DiClemente and Hughes, 1990; Isenhart, 1994; Miller and Tonigan, 1996; Maisto et al., 1999). Patients in primary care may present in a weaning condition. It is unlikely that an AUD diagnostic evaluation is helpful in withdrawing alcohol. In this situation, the patient may not be competent to answer the questions and the dependence on the ediable alcohol that has already been met. The clinical interview and withdrawal scale-alcohol evaluation amendment is a necessary tool to assess the severity of withdrawal, pharmacological activation and other medical interventions, and, if necessary, specialized referrals or treatment (Sullivan et al., 1989). Linda S. Kranitz, ... Ned L. Cooney, in the treatment of evidence-based addiction, 2009 In addition to the many specialized tools described in this chapter, several measures evaluate many areas related to an individual's substance abuse, thus providing a more comprehensive picture of the individual and the problem. These measures are listed in Table 7.7. Indicators of the severity of addiction (ASI; McLellan, Luborsky, O'Brien, & Woody, 1980; McLellan et al., 1992) is the most widely used of these; it is well studied and has several alternative versions, including a slightly shorter version (ASI-Lite; Cacciola, Alterman, McLellan, Lin, & Lynch, 2007; McLellan et al., 1980) and versions targeting adolescent populations such as Comprehensive Severity Inventory of (Meyers, McLellan, Jaeger, & Pettinati, 1995) and Teen Severity Index (Kaminer, Bukstein, & & 1991). Other comprehensive measures include the Chemical Dependence Assessment Record (Harrell, Honaker, & Davis, 1991) and the Comprehensive Drinker Profile (Miller & Marlatt, 1984). Table 7.7. Multi-directional measuresThe fight and number of itemsAdministration (time in minutes if known and method)AvailabilityDomains assesstarget population (s) Addiction Severity Index, 5th ed. (200 items)1 h; paper and pencils; computer; clinical interviewOnlineaDemographics; medical history; history of drug and alcohol use; history of treatmentAdults seeking substance abuse treatment; other versions available for teens Chemotherapy dependent evaluation records (224 entries) Paper and pencilFee for usebDemographics; history and patterns of alcohol and drug use; history of treatment; beliefs and expectations; symptoms; self-conceptual; personal relationshipsAdults and adolescents seeking alcohol or drug treatmentComprehensive Drinker Profile (88 entries)Clinical interviewOnlinecDemographics; drinking history and patterns; alcohol-related life issues; situations of drinking and drug use; medical history; motivation; TargetAdults seeks the treatment of alcoholBenjamin J. Morasco, in Intervention for Addiction, 2013 This manuscript was supported in part by the K23DA023467 award from the National Institute on Drug Abuse. The contents of this manuscript are solely the responsibility of the author and do not necessarily represent the official view of the National Institutes of Health, the National Institutes of Drug Abuse, or Department of Veterans Affairs.ASIAddiction Severity IndexCBTcognitive-behavioral therapyGAGamblers AnonymousGBIGambling Behavior InterviewMETmotivational enhancement therapyNODSNational Opinion Research Center DSM Screen for Gambling ProblemsPGpathological GamblingSCIDStructured Clinical Interview for DSM-IVSOGSSouth Oaks Gambling ScreenSUDssubstance using disordersTLFBTimeline FollowbackBiographyBenjamin Morasco received his doctorate in clinical psychology from Saint Louis University in 2003. He completed a post-doctoral fellowship in health psychology at Hartford Hospital and a fellowship in addictive behaviors at the University of Connecticut Medical Center. He is currently a staff psychologist at Portland VA Medical Center and Assistant Professor in the Department of Psychology at oregon University of Science and Health. He provides clinical services in the substance abuse treatment program and directs the pathological gambling treatment program. Dr. Morasco's main research interest is in treating patients with chronic pain and accompanying substance use disorders, examining factors related to prescription opioid use and pathological gambling. Delinda Mercer, in Intervention for Addiction, 2013These Treatment Manual was developed for use in the National Institute on Drug Abuse (NIDA) Cocaine Research Collaboration. This is a multi-centre investigation examining the effectiveness of four psychoscrupering treatments for cocaine-dependent patients. Four and eighty-seven patients were randomly prescribed for one of four manual guided treatments: IDC plus GDC, cognitive therapy plus GDC, supportive express therapy plus GDC, or GDC alone. Intensive treatment, including 36 possible individual sessions and 24 meetings in 6 months. The main result measures are the Addiction-Use Composite severity index and the number of days of cocaine use over the past month. Compared to the two psychotherapies and with GDC alone, IDC plus GDC showed the biggest improvement in the addiction-drug severity index using composite scores and the number of days of cocaine use in the past month. Overall, compared to professional psychotherapy, IDC was more effective in reducing cocaine use in this study. Another study attempted to make IDC and GDC models more community-friendly to facilitate the dissemination of evidence-based treatments to the community environment and support effective testing. Modified versions of IDC and GDC treatment guidelines for cocaine dependence have been developed, and a preliminary study of their effectiveness has been conducted. It was concluded that the adviser was able to carry out the new therapeutic manual with acceptable levels of compliance and competence. The results showed that significant changes in drug use were obvious, but the amount of abstinence obtained was limited. Sharon Dawe, ... Natalie J. Loxton, in Intervention for Addiction, 2013M some of the screening measures considered above are also used as symptom remedies to track progress over time. Other measures that tend to be longer are also available to track changes over time. One of the most widely used of these in the field of substance abuse is the Addiction Severity Index (ASI), which has been used for more than 25 years. ASI is a semi-structured interview that assesses the frequency of substance use and areas of daily activity that are also affected by substance abuse, i.e. poor physical health, distress, family/social environment, employment/financial issues and legal difficulties. Each item is evaluated with reference to two timeframes: lifetime and current (past 30 days). The instrument is sensitive to the therapeutic effect and can be used to monitor individuals during a number of hospitalizations. ASI is the most widely used tool in U.S. substance abuse clinics and is used more and more in other countries. It has been provided freely in the public domain, promoting its use and increasing the rich source of information on application and cross-cultural validity. There are also shorter versions that tend to be used by treatment bodies rather than researchers. ASI-Lite, which is made up of 111 items and can be managed in about 30-40 minutes. Another commonly used measure is Health of the Nation Scale (HoNOS). This is a clinician-rated instrument with 12 items measuring behavior, deterioration, symptoms, and social activity on a five-point scale (0 = no 1–4 = minor problem for very serious problem) in the previous two weeks. There are versions designed for adults, children and older people. While HoNOS appeared psychologically sound, there were concerns about the accuracy of the symptom description, the complexity of social items and the subjective nature of the term used. In addition, this measure does not seem to be sensitive enough to cultural differences. As with other clinically evaluated instruments, ongoing training and monitoring of reliability between clinics is necessary to ensure accurate ratings. There are also many self-reported tools that can be used to monitor symptoms for mood and anxiety disorders. Those widely used include The Beck Depression Inventory (BDI), a 21-question self-reported inventory, Speilberger state-characterized anxiety inventory, and depression anxiety and stress scales. All are well confirmed and have been shown to be sensitive to therapeutic benefits. The adult health scale, although little known, has been recommended as a key measure of parental activity within the framework of child assessment, Ministry of Health, UK. In addition to these measures are a number of tools developed to assess the severity of psychiatric symptoms. One of them is the Brief Psychiatric Evaluation Scale. This is administered by a clinician or researcher to measure psychiatric symptoms such as depression, anxiety, hallucinations, and abnormal behaviors associated with psychosis. Finally, the Posttraumatic Stress Symptom Scale Self-Report (PSS-SR) is a self-reported version of the structured interview for PTSD. The 17 items on this scale are identical in content for the interview, but contain simple words. The question corresponds to DSM-IV symptoms to measures that allow the diagnosis of the disorder. PSS-SR is designed for use with individuals with a known offensive history. If the basic information is unknown, PSS-SR should be used in combination with a trauma monitor (Table 31.3). TABLE 30.3. Description of symptom remedies Symptomatic measures: author and dateDescriptionNorms and cut-off point (a) General Mental Health Addiction Severity Index: McLellan et al., 1992, 2006; Makela, 2004. semi-structured interviews about the frequency of substance use and related issues, life expectancy and current (the last 30 days). Extensively available regulatory data, accessible through websites and publications (e.g. McLellan et al., 2006)Health of the Nation Outcome Scale (HoNOS): Wing et al., 1996A semi-structured interview consisting of 12 items assessing psychosocial functioning of respondents in treatment for a range of disorders. Use a five-point rating that includes the previous 2 weeks. Both adults and adolescents/children (Health of the national outcome scale for children and adolescents; HoNOSCA) is available. (b) Mood DisordersBeck Depression inventory-II: Beck et al., 1996The Beck Beck Inventories (BDI, BDI-IA; BDI-II) is a 21-question variety of self-reported inventory options, with entries evaluated from 0-3 by frequency over the past week. Cut scores on BDI-11: 0-13 (minimal depression), 14-19 (mild depression), 20-28 (moderate depression), 29-63 (severe depression)The Speilberger State Trait Anxiety Inventory: Speilberger, 1983The STAI consists of two 20-item scales: state measures that assess how responder feels right now, at this point, and Trait measures targeting how responders often feel. Scale has been used in thousands of studies and translated into more than 30 languages. Both the percental rank and the standard score (T) are available to male and female adults in three age groups (19-39, 40-49, 50-69). Targets are also available for high school students. The Adult Well Being Scale: Snaith, 197818 adult measurement entries were also with four subscales: depression anxiety, external discomfort, and internal discomfortScoring available on the site framework for evaluation of children, UK. (c) PsychosesBrief Psychiatric Assessment Scale: (BPRS) Overall and Gorham, 1962; Leucht et al., 2005The BPRS is an evaluation scale in which a clinician or researcher can use to measure psychiatric symptoms such as depression, anxiety, hallucinations, and abnormal behavior. Each symptom is evaluated 1-7 and depending on the version between a total of 18-24 symptoms are recorded. The diagnoses are available for a wide range of diagnostic samples. (d) Trauma/PTSDPosttraumatic Stress Symptom Scale Self Report (PSS-SR): Foa et al., 1993, 1997, 1999Is a 17 item self-report version of Foa's structured interview for PTSD. The question corresponds to DSM-IV symptoms to measures that allow the diagnosis of the disorder. Subscale scores are calculated by summing up symptoms in reexperiencing (four items), avoiding (seven items), and stimulating (six items) clusters. Cutting scores by 13 suggests the possibility of PTSD. Standards are available for men and women who have suffered a traumatic event. Joel R. Grossbard, ... Nadine R. Mastroleo, in Intervention for Addiction, 2013 Evaluation understands more time-consuming substance use and requires greater training to manage and score, but delivers more in-depth diagnostic data, while evaluating other areas of activity. Adolescent Diagnostic Interview (ADI) is a 213-question structured interview based on DSM-IV criteria for substance use disorder. In addition to substance use, it assesses psychoso-social stress, school and function between individuals, and cognitive decline. It can be used to determine the need for treatment and treatment planning. ADI can be managed for 50 minutes and scored in 20 minutes by a trained mentor or interviewer. The Global Assessment of Personal Needs (GAIN) is a semi-structured interview that measures recent and lifelong activity in a number of areas, including substance use, legal and school activities, and Mental. Favorable internal consistency, re-test reliability, and Valid gain-related data, including evidence that GAIN scores are significantly related to independent ratings for the severity of drug-related problems, and adolescents referred to drug treatment scores higher on these core parts than adolescents who were not referred for treatment. Gain's comprehensiveity and multi-face look require a relatively long management period and long and detailed training. Gain-Short Screen (G-SS) is a shorter version of GAIN that also assesses the total severity and substance use issues by specific domain; it may be a more optimal screening tool given that it requires less time managing and scoring points. Adapted from the Addiction Severity Index (ASI) developed for use with adults, the Teen Addiction Severity Index (T-ASI) is a semi-structured interview covering seven areas of content: chemical use, school status, employment support status, family relationships, legal status, peer social relationships, and mental status. Youth severity ratings and interviewers are elicited on a 5-point scale for each content area. Psychological data show that the agreement between the advantages and the link of different scales with the existing valid measures of the same structures. A computer, Internet-based and telephone, modified version named T-ASI-II and its psychology have been piloted on a large number of adolescents and will be available for clinical use. Another multi-level questionnology is Personal Experience Inventory (PEI), which includes a number of scales that measure the severity of drug use problems, psychoso-social risks, and tend to deform responses. Screen issue supplements measure eating disorders, potential suicide, physical/sexual abuse, and the history of parental drug abuse. Computerized reporting includes standardized stories and scores for each scale as well as other clinical information. Drug clinic and non-clinical control criteria are provided. Psychological data includes internal consistency and re-examination reliability data and a range of converging, distinguishing, and criterional effects (e.g., scores against existing confirmed measures, independent clinician ratings, and storage data). The 139-item Problem-Oriented Screening Tool for Adolescents (POSIT) is part of the Adolescent Assessment and Referral System developed by the National Institute on Drug Abuse (NIDA). It screenes for 10 areas of functional adolescent problems: substance use, physical health, mental health, family relationships, peer relationships, educational status, occupational status, social skills, entertainment and entertainment, and aggressive/illegal behavior. The cut-off point for determining the need for further evaluation has been set to be reasonable, and evidence of converging and discrete validity for POSIT has been reported by a number of investigators. A tool is the Drug Use Screening Inventory 159 items (revised) (DUSI-R), including items referring to AOD AOD use severity and related issues. It produces scores above 10 subscales as well as a lie scale. Domain scores are associated with DSM-III-R substance use disorder criteria in a sample of adolescent substance abuser, and published reports have shown evidence of scale sensitivity. In addition, adolescent Self-Assessment Records (as soon as possible) is a self-reported tool of 225 items that includes sub-scales that represent risk resilience factors established in the document, including family, mental health, school adjustment, peer impact , deviations and symptoms of drug use. Another in-depth review of drug use is the Chemical Dependency Assessment Profile (CDAS), which includes 232 entries evaluating 11 drug use sizes (e.g., quantity and frequency, expected use). Finally, there are several structured and semi-structured diagnostic interviews used specifically to evaluate DSM-IV criteria for substance abuse and dependence. Structured clinical interview for DSM (SCID) is a semi-structured interview used to assess the diagnostic criteria of a full range of psychological disorders. While the entire interview takes about 2 hours to complete, the Substance Abuse Module can be completed in 30-60 minutes, and should be administered by a trained clinical reviewer or mental health professional. The Diagnostic Interview Schedule for Children (DISC) is a highly structured diagnostic interview designed to be

administered by home interviewers to assess most common mental disorders of children and adolescents present in the DSM diagnostic system. DISC is probably the most extensive trial of all child and adolescent diagnostic interviews, and its performance has been evaluated using both clinical and community samples. Another interview evaluating DSM criteria for substance use disorders, in addition to specific patterns of use and consequences, is the Common Alcohol and Drug Use Profile (CDDR). Evidence from psychological studies shows good reliability and validity of CDDR. CDDR.