Measuring “addiction” in Europe: The diffusion of the Addiction Severity Index, and its purposes and functions

Kerstin Stenius & Robin Room

Centre for Social Research on Alcohol and Drugs (SoRAD), Stockholm University, Stockholm, Sweden

Abstract
This paper discusses what an instrument like the Addiction Severity Index (ASI) offers to various actors in the diverse addiction treatment systems of Europe and what the use of the ASI means and implies at the treatment system level. It is concluded that the adoption of the ASI can be linked to a number of factors, including the demands for cost-efficiency, scientific legitimacy of addiction treatment, professionalization, internationalism, and unification of a diverse system. Furthermore, it considers the specific choices embedded in the structure and content of the ASI—how the use of the ASI structures the user’s view of the situation and life-trajectory of the individual client. Features such as the length of the interview, the time frames of the question, the exclusion of measures of dependence and alcohol-/drug-attributable problems and the inclusion of client’s rating, are discussed. It is concluded that the opinions about the usefulness of the ASI in Europe vary. For the future of measurement of alcohol and drug problems in Europe, for system monitoring and international comparisons, shorter instruments seem to be the likely path forward. The article draws to a large extent on the papers presented at a conference, ‘‘Measuring ‘addiction’ in Europe: clinical, sociological, cultural and policy aspects of Addiction Severity Index (ASI) and other international instruments’’, at Skarpö, Sweden, in January 2003.

Keywords: Addiction Severity Index, treatment system, Europe.

Introduction
The papers in this issue are selected and revised from papers presented at a conference, ‘‘Measuring ‘addiction’ in Europe: clinical, sociological, cultural and policy aspects of the Addiction Severity Index (ASI) and other international instruments’’, which was held at Skarpö, near Stockholm, on 21–23 January 2003. The idea for the conference emerged as we studied the Swedish addiction treatment system (Room, Palm, Romelsjö, Stenius, & Storbjörk, 2003), and compared notes with others studying treatment systems in Europe. One interesting feature of the field in many places in Europe was the move, in recent years, to adopt standardized instruments to be administered to clients at intake into the system. While a number of other instruments have been developed and used internationally in Europe (e.g., the Maudsley Addiction Profile; Marsden et al., 2000), we were struck by the wide adoption of the Addiction Severity Index (ASI), originally developed in the late 1970s by Thomas McClellan and colleagues in Philadelphia. During the 1990s, a version of the ASI slightly adapted to European circumstances was developed, in an instrument called the EuropASI (Kokkevi & Hartgers, 1995). While some other intake instruments were also considered at the conference, most papers focused on the ASI, considering questions such as the following, which were among those posed in the Call for Papers:
1 What are the political, administrative, professional or research reasons behind the spread of or resistance to the ASI and other instruments?

2 How are the ASI or other instruments actually used in different international, national or regional settings: for research, assessment, evaluation, or feedback to clients?

3 What are the major benefits or problems with the use of the ASI in different settings and circumstances? Particularly: is it translatable into different settings and languages?

4 What are the implications of the use of the ASI for the treatment system and for research?

These and related questions became the main foci of the papers in this issue.

To introduce the issue, we first consider what an instrument like the ASI offers to various actors in the diverse addiction treatment systems of Europe—what the use of the ASI means and implies at the treatment system level. We then turn to a consideration of the specific choices that are embedded in the structure and content of the ASI—how the use of ASI structures the user’s view of the situation and life-trajectory of the individual client.

**ASI and the European treatment system**

There is as yet no comprehensive comparative history of alcohol and drug treatment in Europe, but some general outlines are known (see Baumohl, & Room, 1987; Klingemann, Takala & Hunt, 1992; Klingemann, & Hunt, 1998). From the earliest days in the late nineteenth century, there were two main streams of treatment for “inebriety”, under medical (usually psychiatric) care, and as a kind of what would now be called social work, often linked to the temperance movement or religious organizations. Inpatient care, often lasting months or years, was dominant before about 1910. After that, outpatient advice clinics (Fürsorgestellen) spread from Germany to nearby countries, with local temperance boards filling similar functions in Norway, Sweden and Finland.

There was little formal provision of treatment for inebriety, however, south of the Alps and the Pyrenees. Alcohol-treatment systems grew greatly with the flowering of the welfare state in the late twentieth century, along with the advent of drug-treatment systems. In Norway, Sweden and Finland, the temperance board system was dissolved into the general welfare system, which remains the dominant source of treatment, although medical treatment has been a growing factor. In many countries—for instance, France, Germany, Austria, Hungary and Ukraine—the dominant source of treatment has been the medical system, often specifically psychiatry. In other countries such as the Netherlands, Switzerland and the UK, both the welfare and the medical systems are important in the provision of treatment and care. Drug treatment and alcohol treatment have also in some countries been placed in separate administrations.

In their book about alcoholism treatment in 16 countries, Takala, Klingemann, and Hunt (1992) identified certain general trends in the treatment system in the 1980s: growth, de-institutionalization, decentralization and differentiation. Among the more important reasons behind these developments were, on the one hand, cost-savings and, on the other, democratization of treatment (particularly a questioning of long, compulsory institutional treatment). The recession in many western European countries in the 1990s strengthened the 1980s’ trend towards cost-saving, while the democratic aspect was weakened. On the other
hand, a growing emphasis on the client’s own responsibility was visible (Kaukonen, & Stenius, in press). In the former communist countries, the economic crises have not been less dramatic, and treatment has had to adapt to a rapidly changing and unstable social situation, with increasing drug and alcohol problems, but also growing demands for democratization (Klingemann, 1998).

There has long been a stronger emphasis on a scientific basis in medical practice than in welfare practice. In recent years, the emphasis on ‘evidence-based’ therapy has increased in the medical world and has also become a factor in addiction treatment. A signal of this in Sweden was the review of addiction treatment effectiveness by the SBU, a state agency specializing in treatment effectiveness reviews (Berglund, Thelander, & Jonsson, 2003). Now there are signs of the same emphasis coming into play in the world of social welfare. The thrust towards putting treatment on a scientific basis has brought changes not only in the substance of treatment but also in its organization and documentation. Those involved in managing agencies or systems have often felt the need for better documentation of what is being accomplished and to demonstrate that their agency or system was operating in the forefront of science-based practice. This is the set of needs that the ASI and instruments like it have been seen as filling.

A single instrument, multiple functions

The ASI1 in itself is a multi-purpose technical device, not a policy. In many ways, it seems rather neutral: it is not strongly tied to any particular view of the nature of addiction problems, and neither does it prescribe or indicate any specific concrete methods to solve them. But it is undeniably an instrument that, when used, may have direct as well as indirect impacts on treatment and treatment administration as social institutions. The ASI may have behaviour-regulating and normative impacts on the actors in the treatment field (Hänninen, 2004). As an instrument, the ASI may have supported, if not caused, some general trends in the institutional development of treatment in Europe.

It is clear from the pictures from different countries presented in this issue that the specific motivations behind ASI’s introduction and its use have varied. In Sweden and Holland, the stress has been on establishing a systematic data-collection procedure in an addiction-treatment system with a strong social-welfare emphasis, and on creating a common “language” within the divided addiction field. In Ukraine, one important interest has been to broaden the epistemological frame of the system to include social factors, in a frame of reference that had been dominated by a conventional psychiatric approach. Similar needs have been expressed in Hungary. In Belgium’s de Sleutel system, one reason for its systematic use has been the need to document results and professionalism for the purchasing body, the national insurance system, in a competitive treatment market. In Norway, the main motive has been research, and the wish to be able to publish results for an international audience.

Through the papers presented at the conference, we can identify certain general patterns behind the introduction and use of the ASI in Europe. We can call them “the promises of ASI” or “the metafunctions of ASI”.

The promise of systematic data collection for cost-efficiency and quality control

As several authors in this issue state, the introduction of the ASI was closely linked to the need to show cost efficiency and to establish scientific legitimacy for the measures within addiction treatment, as within other parts of the welfare state. The ASI’s wider spread in
Europe coincides in time with the first reference in the ETOH database, covering the alcohol literature, to “evidence based” (from 1994) and with the foundation of the Cochrane Collaboration (in 1993) (http://www.cochrane.org/general.htm), followed in 2000 by the Campbell Collaboration (http://www.campbellcollaboration.org/FraAbout.html). To demonstrate cost-efficiency you need systematically collected and standardized data about measures and their effects. The ASI seems to give this possibility. Comprehensive and state-supported Danish, Swedish and Dutch attempts to build data systems with the ASI for the whole or crucial parts of the treatment system are a reflection of this expectation. It is no coincidence that these efforts have been strongest in countries with a developed welfare-state tradition.

So far, though, these efforts to build comprehensive monitoring and documentation systems with the ASI have not been very successful. The instrument may be too complicated and too time consuming in the ordinary treatment reality for this use, as the Norwegian, Dutch and Swedish experiences seem to show (Lauritzen & Ravndal, 2004; Broekman, Schippers, Koeter, & van den Brink, 2004; Wicks, 2004). The resistance and/or scepticism to a centrally promoted reform in a basically decentralized system in general are hard to overcome. The role of the counsellor in a social-work-based system, as an advocate of their clients, may be difficult to reconcile with registration for centrally assigned purposes (Schmid & Vogt, 2004). Another source of the social workers’ resistance may be the fear that data collected within the treatment system may be used for non-therapeutic purposes, for instance by the police (Schmid & Vogt, 2004). Even in Hungary, where the use of the ASI became obligatory in psychiatric outpatient settings, the actual use of it is rare (Gerevich, Bácskai, & Rózs, 2004). With a lack of success in systematizing the data collection, the impact of the ASI in the evaluation and steering of the treatment system cannot be strong. In Holland, with the longest history of widespread use of the ASI, most treatment centres use the ASI to some extent, but very few in a comprehensive way. And, interestingly, in the Dutch centre with the most active ASI data collection, “almost nothing has been done to analyse these data or profit from it on a more abstract level for managerial or scientific purposes” (Broekman et al., 2004).

It will be interesting to see if the use of the ASI will be systematic in the Swedish prison system, as planned, and if so whether it will strengthen the treatment aspect in prisons. The prison system is centrally regulated and lacks a strong core profession, which can make it easier for the administration to manage than the health or social service system (Tengvald et al., 2004).

As the Danish and German experience indicates, the use of the ASI will become more widespread when it is linked to other obligatory, national or international, data collection (Vind & Hecksher, 2004; Schmid & Vogt, 2004). However, it is worth noting that, in this case, it is a question of using a small part of the ASI instrument. The Norwegian experience of comprehensive data collection from the treatment system is also that the data-collecting instrument should be very short (Lauritzen & Ravndal, 2004). This conclusion is reinforced by the Dutch authors (Broekman et al., 2004; see also below in this article).

The promise of unification of the system
Many European countries have a decentralized alcohol- and drug-treatment system, with both public and partly private provision, still partly professionalized and partly lay dominated. One way to improve the possibilities to manage the resource distribution in such a system is to introduce common norms and terminology. The advocacy of the ASI can be linked to this
need. The promise of strengthened connections between different treatment providers has been a strong motive in several countries for the introduction of the ASI. As one of the Swedish key persons put it: ‘‘The fact that municipal services buy certain services from other providers makes the connections between assessment, measures and results less obvious. The use of a common instrument in different parts of the system could improve this situation’’ (Tengvald, personal communication, March 2001). In Hungary, the ASI is expected to alleviate another problematic diversification, expressed as ‘‘substantial regional inequalities in the professional standard and infrastructure of the addiction medicine and drug treatment centres’’ (Gerevich et al., 2004).

Part of the appeal of the ASI must be its straightforward construction and broad scope. The ASI interview collects information about the client’s social situation, criminal behaviour and psychiatric and physical health problems, and this is in itself an invitation to cooperation between different social and health agencies. For instance, well before ‘‘dual diagnosis’’ became a common consideration in addiction treatment, the ASI included a facet measuring mental problems. The items are also usually worded fairly straightforwardly and do not feel strange for most staff in the treatment system. As we will note below, however, there are complications, mostly in connection with the various exclusions.

A related aspect of the use of the ASI is that its use can introduce, if not a common view of addiction problems, at least a common ‘‘language’’ or terminology (Wicks, 2004). Interviews with Swedish social workers from an ASI course in 2001 indicated that some concepts from the instrument have been integrated into their communication about clients across treatment-system borders. Social workers describe the clients’ problems for healthcare staff or the criminal justice system by referring to the seven areas of the ASI interview and talking about ‘‘the dominating problem’’ (Stenius 2001).

The effect of the ASI as a regulator of the behaviour of (a part of) the treatment system has so far, in the countries represented in this issue, probably been greatest in the Belgian de Sleutel. Here, ASI data have been used in the development of a treatment sub-system, with different levels and routes, with internal specialization and cooperation, creating a common terminology and data production. The Belgian experience shows that, perhaps particularly in a competitive situation, with disparate treatment services, the ASI may function as part of an institution-building project, imposing and giving promises of a common vision and a common language for both treatment provision and decision makers.

It is not clear how extensive the integrative impact of the ASI has been in all circumstances. The Dutch experience (Broekman et al., 2004) is that ‘‘no decision paradigm had been developed that was based on the criteria of the ASI (or any other instrument)’’. This can be linked, at least partly, to the fact that the ASI seems to be ‘‘less applicable for a relatively large group of patients … persons who are difficult to reach, who tolerate no more than short, causal contacts, who have cognitive and/or verbally limited capacities’’.

The promise of professionalisation
In some treatment systems, the use of the ASI has become a mark of professionalism or a mark of professional specialization. Even if ASI interviewing does not demand specific professional skills, the ASI can only be used after a rather extensive training. Learning to apply the interviewer’s ratings and to exclude alcohol- and drug-induced problems, as instructed, both require substantial training. Counsellors and others in the field can take such training and receive certification as a trained ASI interviewer. In a modest way, the diffusion
of the ASI has become an instrument of professionalization of the field. The ASI-trained persons will have a monopoly on the collection of a certain type of data that may be sought for. In Hungary, the use of the ASI and of data collected and published with this instrument have been an integral part of attempts to develop the quality and professionalism of drug treatment and addiction medicine, as distinguished from general psychiatry, and to unify the data management in a very diversified system. The emphasis here is on the “diagnostic and prognostic” qualities of the ASI and its usefulness in evaluation of treatment measures (Gerevich et al., 2004).

The promise of scientific thinking
Linked to the professionalization question is one of the most openly expressed expectations concerning the ASI’s normative influence, which we may call an educative process among the treatment staff. The fact that the use of the ASI could teach clinicians and counsellors, particularly within the social work system, systematic data collection and thinking, in order to promote an “evidence-based thinking” or at least standardized assessments and a role for science, has been stressed in Sweden and Holland (Broekman et al., 2004; Tengvald et al., 2004). In Sweden, with the strong role of lay and social work in addiction treatment, a report on the implementation of the ASI in the social service system in a northern Swedish town states:

The health care system and medical science are interesting models for alcohol and drug abuse treatment…. Within the health care system and the medical science there is more integration between research, generation of knowledge and treatment than within social work. (Engström & Larsson, 1998, p. 8)

The ASI is linked to an aspiration to make addiction workers more “scientifically” oriented, often meaning an interest in evaluation. The ASI’s scientific promises are also related to the possibilities to compare groups statistically, over time and in different parts of the system.

A help to the ASI’s scientific status and diffusion is the fact that it has been possible to make claims about its validation and reliability based on methodological studies. This has probably particularly helped in its adoption at system levels as a monitoring instrument. However, as Mäkelä’s review (2004) shows, the strength of the ASI’s psychometric position has often been over-estimated.

The promise of internationalism
Not least important for the popularity of the ASI, as can be seen in most of the countries represented in this issue, is the possibility to make references to and compare data across countries with a common instrument. The use of the ASI can be linked to the advent of other international data collections, in order to promote comparisons and international standards. One important such data collection, mentioned by the Norwegian (Lauritzen & Ravndal), Danish (Vind & Heckschher), German (Schmid & Vogt) and Belgian (Raes & Lombaert) authors in this issue, was the need to produce data about drug-treatment caseloads for the EU monitoring centre, EMCDDA.

The ASI gives the promise of internationality. The fact that it comes from the USA has probably been a help in many European countries (more so in Sweden than in Britain, for instance). In the addiction area, as in science and policy more generally, European views of US developments are complex, but a leading role for the USA in research tends to be taken for granted. There have thus been other diffusions of treatment artefacts eastward across the
Atlantic (e.g., Stenius, 1991). Diffusions in the opposite direction, like the sobering-up stations from eastern Europe, have mostly been unacknowledged (Room, 1976). It has also certainly been a help to the diffusion that the ASI and the material surrounding it have not been copyrighted, but have been made freely available, including by downloading from the Web (see Wicks, 2004). This is a positive contrast, for instance, with US mental-health-screening measures, many of which have required royalties for use.

The picture of the comparability and internationality of the ASI data is, however, complicated, not only by the well-known difficulties with some of the crucial questions, which are too US-specific (see Melberg, 2004), but also by the numerous different national versions of ASI. It does not seem that any country has been able to keep to only one version.

As Segraeus et al. (2004) show, the use of the ASI in comparative projects demands substantial efforts. So far, there have been relatively few published comparative analyses of clinical populations using the ASI. When such comparisons are made, they will undoubtedly open up new questions. If those in methadone treatment in country A have a different score on the ASI’s Family/Social Status Composite Score from those in country B, for instance, this may reflect differences in the social position of methadone-treatment services, or it may reflect differences in heroin use, or both. Interpreting differences in scores in samples of clients will thus require systematic comparisons of the treatment system and its social position.

The promise of the introduction of the client’s view
A normative aspect of the ASI, which is not prominent in other similar instruments, is the inclusion of the client’s view of his/her situation and need of help. Even if this has been surprisingly little emphasized by the authorities advocating the use of the ASI, the clients are invited, as Lauritzen and Ravndal note in their article in this issue, to reflect upon their situation. This is an aspect of the instrument that could make it more attractive for counsellors who view themselves as advocates of the clients. There are several reports claiming that the use of the ASI is popular among clients/patients (Lauritzen & Ravndal, 2004; Engstro¨m & Larsson, 1998). However, if feedback and follow-up are not systematically used (as they probably are not in many settings), the involvement of the client will be rather weak.

The Addiction Severity Index itself: Embedded choices
Embedded in the ASI are a series of specific choices, at different levels of generality. At the broadest level, the instrument aspires to summarize and measure a client’s life-trajectory: what are the dimensions of social and personal functioning, and (where a follow-up is used) how is the client doing on these dimensions at time Y, compared with time X? At more detailed levels, the instrument embeds choices about what is to be measured and potentially problematized, and how it is to be measured. When a researcher or clinic or treatment system decides to adopt the ASI, as with any other assessment instrument, they are buying into the choices embedded in the instrument. Examination of the content of the ASI may offer us some clues as to why it has found such wide favour in Europe, but also tells us something about why it is, in some ways, problematic. In Table I and here, we consider some of the choices built into the ASI, in the context of a somewhat broader range of potential inclusions.

Length
The ASI takes at least 45 min to administer. This is relatively long for an intake instrument—at least twice as long, for instance, as the Maudsley Addiction Profile (MAP; Marsden et al., 2000). Such a length makes it an unlikely instrument for use at the actual time of reception.
for anyone seeking acute care; it is more easily applied to clients with time on their hands (e.g., stabilized inpatient clients). Using it is resource intensive, whether the interviewing is by treatment agency staff or by outside interviewers (see Lauritzen & Ravndal, 2004; Broekman et al., 2004; Wicks, 2004).

While a good case can be made for the utility, under ideal circumstances, of most of the ASI in the specific context of treatment planning (e.g., Treatment Research Institute, 2002b), for most purposes a considerably shorter instrument would suffice. The seven composite scores (CSs) (of which some are rather problematic; see Melberg, 2004) intended for use in treatment outcome studies (medical status, employment status, alcohol use, drug use, legal status, family/social status, and psychiatric status), altogether use 47 items, which is less than one-third of the items in the instrument as a whole. As an intake form, the ASI is thus a rather lengthy instrument. For treatment follow-up or system-monitoring purposes, if only the CSs are to be used, it could be shortened by over two-thirds, by omitting items not used in the CSs. On the other hand, the wider range of items make sense for inclusion if the ASI is really put to full use in clinical assessment and treatment planning.

**Time frames**
The ASI uses a number of different time frames for its questions. For example, alcohol and other drug-use data are collected in terms of the last 30 days (number of days) and lifetime (number of years). The client is also asked about how many months ago a period of abstinence ended, and about treatment episodes on a lifetime and last-30-days basis. Several questions, including the ratings by the client of how important to him/her treatment for alcohol or drug problems is, and by the interviewer on need for treatment, are asked in the present tense or in terms of “now”.

Other sections of the instrument also focus on these three time frames: now, the last 30 days, and lifetime. A few questions are asked in terms of the last 3 years, and no dating is specified for the family history questions (see Table I). Some arbitrariness is involved in whatever time frame is chosen as indicating current status. The tradition in survey research on alcohol problems has been to use the “last 12 months” as the time frame, and psychiatric nosology has also fixed on a 12-month period in terms of diagnosing current alcohol or drug dependence. Implicit behind this choice of a time period is the idea that some sequelae of heavy drinking or drug use occur sporadically, rather than necessarily each month.

For a follow-up study to yield usable results, the period asked about should not include any time before treatment. A 30-day time-window ensures no overlap with the pretreatment period even with a short-term follow-up. On the other hand, such a short time-window may give a false picture of results. Indeed, the advantage of a 30-day time-window, from the perspective of a treatment evaluator, is that it will improve the success rate in a follow-up study. The use of a 30-day window in the 6-month follow-up study for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) on which the RAND studies of the 1970s (Armor et al., 1978; Polich et al., 1981) were based meant that improvement rates from treatment of above 70% were reported—although by the same criterion there was about 50% improvement in the control sample of those who had contact with a treatment clinic but no actual treatment (Room, 1980). On the other hand, the use of a long time-window lowers the success rate drastically: only 15% remained abstainers or moderate drinkers throughout the 4K years of the RAND follow-up (Room, 1980).
Put another way, for clients whose alcohol- or drug-use patterns have some ups and downs, the 30-day window before coming to treatment is most likely to be measuring their patterns at their worst, while in any particular 30-day window in the follow-up period they are likely to be doing better, even if the treatment intervention had no effect at all. In the absence of an untreated control group, a 30-day window over-estimates the effects of treatment.

**Exclusion of measures of dependence/addiction**
The most surprising aspect of the ASI is that, in spite of its name, it does not directly measure addiction or dependence at all. There is no question that choosing to go for the diagnostic level in an instrument requires quite a few questions (12 for alcohol, and 12 for the main other drug, in a current Swedish study of clinical populations; see Romelsjo¨ , 2004). Other instruments have chosen instead to go for a level of symptomatic behaviours; thus the AUDIT screening measure for alcohol problems included five items that might be regarded as dependence symptoms (items 4–8, http://www.niaaa.nih.gov/publications/insaudit.htm). Remarkably, the only item the ASI includes that goes beyond drinking- / drug-use patterns per se is a question about how often the respondent has had alcoholic DTs.

The tradition of asking about dependence/addiction has always been stronger on the alcohol than on the drug side of the literature, and the ASI’s failure to include this topical area may well reflect its provenance from the drug side. The omission both of this area and of any questioning about amounts consumed when drinking heavily makes the ASI slightly at odds with the alcohol literature. The lack of a link between the ASI and other established diagnostic instruments may be used as an argument for either choosing another instrument or adding other ones on top of the already extensive ASI (Broekman et al., 2004; Segreaus et al., 2004; Lauritzen & Ravndal, 2004).

**Exclusion of referral source/route**
One of the most common topics for inclusion in both outcome studies and system-monitoring instruments is questioning about the referral source. The ASI includes one relevant item (L1): “Was this admission prompted or suggested by the criminal justice system?” While this is probably the single most important source to ask about, it is surprising that the ASI does not ask about other sources of referral. Well-designed questions in this line are particularly useful for system-monitoring purposes.

**Focus on life-area functioning**
Over one-half of the ASI questionnaire is concerned with the client’s general functioning in different life areas: employment, family and social relations, and health and mental health. This is an unusually large commitment to measuring general life-area functioning in an alcohol-/drug-treatment outcome or system-monitoring questionnaire. The ASI’s strength in this area may be one source of its popularity in countries like Sweden and the Netherlands, with strongly developed welfare states and traditions of a welfare orientation to alcohol and drug problems. That an instrument developed in the USA is oriented in this direction may reflect its provenance from the US Veterans Administration system, which is the closest that the USA comes to a fully developed welfare system like those in Europe.

**Inclusion of family history**
A history of alcohol or drugs problems in other members of the family reflects the strong emphasis in the research literature, particularly in the USA, on this topic. But it can be
questioned how much priority it deserves in an intake questionnaire, for any of the purposes we are discussing.
### Table I. Topical areas: ASI inclusion and time period, and utility for three purposes.

<table>
<thead>
<tr>
<th>Topical area</th>
<th>ASI inclusion &amp; time period</th>
<th>Purpose: Assessment, treatment planning</th>
<th>Purpose: Outcome studies</th>
<th>Purpose: System monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s perception of treatment needs</td>
<td>C</td>
<td>Useful</td>
<td>Not usually included</td>
<td>Exogenous</td>
</tr>
<tr>
<td>Interviewer’s perception of needs</td>
<td>C</td>
<td>Useful</td>
<td>Not usually included</td>
<td>Not usually included</td>
</tr>
<tr>
<td>Drug/alcohol use: frequency</td>
<td>30, L</td>
<td>Useful, but more needed on alcohol</td>
<td>Needed (but something about amounts needed)</td>
<td>Useful</td>
</tr>
<tr>
<td>Dependence symptoms or diagnosis</td>
<td>–</td>
<td>A core issue for many modalities</td>
<td>Useful</td>
<td>Useful</td>
</tr>
<tr>
<td>Drinking/drug history</td>
<td>–</td>
<td>Needed</td>
<td>Control variable</td>
<td>Min. version useful</td>
</tr>
<tr>
<td>Social &amp; health problems attributed to drinking/drug use</td>
<td>–</td>
<td>Whether the client makes the attribution is clinically useful</td>
<td>Useful</td>
<td>Not usually included</td>
</tr>
<tr>
<td>Family history of alcohol/drug problems</td>
<td>X</td>
<td>Potentially useful</td>
<td>Control variable</td>
<td>Exogenous</td>
</tr>
<tr>
<td>Addiction system treatment history</td>
<td>L, 30</td>
<td>Needed</td>
<td>Control variable</td>
<td>Min. version useful</td>
</tr>
<tr>
<td>Demographics: age, gender, ethnicity, social class, etc.</td>
<td>C</td>
<td>Minimum version useful</td>
<td>Control variables</td>
<td>Needed</td>
</tr>
<tr>
<td>Life-functioning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital &amp; family</td>
<td>C, 3yr, 30</td>
<td>Useful background</td>
<td>Not usual beyond demographic min.</td>
<td>Not usual</td>
</tr>
<tr>
<td>Friendships &amp; social life</td>
<td>L, 30</td>
<td>Useful background</td>
<td>Not usual beyond demographic min.</td>
<td>Not usual</td>
</tr>
<tr>
<td>Work</td>
<td>L, 3yr</td>
<td>Useful background</td>
<td>Useful</td>
<td>Not usual</td>
</tr>
<tr>
<td>Psychological problems</td>
<td>L, 30</td>
<td>Needed</td>
<td>Control variable</td>
<td>Useful, but not usual</td>
</tr>
<tr>
<td>Mental health sys. treat. history</td>
<td>L</td>
<td>Potentially useful</td>
<td>Not usual</td>
<td>Useful, but not usual</td>
</tr>
<tr>
<td>Health problems</td>
<td>30</td>
<td>Needed</td>
<td>Useful</td>
<td>Useful, but not usual</td>
</tr>
<tr>
<td>Health system treatment history</td>
<td>L</td>
<td>Potentially useful</td>
<td>Not usual</td>
<td>Useful, but not usual</td>
</tr>
<tr>
<td>Criminal activity</td>
<td>30</td>
<td>Potentially useful</td>
<td>Important in illicit drug-treatment evaluations</td>
<td>Not usual</td>
</tr>
<tr>
<td>Criminal justice sys. involvement</td>
<td>L, 30</td>
<td>Potentially useful</td>
<td>Important in illicit drug-treatment evaluations</td>
<td>Useful, but not usual</td>
</tr>
<tr>
<td>Welfare support</td>
<td>30</td>
<td>Needed</td>
<td>Control variable</td>
<td>Useful, but not usual</td>
</tr>
<tr>
<td>Welfare system involvement</td>
<td>–</td>
<td>Potentially useful</td>
<td>Useful, but not usual</td>
<td>Useful, but not usual</td>
</tr>
<tr>
<td>Referral source/route</td>
<td>–</td>
<td>Useful</td>
<td>Control variable</td>
<td>Needed</td>
</tr>
</tbody>
</table>

Key to ASI inclusion and time period: –, not at all; C, current; X, no time frame specified; 30, 30-day time frame; 3yr, 3-year time frame; L, lifetime time frame.
Inclusion of interactions with health, mental health, addiction and criminal justice systems, but not welfare systems

The section of the ASI on legal status, health status and psychiatric status includes questions on the client’s handling by the social institutions in each of these areas—courts and hospitals. The ASI does include items about getting money from welfare or disability systems, but not in a way that gives any sense of the client’s history of interaction with welfare and disability agencies. Again, this may reflect the peculiarities of the US system, in which it is only in the last few years that a connection has officially been recognized between welfare supports and alcohol or drug problems (Schmidt & McCarty, 2000).

No alcohol/drug attribution questions

ASI is unusual among US addiction-treatment outcome instruments in asking no questions about social, health or mental problems attributed specifically to alcohol or drugs. For instance, over half the 50 items in the Drinker Inventory of Consequences (DrInC), developed for the Project Match randomized trial, might be counted as such attributed-harm items (example: “My marriage or love relationship has been harmed by my drinking”). There is also a strong tradition of such questions in general-population alcohol studies in the USA and elsewhere (Room, 2000). The relationship between those reporting a particular kind of harm without attribution and those reporting an alcohol related harm of the same type is modest, at least in a general population context (Gmel, Rehm, Room, & Greenfield, 2000).

Again, this absence may reflect the ASI’s provenance from the drug side of the literature, where asking such questions about the client’s attribution of harms to drug use has been much less common (Hall, Room, & Bondy, 1999). The governing assumption with respect to drugs has tended to be that the use is itself the harm.

Instructions to exclude alcohol-/drug-attributable problems

Pushing in the other direction from attributed-harm questions, in fact, the ASI instructions attempt specifically to exclude alcohol- or drug-induced harms from the positive reports on various harm questions. Thus interviewers are instructed not to count alcohol-/drug-induced positive answers to “How troubled or bothered have you been in the last 30 days by family problems?”: “Do not include problems that would be eliminated if the patient’s abuse problems were absent” (Treatment Research Institute, 2002a, emphasis in original). Similarly, clients are supposed to exclude “the direct effects of alcohol, drug or withdrawal” in answering the psychiatric symptom items on depression, etc. The ASI manual adds that: “It has been our experience that the patient will usually be able to differentiate a sustained period of emotional problems from a drug- or alcohol induced effect” (Treatment Research Institute, 2002a). This assertion seems somewhat optimistic, since clinicians and research studies have found such a distinction very difficult to make.

The requirement to try to exclude harms directly attributable to alcohol or drugs considerably complicates the interviewing task, and is one reason why ASI interviewers are considered to need special training. However, it is not clear what the rationale for the exclusion would be, and it is doubtful that the exclusion is reliably or validly measurable. McLellan (personal communication, June 2002) reports that dropping the exclusion in the computer-administered form of the ASI made no difference in the results.

Client’s ratings

In each of eight areas of problems—medical, employment, alcohol, drugs, legal, family, social and psychiatric—the client is asked two evaluative questions, of the form: “How
troubled or bothered have you been by these problems in the past 30 days? How important to you now is treatment/counselling for these problems?” Clients are asked to respond on a five-point scale, ranging from “not at all” to “extremely”. In six areas—medical, alcohol, drugs, legal, family and psychiatric—the responses are factored into the CS, and in three areas—medical, legal and family—the two items are likely to account for half or more of the variance.

It is refreshing and unusual for an intake interview to give so much explicit attention to the client’s desires, and to build them into the main scoring system derived from it. Still, a client’s ratings of problems in an area have a different epistemological status from the concrete information about events and experiences which comprises most of the ASI. The advisability of adding the concrete information and the client’s rating together into a single score can be questioned, particularly since the proportions of the two kinds of items vary in the different topical areas. In some areas, indeed, the composite score will mainly reflect a self-recognition of a problem and a request for treatment or counselling (see Melberg, 2004).

Interviewer’s ratings
The ASI manual is somewhat defensive about the interviewer’s severity ratings, noting that “they were historically the last items to be included on the ASI, … considered to be interesting but non-essential items … never intended for research use” (Treatment Research Institute, 2002a, emphasis in original). “Severity” is defined in the ASI in terms of “need for additional treatment”, and the manual notes that some users “do not agree with our definition of severity”. For this and other reasons, the manual considers it “entirely acceptable … to use the ASI without reference to the severity ratings” (Treatment Research Institute, 2002a, emphasis in original). Clearly, the ratings have been an arena of conflict among those using the ASI, and it is felt that their use requires considerable interviewer training. They have not been incorporated into any of the CSs.

Interviewer’s ratings of the severity of the client’s problem in each area constitute a third kind of measure, alongside the concrete items of events and experiences and the client’s ratings. How they relate empirically to the other domains is an interesting empirical and phenomenological question, but somewhat apart at least from the purposes of outcome evaluation and system monitoring.

The future of measurement of alcohol and drug problems in Europe
It became clear at the conference that there was a wide spectrum of opinion among participants concerning future measurement approaches and instruments. A number of participants were strongly committed to building a national system and indeed international comparisons on the basis of the ASI, regarding it as, at a minimum, a “good enough” instrument for their purposes. Others were more questioning and critical. In this connection, a critical assessment of the psychometric literature on ASI has recently been published (Mäkelä, 2004). Whether any single assessment instrument could be suitable for all purposes was questioned, and whether a relatively lengthy instrument would ever in practice be used in all clinical situations was seriously doubted. Ironically, the conference learned that the progenitors of the ASI in the USA had moved on to a shorter adaptation of the ASI. Some European participants that were using instruments based on the ASI (e.g., Denmark) were using considerably shortened versions. In such a shortened form, there is in fact a considerable convergence between the ASI and the MAP. For system monitoring and international comparisons, a shorter instrument taking at most 15–20min seems to be the likely path forward. But agreeing on such an instrument, even in a more integrated Europe, is
no easy task. This might well be an important task for the EMCDDA with regard to drugs. With regard to alcohol, this pan-European need points again to the need for an institution parallel to the EMCDDA for alcohol, or for alcohol to be added to the EMCDDA’s tasks.

Note

References


