# EUROPEAN ADDICTION SEVERITY INDEX EUROPASI

## COST A6

## A GUIDE TO TRAINING AND ADMINISTERING EUROPASI INTERVIEWS[1]

[1] This document has been made only for the Evaluation Instrument Bank – Treatment, and it does not reproduce entirely the original EUROPASI MANUAL.

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## A GUIDE TO TRAINING AND ADMINISTERING EUROPASI INTERVIEWS

Based on:
Addiction Severity Index, Fifth Edition with Preface
A Guide to Training and Supervising ASI Interviews
Based on the past ten years
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# PREFACE

The European version of the Addiction Severity Index (EUROPASI) and the accompanying guide to training and administering (EUROPASI) interviews are an adaptation of the fifth edition of the Addiction Severity Index (manual).[1] This version of the (EUROPASI) is the result of the work of a group of European researchers, who have already been working with adapted and translated versions of the American ASI and are in part supported financially by the Commission of the European Communities COST A6 programme.

At the beginning of 1993 Christina Hartgers (The Netherlands) and Anna Kokkevi (Greece) took the initiative to start the development of what is now called the (EUROPASI). Soon Enrico Tempesta, Gino Pozzi (Italy), Eva-Maria Fahrner (Germany), Ambros Uchtenhagen (Switzerland) and Peter Blanken (The Netherlands) joined the (EUROPASI) working group. Although translations of the ASI were already available in many European countries, the data collected with the instruments were not comparable. The main goal of this working group was to develop a uniform European ASI in order to compare drug and alcohol users (in and out of contact with treatment agencies) across Europe.

The working group decided to use the fifth edition of the American Addiction Severity Index as the basis of the EUROPASI. McLellan and colleagues were informed about the project and welcomed the initiative. Some adaptations were made on the basis of the working group members' experience with the ASI. Given its long tradition and history of psychometric research, other adaptations were specifically derived from the Dutch ASI. [2]

The adaptations can be summarized as follows:

- Some items of the American ASI did not seem relevant, or - in their original format - did not seem suitable in the European context. For instance, in Europe it is less appropriate to ask for the amount of money received or earned from various sources (the Section on Employment / Support Status). Therefore, these questions have been reformulated, now asking whether or not money was received from those sources.
- Other items could not be literally translated to the European situation, because of differences for instance, in the organization of the social security system and the treatment system - and had to be reformulated for that reason.

During the conference "Komorbidität: Psychiatrische Störungen und stofflicher Miβbrauch", (Hamburg, September 1993) the Working Group, by then officially registered as Working Group Four in the COST A6 of the Commission of the European Communities, had it's first workshop of the (EUROPASI) During this workshop the history of the Addiction Severity Index in various European countries as well as a preliminary version of the (EUROPASI) questionnaire were presented. In addition, the importance of (the development of) a European training programme to "train the trainers in training the interviewers" in administering the EUROPASI and a multi-centre (comorbidity and) EUROPASI validation study were discussed. At the end of the workshop, participants from 11 European countries expressed their interest in working with the EUROPASI and in participating in the studies.

Since then eighteen months have gone by since the start of the EUROPASI initiative. This "Guide to Training and Administering EUROPASI Interviews" and the questionnaire itself, are the first version of an instrument that undoubtedly will be very useful for studying drug and alcohol users, in and out of contact with treatment agencies, in many different European countries.

On behalf of the EUROPASI Working Group,
August 1994

Prof. Dr. Anna Kokkevi & Dr. Christina Hartgers
Coordinators Working Group on the European Addiction Severity Index

1 Barbara Fureman; Gargi Parikh; Alicia Bragg; A. Thomas McLellan *(1990):* Addiction Severity Index: A Guide to training and supervising ASI interviews based on the past ten years. (Fifth edition). The University *of* Pennsylvania / Veterans Administration, canter for Studies *of* Addiction.

2 Hendriks VM, Kaplan CD; van Limbeek J; Geerlings P (1990)*:* The Addiction Severity Index: Reliability and validity in a Dutch addict population. *Journal of Substance Abuse Treatment, 6 (2), 133-141;* and: Hendriks VM; Meer CW van der; Blanken P (1991)*: De Addiction Severity Index, ASI. Handleiding bij training en afname* Rotterdam: Addiction Research Institute Rotterdam (IVO).

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## GENERAL INSTRUCTIONS

In order to keep the same method of assessing the severity of problems; which is the central concept of the ASI, section I to VII of the "General Instructions of this EUROPASI manual are literally copied from: Fureman B; Parikh G; Bragg A, McLellan AT, (1990): Addiction Seventy Index: A Guide to training *and supervising ASI interviews based of the past ten* years. (Fifth edition).The University of Pennsylvania / Veterans Administration, Center for studies of Addiction. Section VIII of these general instructions has been adapted.

### 1. INTRODUCTION

The Addiction Severity Index is a relatively brief, semi-structured interview designed to provide important information about aspects of a client's life which may contribute to his/her substance abuse syndrome. It is the first step in developing a client profile for subsequent use by research and clinical staff. Thus, it is particularly important that the client understands the purpose of the interview. If it is to be used solely as a clinical interview it should be described as the first step in understanding the full range of problems for which the client is seeking help and the basis for the initial treatment plan. If the ASI is to be used solely for research purposes then the interviewer should explain that the interview will help to provide a description of his/her condition before and after the intervention or procedure that he/she will undergo. The interviewer should also take the opportunity to describe any potential benefits that the client may expect from participating in the research project.

The interviewer should introduce himself and briefly state that he wishes to ask the client some questions regarding the plan for treatment. The interviewer should add that all applicants are asked these questions for treatment/research, that the interview will be completely confidential, and that the information will not leave the treatment/research setting. NOTE: This should be re-emphasised throughout the interview.

The interviewer should then describe the design of the interview, stressing the seven potential problem areas. These areas are: Medical, Employment/Support, Alcohol, Drug, Legal, Family/ Social, and Psychiatric. It is important that the interviewer stress the nature of the client's contribution. For example, the interviewer should state:

> *"We have noticed that while all of the clients have alcohol/drug problems, many also have significant problems in other areas such as medical, employment, family, etc. In each of these areas, I will ask you if you feel you have problems in these areas, how much you have been bothered by these problems, and how important you feel treatment for those problems is to you. This is an opportunity for you to describe your most important problems,. the ones you feel you need the most help with. "*

The final step of the introduction is the explanation of the patient rating scale (see Section 11 for specific instructions). This 5 point scale will be used by the client to answer subjective questions in each problem area and will be presented for reference at this point in the interview. The interviewer should describe the use of the scale and offer an example to test understanding by the client.

As the focus of the interview moves from one area to the next, it is very important for the interviewer to introduce each new section and to change the client's focus from the previous area. For example:

> *“Well, we've talked about your medical problems, now I'm going to ask you some questions about any employment or support problems you may have."*

This way the client will be prepared to concentrate on each of the areas independently. It is important that the client does not confuse problems in a particular area with difficulties experienced in another area, such as confusing psychiatric problems with those due directly to the physiological effects of alcohol or drug intoxication.

FOLLOW-UP INTERVIEWS

If a follow-up interview is to be done at some later point, this should also be included in the introduction. For example:

> *"With your permission, we would like to get in touch with you in about six months to ask you some similar questions. This will enable us to evaluate our programme, to see how helpful it has been."*

By introducing the interview in a clear, descriptive manner, by clarifying any uncertainties, and by developing and maintaining continued rapport with the client, it is expected that the admission interview will produce useful, valid information. NOTE: The specific instructions for performing follow-up interviews are discussed later in this part of the workbook.

II. CLIENT'S RATING SCALE

It is especially important that the client develops the ability to communicate the extent to which he/she has experienced problems in each of the selected areas, and the extent to which he/she feels treatment for these problems is important. These subjective estimates are central to the client's participation in the assessment of his/her condition.

In order to standardize these assessments we have employed a 5 point (0-4) scale for clients to rate the severity of their problems and the extent to which they feel treatment for them is important.

0 - NOT AT ALL
1 - SLIGHTLY
2 - MODERATELY
3- CONSIDERABLY
4 - EXTREMELY

For some clients it is sufficient to simply describe the scale and its values at the introduction of the interview and occasionally thereafter. For other clients, it may be necessary to arrive at an appropriate response in a different fashion. The interviewer's overriding concern about these items is to get the client's opinion. Getting the client to use his/her own language to express an opinion is more appropriate than forcing a choice from the scale.

Several problems concerning these ratings can occur. For example, the client's rating of the extent of his/her problems in one area should not be based upon his/her perception of any other problems. The interviewer should attempt to clarify each rating as a separate problem area, and focus the time period on the previous 30 days. Thus, the rating should be made on the basis of current, actual problems, not potential problems. If the client has reported no problem during the previous 30 days, then the extent to which he/she has been bothered by those problems must be 0 and the interviewer should ask a confirmatory question as a check on the previous information.

> *"Since you say you have had no medical problems in the past 30 days, can I assume that, at this point you don't feel the need for any medical treatment?'*

NOTE: If the client is not able to understand the nature of the rating procedure, then insert an "X" for those items.

III. ESTIMATES

Several questions require the client to estimate the amount of time he/she experienced a particular problem in the past 30 days. These items can be difficult for the client, and it may be necessary to suggest time structuring mechanisms; e.g., fractional periods (half the time, etc.) or anchor points (weekends, weekdays, etc.). Finally, it is important that the interviewer avoid imposing his/her responses on the client (e.g. "Sounds like you have an extremely serious medical problem there"). The interviewer should help the client select an appropriate estimate without forcing specific responses.

IV. CLARIFICATION

During the administration of the ASI there is ample opportunity for clarification of questions and responses and this is considered essential for a valid interview. To insure the quality of the information, make sure the intention of each question is clear to the client. Each question need not be asked exactly as stated, paraphrase and use synonyms appropriate to the particular client and record any additional information in the "Comments" sections.

NOTE: When it is firmly established that the client cannot understand a particular question, the response should be recorded. Enter an "x" in the first block of that item in these cases. Where the client appears to have trouble understanding most questions, it may be advantageous to discontinue the interview. In this case, it is far better to wait a day or more for a client to recover from the initial confusing, disorienting effects of recent alcohol/drug abuse than to record confused responses.

V. INTERVIEWER SEVERITY RATINGS

GENERAL NOTE REGARDING SEVERITY RATINGS: Much has been made of these severity ratings because they have been shown to be reliable, valid and clinically useful. It should be understood however that these ratings are only estimates of problem status, derived at a single point in time and are subject to change with alterations in the immediate context of the client's life. Furthermore, these ratings cannot take the place of the more detailed information supplied by the client in each of the problem areas. Finally, since these are ultimately just ratings, it is recommended that they not be used as measures of outcome in research or programme evaluation studies. More objective, mathematically based composite scores in each problem area have been developed for research purposes. (See McGahan, et. at. 1986).

The severity ratings derived in each of the individual problem areas by the interviewer can be clinically useful. Ratings *in each problem area are based solely on responses to the objective and subjective questions within that area and not on extra information obtained outside the interview.* Although it is recognized that the interviewer's opinions, which are often important, will affect the severity ratings they introduce a non-systematic source of variation, lowering the overall utility of the scale. In order to reduce the variation and increase reliability of the estimates, all interviewers must develop a common, systematic method for estimating the severity of each problem.

We have established a two-step method for estimating severity. In the first step, the interviewer considers only the objective data from the problem area with particular attention to those critical items (see Appendix 2) in each problem area which our experience has shown to be most relevant to a valid estimate of severity. Using the "objective" data, the interviewer makes a preliminary rating of the client's problem severity (need for treatment) based only upon this objective data. In the second step, the client's subjective reports are considered and the interviewer can modify the preliminary rating accordingly However, if a particularly pertinent piece of information which is not systematically collected, figures into the derivation of a severity rating, it must be recorded in the "Comments" section. If the client suggests that he/she feels a particular problem is especially severe, and that treatment is "extremely important" to him/her, then the interviewer may increase his final rating of severity. Similarly, in situations where the client convincingly presents evidence that decreases the apparent severity of a problem area, the interviewer may reduce the final rating.

For the purpose of this interview, *severity will* be defined as need for treatment where none exists, or for an *additional* form or type of treatment where the client is currently receiving some form of treatment. These ratings should be based upon reports of amount, duration, and intensity of symptoms within a problem area. The following is a general guideline for the ratings:

0 - 1 NO REAL PROBLEM, TREATMENT NOT INDICATED
2 - 3 SLIGHT PROBLEM, TREATMENT PROBABLY NOT NECESSARY
4 - 5 MODERATE PROBLEM, SOME TREATMENT INDICATED
6 - 7 CONSIDERABLE PROBLEM, TREATMENT NECESSARY
8 - 9 EXTREME PROBLEM, TREATMENT ABSOLUTELY NECESSARY

It is important to note that these ratings are not intended as estimates of the client's potential benefit from treatment, but rather the extent to which some form of effective intervention is needed. regardless of whether that treatment is available or even in existence. For example, a client with terminal cancer would warrant a medical severity rating of 9, indicating that treatment is absolutely necessary for this life-threatening condition. A high severity rating is recorded in this case even though no effective treatment is currently available. Clients presenting few problem symptoms or controlled symptom levels should be assigned a low level of problem severity. As amount, duration, and/or intensity of symptoms increase, so should the severity rating. Very high severity ratings should indicate dangerously (to the client or others) high levels of problem symptoms and a correspondingly high need for treatment.

**SEVERITY RATING DERIVATION PROCEDURES**

STEP 1:

Derive a range of scores (2 or 3 points) which best describes the patient's need for treatment at the present time based on the "objective" data alone.

1. Develop a picture of the patient's condition based on the "objective" items and the critical items (Appendix 2).
2. Formulate an approximate range.

STEP 2:

Select a point within the range above, using only the subjective data in that section.

1. If the patient considers the problem to be considered and fees treatment is important, select the higher point within the scope.
2. If the patients considers the problem to be less serious and considers the need for treatment less important, select the middle or lower rating.

While it is recognized that the criteria for establishing the degree of severity for any problem varies from situation to situation, we have found the above derivation procedures to produce reliable and valid ratings. (See McLellan et. al., 1985).

**Exceptions**: In cases where the client obviously needs treatment and reports no such need, the interviewer's rating should reflect the obvious need for treatment. E.g., client reports 30 days of family arguments leading to physical abuse in some cases, but reports no need for family counselling. The obvious nature of this need must be stressed. Avoid inferences, hunches or clinical assumptions regarding this problem in the absence of clear indication and beware of over interpreting "Alcoholic Denial". Clarify through probes where necessary.

If the client has reported no recent or current problems, but does report a need of treatment, clarify the basis of this rating. E.g., client reports no use of drug or alcohol in past 30 days and no urges or cravings for drugs, but claims treatment in the form of continued AA meetings is "extremely important" with a rating of 4. Here the client is currently receiving adequate treatment and does not need any new, different or additional treatment.

**IMPORTANT**: Using the method described, there is ample evidence that the severity ratings can be both reliable and valid estimates of client status in each problem area. However, we do not recommend that the severity ratings be used as outcome measures. It is important to remember that these ratings are ultimately subjective and have shown to be useful only under conditions where all data are available and the interview is conducted in person. This is not always the case in a follow-up evaluation. We have created composite scores in each of the problem areas, composed of objective items that have been mathematically constructed to provide more reliable estimates of client status at follow-up[2]. We have used the severity estimates clinically and as predictors of

[2] The composite scores for the EUROPASI still have to be developed.

outcome but we have also used the composite scores as outcome measures. See McGahan et. al., 1986; Composite Scores from the Addiction Severity Index for a description of these measures and their general use.

VI. CONFIDENCE RATINGS

Confidence ratings are the last two items in each section and appear as follows: Is the above information significantly distorted by:

PATIENT'S MISREPRESENTATION? 0 - No; 1 - YES
PATIENT'S INABILITY TO UNDERSTAND? 0 - No; 1 - YES

Whenever a "yes" response is coded, the interviewer should record a brief explanation in the "Comments" section.

The judgement of the interviewer is important in deciding the veracity of the client's statements and his/her ability to understand the nature and intent of the interview. This does not mean a simple "gut hunch" on the part of the interviewer, but rather this determination should be based on observations of the client's responses following probing and inquiry when contradictory information has been presented (e.g. no income reported but $1000.00 in drug use). The clearest examples are when there are discrepancies or conflicting reports that the client cannot justify. The interviewer should then indicate a lack of confidence in the information. It is less clear when the client's demeanor suggests that he/she may not be responding truthfully and in situations where the client will not make eye contact, or rapid, casual denial of all problems. This should not be over interpreted since these behaviors can also result from embarrassment or anxiety. It is important for the interviewer to use supportive probes to ascertain the level of confidence.

NOTE: It is the responsibility of the interviewer to monitor the consistency of information provided by the client throughout the interview. It is not acceptable to simply record what is reported. Where inconsistency is noted (e.g., no income reported but claims of $500 per day spent on drugs) the interviewer must probe for further information (stressing confidentiality of the information) and attempt to reconcile conflicting reports. Where this is not possible. information should not be recorded and x's should be entered with a written note for the exclusion of information.

VII. DIFFICULT OR INAPPROPRIATE SITUATIONS

Previous Incarceration or In-patient Treatment - Several questions within the ASI require judgements regarding the previous 30 days or the previous year. In situations where the client has been imprisoned or treated in an in-patient setting for those periods it becomes difficult to develop a representative profile for the client. That is, it may not give a fully representative account of his/her general or most severe pattern of behaviour. However. it has been our policy to restrict the time period of evaluation for these items to 30 days prior to the interview regardless of the client's status during that time. This procedure accurately represents the client at the time of treatment or at the follow-up.

Even with this general understanding there are still individual items that are particularly difficult for clients who have been imprisoned or in some controlled environment to answer. Perhaps the most common example is found in the employment section. Here we have defined "days of problems" as counting only when a client has actually attempted to find work or when there are problems at the job. In a situation where the client has **not had the opportunity to work** it is, by **definition, not** possible for him/her to have had employment problems. In situations like this where the client has not had the opportunity to meet the definition of a problem day, the appropriate answer is an "N" and the client's rating that follow should also be "N'S" since they depend on the problem days question.

**Patient Misrepresentation** - We have found that some clients will respond in order to present a particular image to the interviewer. This generally results in inconsistent or inappropriate responses which become apparent

during the course of the interview. As these responses become apparent, the interviewer should attempt to assure the client of the confidentiality of the data, reiterate the purpose of the interview, probe for more representative answers and clarify previous responses of questionable validity. If the nature of the responses does not improve, the interviewer should simply discard all data which seems questionable by entering "X" where appropriate and record this on the form. In the extreme case, the interview should be terminated.

**Poor understanding** - Interviewers may find clients who are simply unable to grasp the basic concept of the interview or to concentrate on the specific questions, usually because of the effects of drug/alcohol withdrawal or due to extreme states of emotion. When this becomes apparent, the interview should be terminated and another session rescheduled.

**VIII.** FOLLOW-UP INTERVIEWS

Follow-up interviews may be carried out no earlier than one month after the previous interview since the evaluation period is the previous 30 days. The interview may be conducted reliably and validly over the telephone as long as the interview is conducted in a context where the respondent may feel free to answer honestly and the interviewer has given an appropriate introduction to the interview, stressing confidentiality of information (See McLellan at. al., 1980; 1985). Only the questions mentioned in Appendix 7 (EUROPASI follow-up interview instructions) should be asked at follow-up since these are the items that are able to reflect client change. See appendix 7 for further instructions.

## SPECIFIC INSTRUCTIONS

NOTE: It is important to distinguish items which are not applicable to the client (which should be coded "N"), from items that the client cannot understand or will not answer (which should be coded "X"). Do not leave items uncoded.

NOTE: Be sure to answer all items on follow-up ASI interviews, utilizing the procedures outlined in section VIII of the General Instructions ("Follow-up Procedure"), Appendix 7 and the special publication on follow-up procedures (See: Erdlen et al., 1987: Doing Follow-ups with the ASI).

NOTE: Items marked "| |" are optional items.

**HEADINGS**:

General guidelines on the procedures used in filling in the form are given at the top of page 1. A brief description of severity ratings, and a summary of the Client's Rating Scale are also included.

### LEFT COLUMN

This series of items was designed to provide administrative information. Some facilities may wish to change this section to conform to important local information regarding insurance coverage, particular programme codes, referral arrangements, case manager assignments, etc.. This is entirely appropriate and completely different face sheets may be used. Additions or changes to these items should be made freely as needed to reflect the administrative needs of your facility.

ID-NUMBER: Site specific.

TYPE OF SERVICE TREATMENT: Specify the context in which the subject is interviewed, choosing among the following:

0. NO TREATMENT. The respondent is not in a treatment setting.

1. OUT-PATIENT DETOXIFICATION. Detoxification has to take place under professional supervision with the objective to reach a drug-free status for the drug(s) of abuse, in a period no longer than six weeks. Detoxification may be performed either without medication, or by administration of symptomatic drugs (e.g., clonidine, benzodiazepines, non-steroid anti-inflammatory drugs NSAID, etc.) or by short-term (generally less than six weeks) administration of agonist drugs (e.g., methadone or buprenorphine for opiates; 4-OH-butirate for alcohol; etc.) with progressive reduction.

2. DETOXIFICATION RESIDENTIAL. Environmental restriction is provided by appropriate accommodation in a specialized institution for the treatment of substance abuse (but not hospitals, see below).

3. OUT-PATIENT SUBSTITUTION, Substitution implies long-term treatment with agonist drugs (e.g., LAAM, methadone or buprenorphine for opiates; 4-CH-butirate for alcohol; etc.) for a period of at least six weeks. Any type of psycho-social intervention (except for structured day care programmes) can be included, although this is no prerequisite.

4. OUT-PATIENT DRUG-FREE. The concept of drug-free refers only to substances of abuse (either alcohol, street drugs or prescribed drugs) and to substitutive drugs (agonists). The client may receive antagonist (e.g., naltrexone for opiates) or aversive (e.g., disulfiram for alcohol) medication, or a psychotropic prescription for co-occurrent mental disorders (see "Psychiatric Section" of the ASI). Psychotherapies are the most prominent type of intervention in this group.

Mental health out-patient treatments are also included in this group.

5. DRUG-FREE RESIDENTIAL. Therapeutic communities, either for mental or for substance use disorders, are the most prominent type of intervention in this group.

6. DAY CARE. A structured programme that the client attends several hours per day for several days per week. Any type of integrated pharmacological intervention can be included.

7. PSYCHIATRIC HOSPITAL. Includes private clinics and state hospitals. Psychiatric hospitalization may be involved in the treatment of addicts for co-occurrent mental illness and/or for behavioural consequences of intoxication, and/or sometimes for detoxification.

8. OTHER HOSPITAL/WARD. General hospitals are involved in the treatment of addicts for co-occurrent physical/mental illness, and/or sometimes for detoxification.

9. OTHER/NOT SPECIFIED. Include alcohol or drug treatment services that have a central intake procedure, in which it is not yet clear to what treatment procedure the client will be referred.

DATE OF ADMISSION: Code the day (two digits), then the month (two digits), and finally the year (two digits). For instance: 6 April 1992 will be coded as: 060492.

DATE OF INTERVIEW: See "Date Of Admission"

| | TIME BEGUN: First, code the hours (two digits, on a 24 hours per day basis) and second, code the minutes (two digits). For instance: five minutes past two in the afternoon **will** be coded as: 1405

| | TIME ENDED: See "Time Begun"

CLASS: In case of multiple follow-up assessments, the first follow-up assessment will be coded "2", the second follow-up assessment will be coded "3", and so on.

CONTACT CODE: Self-explanatory.

GENDER: As it appears to the interviewer.

INTERVIEWER CODE NUMBER: Site specific.

SPECIAL: Self-explanatory.

**CENTRE COLUMN**

These questions are generally demographic in nature, and require little clarification.

1 CURRENT RESIDENCE: Specify where the respondent actually lives, not the place where he/she is officially registered as resident.

2 CITY/POSTCODE: Again, code where the respondent actually lives.

| | 3 LIVED AT ADDRESS:

| | 4 RESIDENCE OWNED BY:

5 AGE:

6 NATIONALITY: Refers to citizenship, not to race.

7A+B+C COUNTRY OF BIRTH FATHER, MOTHER AND CLIENT: Use "WHO Country Codes".

8 CONTROLLED ENVIRONMENT: A controlled environment will refer to a living situation in which the subject was restricted in his/her freedom of movement and his/her access to alcohol and drugs. This usually means residential status in a treatment setting or penal institution.

A halfway house is generally not a controlled environment. If the subject was in two types of controlled environments, enter the number corresponding to the environment in which he/she spent the majority of time. In these cases, time spent in a controlled environment (item 9) will reflect the total time in all settings. If response to Item 8 is "No" ("1"), enter "N" for Item 9.

NOTE: In some countries (e.g., Italy) clients in day care treatment may also be under controlled environment if their family provides an uninterrupted overnight control.

9 DAYS: See specific instructions for Item 8.

**RIGHT COLUMN**

Space is provided for recording suggested psychological test data. These may be changed freely to the tests administered at your facility.

SEVERITY PROFILE: The graph is provided as a summary of the client's problem severity profile. Upon completion of the interview, the interviewer should mark the appropriate ratings on the grid.

**MEDICAL STATUS**

1 HOSPITALIZATION. Enter the number of overnight hospitalization for medical problems. Also, include hospitalization for overdoses (ODS) and delirium tremens (DTS), but exclude detoxification or other forms of alcohol, drug, or psychiatric treatment. Normal childbirth does not count, since it is not a medical problem resulting from sickness or injury.
However, complications resulting from childbirth are counted, and documented in the "Comments' section.

2 LAST HOSPITALIZATION. Enter the number of years and months since the client was last hospitalized for a medical problem. If never hospitalized for a medical problem enter "N" for years and "N" for months.
NOTE: If the client was hospitalized less than one month ago, code "01 " month.

3 CHRONIC MEDICAL PROBLEM. A chronic condition is a serious or potentially serious physical or medical condition that requires continuous or regular care on the part of the client (e.g., medication, dietary restrictions, inability to take part in or perform normal activities). Some examples of chronic conditions are: hypertension, diabetes, epilepsy, and physical handicaps.
In extreme cases, chronic menstrual problems could be counted if they interfere with daily life or are only managed through regular medical treatment.
Enter "yes", if the client has a chronic medical problem that will continue to prevent him/her from taking full advantage of his/her abilities.
If a client states his/her need for reading glasses, or minor allergies are a chronic problem, this is a misunderstanding of the question.
If the client does report a valid, chronic problem, comment on the nature of that problem in the space provided.

COMMON CHRONIC MEDICAL PROBLEMS for alcohol dependent persons:
Gastrointestinal (esophageal bleeding or varices, ulcers, gastritis, pancreatitis), Liver (fatty liver, cirrhosis, hepatitis), Other (hypertension, diabetes, seizures - may or may not be part of withdrawal)
COMMON CHRONIC MEDICAL PROBLEMS for drug dependent persons:
Hepatitis, hypertension, abscesses (arms, legs), fluid in lungs, heart conditions.
AIDS-related problems could be a wide range of things, but particularly oral thrush, unusual infections, and pulmonary problems. Asymptomatic HIV infection is not a chronic medical problem.

4 HEPATITIS. The aim of this question is to identify behaviour-related infections (unsafe sex, needle-sharing, etc.) so only B, C, and Delta virus hepatitis should be counted (since A virus hepatitis is an oral-foecal infection). However, if the client cannot specify the exact serology, but knows he had a hepatitis virus, code "Yes". Toxic hepatitis is obviously excluded (even if common among drug and alcohol users).

NOTE: In order to avoid invalid responses, no pressure should be made in cases in which the client is reluctant to give information about virus infections (particularly with respect to HIV). So, a different coding system has been adopted for items 4, 5, and 7, namely:

0 = No/ Negative;
1 = Yes/Positive;
2 = Don't know; and
3 = Refuses to answer.

5-7 HIV

8 PRESCRIBED MEDICATION. The purpose of this question is to validate the severity of the disorder by the independent decision to medicate the problem by a physician. Therefore, if the medication was prescribed by a legitimate medical professional, for a medical (not psychiatric or substance abuse) condition, it should be counted, regardless of whether the client actually took the medication.
If the client is taking medication, it must have been prescribed by a physician.
Medication only prescribed for short periods of time, or for specific temporary conditions (e.g., colds, detoxification) should not be counted. Only the continuous need for medication should be counted (e.g., high blood pressure, epilepsy, diabetes, etc.).
Do not include medication for psychiatric disorders, this will be recorded later.
Medication for sleep problems are usually temporary and generally fall under the "Psychiatric section".

9 PENSION. The benefit must be for a physical (not psychiatric) disability. [Country specific terminology or examples can be listed here].

10 TREATED BY PHYSICIAN. The aim of this question is to test the client's concern about his/her physical health problems, not simply their severity. So, any visit to the family doctor (GP), specialist or hospital out-patient department should be counted. Include only treatment for medical problems. Specific temporary, or less serious conditions (e.g., a cold or the flu) should also be counted. However, if the client asked for a certificate or a prescription merely for administrative purposes, this should be excluded. Psychiatric problems and medical problems that are a direct result from alcohol or drug use (such as hangovers, vomiting, lack of sleep, withdrawal, etc.), which would disappear if the client was abstinent, should also be excluded.

11 DAYS EXPERIENCING PROBLEMS. Ask the client how many days has he/she experienced physical/medical problems in the past 30. Do not include problems directly caused only by alcohol or drugs. This means problems such as hangovers, vomiting, lack of sleep, etc., which would disappear if the client was abstinent. However, if the client has developed a continuing medical problem through substance abuse which would not be eliminated simply by abstinence, include the days on which he/she experienced these problems (e.g., cirrhosis, phlebitis, pancreatitis, etc.).
Include minor ailments, such as a cold or the flu, though these ailments would warrant a low severity rating.

12 & 13 PATIENTS' RATING. Be sure to have the client restrict his/her response to those problems counted in Item 11. If no medical problems were mentioned in Item 11, ask a confirmatory question and code "not at all" - "0".
For Item 13, emphasize that you mean additional medical treatment for those problems specified in Item 11. If medical problems that are treated adequately have been reported, ask a confirmatory question and code a low score ("not at all").

14 SEVERITY RATING. in many cases clients suffer from conditions which may only be controlled and, at least for now, cannot be cured (diabetes, hypertension, epilepsy, AIDS-related pathologies, etc.). If the client appears to be taking appropriate care of his/her condition (medication, proper diet, etc.) and it is under control, there may be no need for an additional form or type of treatment beyond that which he / she is currently receiving. The client's severity rating may be low since additional treatment is probably not necessary.
If the condition is serious and problematic it should be rated as severe even if there is currently no effective treatment for that condition. However, if the medical care that the client is currently receiving has brought the

condition to a controlled, non-problematic state (e.g., in the case of diabetes, insulin is controlling the reported diabetes) this should not be rated as severe, even if the condition is serious.

**EMPLOYMENT & SUPPORT STATUS**

1 EDUCATION 1 YEARS OF SCHOOL: Enter the number of **completed years of formal education.** Interrupted and repeated years (in case of failure) should not be counted. The following types of education should be included as formal education:

• Country specific examples

• Country specific examples

Correspondence school will not be entered here.

2 Years Of HIGHER EDUCATION: Enter the number of completed years of higher education. In general, high school degrees (age 18 or more) are requested for access to higher education. The following types of education should be included as higher education:

• Country specific examples

• Country specific examples

3 HIGHEST DEGREE 0BTAINED: Country specific.

4 LICENCE: Any valid driver's licence that has not expired, been suspended or revoked. This item is simply an indication of the opportunity to become employed, in that many jobs require driving while at work, or at least the ability to get to work in places where public transportation is not available.

5 LONGEST PERIOD EMPLOYMENT: Stress the fact that you are interested in the longest, uninterrupted period that the client has been employed. It is not necessary for this period to be with one employer. Part-time employment is included only when it is for two-and-a half days (20 hours) per week or more.

Both paid (either legal (registered) or "work on the side") and voluntary (unpaid) employment should be coded.

Dealing, prostitution, stealing, etc. are not considered to be regular employment. Employ ment while in military service should be counted only when it is beyond the subject's original enlistment period (i.e. [country specific] "xx" months). Employment as substitution for compulsory military enlistment should not be coded.

Finally, valuable as it is, running a household does not count either.

6 LONGEST PERIOD UNEMPLOYMENT: Stress the fact that you are interested in the longest, uninterrupted period that the client has been unemployed. This includes periods in which he/she was not legally (registered) employed; and he/she had no "work on the side"; and he/she was not working voluntarily (unpaid); and he/she was not enrolled in day-time education.

If the client is employed part-time for less than two-and-a-half days (20 hours) a week, this is registered as unemployment. Likewise, dealing, prostitution, stealing, etc. are to be coded as unemployment. Again, running a household has to be coded as unemployment.

Finally, if the respondent has never been employed, count the years of unemployment from the end of the last year of formal or higher education (or from 15 years old if the respondent did not receive formal education).

7 OCCUPATION: Code the appropriate occupational category (See Appendix 4). Be sure to specify within general classes of work (i.e., if salesman, then computer sales, used car sales, etc.). If the client has recently been working in a different capacity, record his/her regular occupation. If the client does not have a regular occupation, record the most recent job. Code as "N" only when the client has not worked at all.

8 EMPLOYMENT PATTERN: The interviewer should determine which choice is most representative of the past three years, not simply the most recent. Full time work (including "work on the side') and work for over "xx" hours per week *[country specific], is* regular.

Regular part-time work is a sustained job in which the client has a work schedule less than " xx" hours per week *[country specific],* but it is regular. Irregular part-time work refers to jobs in which the client works on a part-time basis, but not on a reliable schedule; i.e., Manpower, day work, etc

Military service is restricted to the compulsory enlistment period. Military service beyond this compulsory enlistment period should be recorded as "regular employment".

When there are equal times for more than one category, record that which best represents the current situation.

9 DAYS WORKING: Record number of days in which the client has worked, regardless whether he/she was paid (thus, including voluntary (unpaid) jobs and "work on the side'). Paid sick days and vacation days are included.

Running a household and jobs held in prison, a therapeutic community, or hospital are not counted, even if paid. Dealing, prostitution, stealing, etc. are also excluded.

10-16 SOURCES OF FINANCIAL SUPPORT: If the client is reluctant to answer this section, remind him/her that the information is confidential.

EMPLOYMENT. Include both paid regular and paid "work on the side".

UNEMPLOYMENT COMPENSATION: Self-explanatory.

PUBLIC ASSISTANCE OR WELFARE: Self-explanatory.

PENSION, BENEFITS, OR SOCIAL SECURITY: This include benefits for disability or retirement pension, veteran's benefits, Social Security, etc.. *[Country specific adaptations may be necessary].*

MATE, FAMILY, OR FRIENDS, The purpose of this question is to determine whether the client had additional pocket money during the past 30 days, not to determine whether he/she was supported in terms of food, clothing and shelter. Record only money borrowed or received from one's mate, family or friends. These refer only to cash given to the client, and not to an estimated value of housing and food provided. Do not record the earnings of a spouse in this item - simply record whether money was actually given to the client to spend. Also, include here coincidental or windfall income from illicit gambling, loans, inheritance, tax returns, etc., or any other unreliable source of income.

ILLEGAL: This includes any money obtained illegally from drug dealing, stealing, “fencing" stolen goods, illicit gambling, etc..

PROSTITUTION: Self-explanatory.

NOTE: If the client has received drugs in exchange for illegal activity or prostitution do not attempt to convert this to a [local currency] value. Simply note this in the "Comments" section here and in the "Legal Section". Again, the focus is on money available to the client, not an estimate of the client's net worth.

18 Major Source Of Support: Amount of money received during the past 30 days.

19 DEBTS: Record the amount of debts the client has *[in local currency].*

The unit of measurement is country specific. For example, when the unit of measurement is 100 DMark and the client reports to have a debt of DMark 3.000 this should be coded as "0030". If the client reports a debt of DMark 999.900 or more, this should always be coded as '9999".

Rules for rounding off debt are dependent on the unit of measurement. In general, when a debt is less than half the amount of the unit of measurement (i.e., less than DMark 50 in the example) it should be rounded off downwards, while debts of half the amount of the unit of measurement or more (i.e., DMark 50 or more, in the example) should be rounded off upwards.

Include debts to both individuals and institutions (e.g., bank, tax/internal revenue, scholarship, etc.). Do not include mortgages. If the respondent runs a firm, financial liabilities should not be counted, unless the money has been subtracted for private purposes by the respondent.

Enter "x" only if the client cannot make a reasonable determination.

20 SUPPORT.' Stress that these people must regularly depend upon the client for financial support, not simply people to whom the client has occasionally given money. Do not include the client himself or a spouse who is self-supporting.

Do not include persons that the client hires (officially or otherwise) and thus pays a salary.

Do include dependents who are normally supported by the client but due to unusual circumstances, have not received support recently. Alimony and child support payments are included as indications of persons depending on the client.

21 EMPLOYMENT /UNEMPLOYMENT PROBLEMS, PAST 30 DAYS: Include inability to find work or problems with present employment (only if the client has tried or if employment is in jeopardy or unsatisfactory, etc.). Problems with employment 1 unemployment that are directly related to alcohol or drug use (i.e., intoxication or withdrawal) are not included.

NOTE: It is important to distinguish whether the problems reported here are simply interpersonal problems on the job (e.g., can't get along with certain members of the workforce), or if the problems are entirely due to alcohol/drug use. Problems such as these should be counted under the *Family/Social Section" or the "Alcohol/Drug Section" rather than this section.

Do not include bad feelings about employment prospects, or the desire to make money or change jobs, unless the client has actively attempted these changes and has been frustrated.

In a situation where the client has not had the opportunity to work, due to incarceration or another controlled environment, by definition it is not possible for him/her to have had employment problems. In situations where the client has not had the opportunity to meet the definition of a problem day, the appropriate answer is "N" and the client ratings that follow should also be “N”, since they depend on the problem days question.

22 & 23 PATIENT RATINGS: These ratings are restricted to those problems identified by Item 21. If no employment / unemployment problems have been mentioned at Item 21, ask a confirmatory question and code "not at all" - "0" at Item 22.

For Item 23 stress that you mean help finding or preparing for a job; not giving them a job. Also, emphasize that you mean additional employment counselling for those problems specified in Item 21. If (un-) employment problems that are addressed adequately have been reported, again ask a confirmatory question and code a low score ("not at all").

**DRUG / ALCOHOL USE**

1 -13 AGE AT ONSET refers to the year when the respondent started using the substance:

A) at least three days per week (irrespective of dosage); or:

B) in "binges" for at least two consecutive days per week, i.e, to the point where it compromises normal activities, such as work, school, family life, other recreational activities, or common everyday life activities, such as car driving, etc..

NOTE: "Binge use" is mainly restricted to cocaine, alcohol and even some other drugs (e.g., amphetamines).

This criterium should be repeated for each substance, until it is clear that the client understands it. For example: "At what age did you start to use heroin three days or more per week?", or: "At what age did you start using cocaine three days or more per week, or in large amounts for at least two consecutive days?"

If the client has never used a substance in a way as defined above, code "N" for that substance. However, if there is use of any substance "less" than defined above this should be noted in the "Comments" section, but do not include under Items 1 - 13.

See also the specific instructions for "Alcohol, over daily threshold", Item 2, and "Multiple Substances", Item 13.

LIFETIME USE. This question is asked in order to determine extended periods of use, defined as "three days or more per week", or "two-day binges".

The duration of substance use can be rounded off to years without loss of information. Thus, use for six months or more, as defined above, will be considered one year; use for less than six months should be noted in the "Comments" section, but not counted as a year. If the client used a substance in different periods over the years, separated by abstinent intervals from that substance, the duration of those different periods of use should be added up, and the sum should be rounded off to years.

If the client never used a substance in a way as defined above, or used a substance for less than six months, code "00" for that substance. However, if there is use of any drug less than defined above or if there is use as defined above for a period less than six months, this should be noted in the "Comments" section, but do not include under Items 1 - 13.

See also the specific instructions for "Alcohol, over daily threshold", Item 2, and "Multiple Substances", Item 13.

PAST 30 DAYS. Each day the client used alcohol or drugs (according to the description in the left column) should be counted. If he/she did not use alcohol or drugs, code "00".

See also the specific instructions for "Alcohol, over daily threshold", Item 2, and "Multiple Substances", Item 13.

ROUTE OF ADMINISTRATION. The usual or most recent method of administration should be coded. In cases where two or more methods are routinely used, the most serious method should be coded.

The codes for the method of administration are listed below the drug grid - and numbered in order of their severity - as follows:

1 = oral;
2 = nasal;
3 = smoking;
4 = non iv injection;
5 = iv injection.

1 -13 CHEMICALS ABUSED: Be sure to prompt the client with examples, using [country specific] slang and brand names of drugs for each specific category. (Refer to Appendix 5, "List *of* Commonly Used Substances").

NOTE: It is important to ask all substance abuse history questions regardless *of* the present problem (e.g., an alcoholic may be combining drugs with drinking; a cocaine user may be unaware of a drinking problem).

Prescribed medication is counted under the appropriate generic category. LAAM should be recorded under "Methadone". Antagonists and aversives (e.g., Antabuse, Naltrexone and Disulfiram) are not recorded under the substance use history section, but should be noted as "Comments" at the bottom of the section.

Refer to Appendix 5 for list of common chemical agents listed by street name and ASI category. If a client reports regular recent and/or past use of a substance that is not listed, then this should be noted and specified under "other".

1 &2 ALCOHOL & ALCOHOL OVER THRESHOLD: Since spirits are subject to a socially-accepted, non addictive use, information about alcohol consumption has been distinguished into two levels.

Question 1, "ANY ALCOHOL" refers to any alcohol use for at least three days per week, including alcohol use over the threshold, as described under Item 2, A and B;

Question 2, "ALCOHOL OVER THRESHOLD" refers to alcohol use over the following threshold:

A) five or more alcoholic "drinks" per day are taken for at **least three days per week** (a drink is the quantity of alcoholic beverage contained in the appropriate glass for the spirit: i.e., about 5 cl. for high spirits, about 15-20 cl. for wines, about 33-45 cl. for beer, and so on); or

B) alcohol is taken to "point of intoxication" for at least **two consecutive days per** week (to the point where psychic or somatic symptoms appear and/or it compromises normal activities, such as work, school, family life, other recreational activities, or common everyday life activities, such as driving. etc.).

6 DEPRESSANTS. This class includes Benzodiazepines, Barbiturates, and other sedative drugs (see Appendix 5). Use (as defined above) should be recorded here irrespective of whether the substance was prescribed or not.. However, in the “Comments" section the prescription qualification should be noted.

7 COCAINE AND ITS DIFFERENT FORMS. Cocaine is used in many forms and these often have different names. "Crack" or "rock" cocaine [or other country specific names] is simply the "freebase" or "base" (smokable) form of cocaine. All these forms of cocaine should be categorized under cocaine and coded as the smoked route of administration. All different forms of cocaine (e.g., crystal cocaine - snorted; freebase cocaine - smoked; crystal cocaine - injected) should all be counted under the cocaine category. If more than one method of administration is used, code the most serious (the route of administration is numbered in order of severity).

8 STIMULANTS. This class includes amphetamines, "anti-appetite drugs" and other related chemicals (see Appendix 5).

12 OTHER. This does not include tobacco.

13 MULTIPLE SUBSTANCES.

Under Age At Onset" ask the client at what age he/she started using more than one (ASI category) substance, excluding alcohol under threshold.

Under "Lifetime Use" ask the client how long he/she started taking more than one (ASI category) substance, excluding alcohol under threshold.

Under "past 30 days" ask the client how many days he/she started taking more than one (ASI category) substance, excluding alcohol under threshold.

14 INJECTION. The aim of this section is to describe the injective behaviour in particular, since it implies both the strongest involvement with drug use and the highest risk for substance related problems. The threshold for registering this behavioural information has been decided at the lowest, that is once.

Thus, the age of first injection will be indicated by the age the respondent injected for the very first time, irrespective of future development of protracted injective behaviour.

With respect to life time injection: Even one injection during any particular year will make that year count for life time injection. Similarly, one injection in a month will make that month count for the number of months injected during the past six months, and one injection in a day will make that day count for the number of days injected during the past 30 days.

14B INJECTION PAST 6 MONTHS. Sharing is defined as injecting with a needle and a syringe which has already been used by someone else, and not (which it often includes) giving away one's own used equipment.

15 ODs AND DTs: If in doubt about a reported OD, ask the client what was done to revive him/her. Simply letting the client "sleep it off" does not constitute an OD. If the client describes any incident in which intervention was needed to recover, do count this as an OD.

The nature of overdose will differ with the type of drug used. While opiates and barbiturates produce coma-like effects, amphetamine overdoses ("overamps") frequently result in toxic psychoses.

Do include suicide attempts if they were attempted by drug overdose. (Remember this in the "Psychiatric" Section and be sure to check the "Medical" Section to note hospitalization).

DEFINITION OF DELIRIUM TREMENS (DTs):

DTS occur 24 to 48 hours after a person's last drink. They consist of tremors (shaking) and delirium (severe disorientation) and are often accompanied by a fever. They sometimes include hallucinations but not always.

Genuine DT's are usually so serious that they require some form of medical care or outside intervention. Impending DTs as diagnosed by a professional would also be considered serious enough to count as DTS.

PROBLEMS SOMETIMES MISTAKEN FOR DTs:

DTs are not to be confused with "the shakes" which occur about 6 hours after alcohol has been withdrawn and do not include delirium.

16 TREATMENT: Please note that in this section of the ASI, treatment refers to the addictive disorder, and not to mental (see "Psychiatric" Section of the ASI) or physical (see "Medical" Section of the AS]) illness. If the client was treated both for substance use disorders and for mental or physical illness, code the treatment both in this section and in the "Psychiatric" or "Medical" Section.

Specify the number of treatment for alcohol and drugs separately. If the client was treated for both alcohol and drug problems simultaneously, count the treatment under both categories. If the client was consecutively treated by the same centre (e.g. for detoxification and long-term psychotherapy), code all treatments separately.

Exclude "Driver's School" for DWI (driving while intoxicated) violations. Ask questions separately for alcohol and drugs. In the case of dual problems try to get the number of treatments in each category.

16.1 OUT-PATIENT DETOXIFICATION. Detoxification has to take place under professional supervision with the objective of reaching a drug-free status for the drug(s) of abuse in a period no longer than six weeks. Detoxification may be performed either without medication, or by administration of symptomatic drugs (e.g., clonidine, benzodiazepines, non-sterioid antiinflammatory drugs, etc.) or by short-term (generally less than six weeks) administration of agonist drugs (e.g., methadone or buprenorphine for opiates; 4-OH-butirate for alcohol; etc.) with gradual reduction.

16.2 DETOXIFICATION RESIDENTIAL. Environmental restriction is provided by appropriate accommodation in a specialized institution for the treatment of substance abuse (but not hospitals, *see below).*

16.3 OUT-PATIENT SUBSTITUTION. Substitution implies long-term treatment with agonist drugs (e.g., LAAM, methadone or buprenorphine for opiates; 4-OH-butirate for alcohol; etc.) for a period of at least six weeks. Any type of psycho-social intervention (except for structured day care programmes) can be included, although this is no prerequisite.

16.4 OUT-PATIENT DRUG-FREE. The concept of drug-free refers only to substances of abuse (either alcohol, street drugs or prescribed drugs) and to substitute drugs (agonists). The client may receive antagonist (e.g., naltrexone for opiates) or aversive (e.g., disulfiram for alcohol) medication, or a psychotropic prescription for co-occurrent mental disorders (see "Psychiatric Section* of the ASI). Psychotherapies are the most prominent type of intervention in this group. Mental health out-patient treatment is also included in this group.

16.5 DRUG-FREE RESIDENTIAL. Environmental restriction is provided by appropriate accommodation. Therapeutic communities, either for mental or for substance use disorders, are the most prominent type of intervention in this group.

16.6 DAY CARE. A structured programme that the client attends for several hours per day, several days per week. Any type of integrated pharmacological intervention can be included.

16.7 PSYCHIATRIC HOSPITAL. Treatment should be prompted by substance use disorder, including detoxification (treatment for independent mental illness should be recorded in the "Psychiatric" Section of the ASI). Includes private clinics and state hospitals. Psychiatric hospitalization may be involved in the treatment of addicts for co-occurrent mental illness and/or for behavioural consequences of intoxication, and/or sometimes for detoxification.

16.8 OTHER HOSPITAL/WARD. Treatment should be prompted by substance use disorder, including detoxification (treatment for physical illness should be recorded in the "Medical" Section of the ASI). General hospitals are involved in the treatment of addicts for co-occurrent physical/ mental illness, and/or sometimes for detoxification.

16.9 OTHER TREATMENTS/NOT SPECIFIED. Include any other type of alcohol or drug treatment, e.g., self-help groups, like AA or NA (if three or more sessions, within a one month period). If this category is coded, shortly describe the treatment in the "Comments" section.

17 ABSTINENT/CLEAN PERIOD: This questions asks about the longest period that the client has been abstinent/clean from the substance(s) addressed by specific treatment, as a result of that treatment. Stress that this was the longest attempt (of at least one month) at abstinence, not necessarily the last.
Periods of hospitalization or incarceration are not counted. Periods of abstinence from street drugs or alcohol during which the client was taking Methadone, Antabuse, or Naltrexone as an out-patient are included.
Enter "00" if the client has not been abstinent as a result of treatment for a period of at least one month.
Enter "N" if the client has not been in treatment.

NOTE: The question about the longest period of abstinence as a result of the treatment modalities mentioned above, should be asked separately for alcohol and other drug(s).

18 MAJOR PROBLEM. The interviewer should determine the major drug of abuse based upon the years of use, number of treatment, and number Of DTS/ODS. If the information does not provide a clear indication of his/her drug problem, ask the client what he/she thinks is the major substance problem.
Record "16" if the client has major problems with more than one drug; or "15" if the client abuses alcohol and one or more drugs.

NOTE: Some clients may report that legal methadone is their primary drug problem, as in the case of clients who are seeking detoxification and drug free treatment. This can be used as the major problem in Item 18 and problems associated with the legal methadone may be recorded in Item 23.

NOTE: For follow-up interviews record what the client thinks is the major substance abuse problem. If at follow-up the client maintains that he/she has no drug or alcohol problem, but reports experiencing drug or alcohol problems in Item 23, then clarify Item 18 by asking if he/she considers that substance to be the current major problem.

19 ABSTINENCE: Ask the client how long he/she was able to remain abstinent from the major drug(s) of abuse (as reported in the previous Item 18). Stress that this was the last attempt (of at least one month) at abstinence, not necessarily the longest.

**Periods of hospitalization or incarceration are not counted.**
If Item 18 is coded "00 - No Problem", enter "N". If Item 18 is coded "'15 - Alcohol and Drug", then abstinence will refer to both alcohol and the major drug(s) . If Item 18 is coded "16 - Polydrug", then abstinence will refer to all abused drugs. Enter "96" if the number of months equals 96 (eight years) or more.
Enter "00" if the client has not been abstinent for a period of at least one month.

20 ENDPOINT: Enter "00" if the period of abstinence is current. Enter "N" if the client has never been abstinent since he/she began using.

21 EXPENSE: This is primarily a measure of financial burden, not amount of use. Therefore, enter only the money spent, not the value of what was used (e.g., dealer who uses but does not buy; bartender who drinks heavily but does not buy, etc.).
The unit of measurement is country specific. For instance, when the unit of measurement is 100 DMark and the client reports to have spent DMark 3.000 this should be coded as "0030". If the client reports spending DMark 999.900 or more, this should always be coded as "9999".
Rules for rounding off expenses are dependent on the unit of measurement. In general, when the money spent on alcohol or drugs is less than half the amount of the unit of measurement (i.e., less than DMark 50 in the

example) it should be rounded off downwards, while spendings of half the amount of the unit of measurement or more (i.e., DMark 50 or more, in the example) should be rounded off upwards.
Enter "X" only if the client cannot make a reasonable determination.

22 OUT-PATIENT TREATMENT: Treatment refers to any type of out-patient substance abuse therapy. This does not include psychological counselling or other therapy for non-abuse problems.
Do include methadone maintenance, AA, NA, or CA meetings, Antabuse, etc.. The mere fact that the client was "officially enrolled" in a programme does not count. Count the number of days in the past 30 days that the client had personal contact with the treatment programme.

23 DAYS EXPERIENCING PROBLEMS: Be sure to stress that you are interested in the number of days the client had problems directly related to alcohol or drug use. **Include only** craving **for** alcohol/drugs, withdrawal symptoms, disturbing effects of drug or alcohol intoxication, or wanting to stop and not being able to do so. Do not include the client's inability to find drugs or alcohol a problem.

24 & 25 PATIENT RATINGS: Stress the past 30 days as the time frame. if no alcohol or drug use problems have been mentioned at Item 23, ask a confirmatory question and code "not at all" - "00" at Item 24.
For Item 25, you are rating the specific need for substance abuse treatment, not general therapy. Stress that you mean current substance abuse problems, not a rating of treatment need for substance abuse problems at their worst. Also, emphasize that you mean additional alcohol or drug use treatment for those problems specified in Item 23. if alcohol or drug use problems that are addressed adequately have been reported, again ask a confirmatory question and code a low scare ("not at all").

## LEGAL STATUS

1 ADMISSION PRESSURE: Enter "1" if any member of the criminal justice system was responsible for the client's current admission, or if the client will suffer undesirable legal consequences as a result of refusing or not completing treatment.

2 PROBATION / PAROLE: It may be helpful to note duration and type of probation separately.

3-6 CHARGES: This is a record of the number and type of official charges (not necessarily convictions) accumulated by the client during his/her life. Be sure to include the total number of charges and not just arrests. These include only formal charges, not times when the client was just picked up or questioned.
Include arrests which occurred during military service, but do not include those that have no civilian life equivalent (e.g., deserting, and insubordination), but do record these in the "Comments" section.
Do not include juvenile (under 18) crimes, unless the court tried the client as an adult, as can be the case in particularly serious offenses.
NOTE: The inclusion of adult crimes only is a convention adopted for our purpose alone as we found it most appropriate for our population. The use of the ASI in different populations may warrant consideration of juvenile legal history.
Examples of "other crimes" are: vandalism, and illegal possession of weapons.

7 CONVICTIONS: Do not include the misdemeanor offences (items 8, 9. 10. and 11) in this Item. Note that convictions include fines, probation, suspended sentences as well as sentences requiring incarceration. [Country specific: *Convictions also include guilty pleas.]*
Charges for parole and/or probation violations are automatically counted as convictions.

8 DISORDERLY CONDUCT, VAGRANCY, DRUNK AND DISORDERLY IN PUBLIC: Charges in this category may include those which generally relate to being a public annoyance without the commission of a particular crime.

9 PROSTITUTION

10 DRIVING WHILE INTOXICATED: Driving while intoxicated or "drunk driving."

11 DRIVING VIOLATIONS: Driving violations are traffic violations (speeding, reckless driving, leaving the scene of an accident, etc.). This does not include vehicle violations, registration infractions, parking tickets, etc.

12 INCARCERATIONS: Enter the number of total months spent in jail (whether or not the charge resulted in a conviction), prison, criminal mental hospital, or detention centre in the client's life from the age of 18, unless the client was detained 1 as an adult while still a juvenile. If the number equals 96 months (8 years) or more, enter "96". Count any period - two weeks or longer - of imprisonment as one month.

13 LENGTH OF LAST INCARCERATION: Enter "N" if the client has never been imprisoned.

14 CHARGE: Use the item number assigned to the crime categories in the first part of the "Legal" Section (03 to 06, and 08 to 11) to indicate the charge for which the client was imprisoned. If the client was imprisoned for several charges, enter the most serious, or the one for which he/she received the most severe sentence.

Enter "N" if the client has never been imprisoned.

15 CHARGES, TRIALS, SENTENCES. Make sure the client does not include civil lawsuits, unless a criminal offence is involved.

16 CHARGE: Same as Item 14. Enter "N" if the client is not awaiting charges, trial, or sentence. Do not include civil lawsuits, unless a criminal offence is involved.

17 INCARCERATION: Include being detained; e.g., arrested but released an the same day.

18 RECENT ILLEGAL ACTIVITIES: Enter the number of days the client was engaged in crime for profit.
Do not count simple drug possession or drug use. However, do include drug dealing, prostitution, burglary, selling stolen goods, etc..

19 & 20 PATIENT RATINGS: Do not include any civil problems (e.g., custody fights, divorce, etc.).
For Item 20, make sure the client is rating the need for referral to legal counsel for defence against criminal charges.
For Item 20, emphasize that you mean additional counselling or referral for legal problems. If legal problems that are addressed adequately have been reported, ask a confirmatory question and code a low score ("not at all").

## FAMILY HISTORY

The family history grid is designed to summarize the psychiatric, alcohol, and drug abuse problems of the client's relatives in each of the specified categories. Usually, the information supplied by the client cannot be validated and thus should be coded cautiously using the following guidelines.

NOTE: The family history grid refers only to "blood-relatives", including "half-siblings" (i.e., siblings with whom the client has only one parent in common).

Step-fathers, step-mothers, step-sisters, or step-brothers, and aunts or uncles that are not a sister or brother of the clients' parents should be noted in the "Comments" section, provided that they were living together with the client during his/her upbringing.

| | Step-fathers, step-mothers, step-sisters, or step-brothers, and aunts or uncles that are not a sister or brother of the clients' parents can also be coded under a separate category of "important others", provided that they were living together with the client during his/her upbringing.

DETERMINATION OF PROBLEM STATUS: It is not necessary for there to be a medical diagnosis or for formal treatment in order to count as a "problem." Again, the client is the best source of information here and should be told to count a problem as "... one that either did or should have led to treatment."

It is particularly important for interviewers to make judicious use of the "N" and "x" responses to these questions.

In general, a "Yes" response should be recorded for any category where at least one member of the relative category meets the criterion. For example, the client has two aunts on his/her mother's side and feels that one of them had a serious drinking problem and the other had a significant psychiatric problem. In this case, "Yes" codes are counted under the Aunt category (mother's side) for both alcohol and psychiatric problems.

A "No" response should ONLY be counted if all relatives in the category fail to meet the criterion.

An "N" should be coded for all categories where there is no relative for the category.

An "x" code should be used for any situation where the client simply can't recall or is not sure for any reason. In general, it is far better to use an "x" than to record possible inaccurate information.

In cases where there are more than two brothers or sisters, the most severe cases should be reported.

**FAMILY / SOCIAL RELATIONSHIPS**

GENERAL NOTE: In this section in particular, there is difficulty in determining if a relationship problem is due to intrinsic problems or to the effects of alcohol and drugs. In general. the client should be asked whether he/she feels that "if the alcohol/drug problem were absent". would there still be a relationship problem. This is often a matter of some question but the intention of the items is to assess inherent relationship problems. rather than the extent to which alcohol/drugs have affected relationships.

1 MARITAL STATUS: Enter code for present legal marital status. [Country specific: Consider common law marriage (seven years) as "Married" ("1")].

2 DURATION: Enter number of years and months client has been in the current marital status. For clients who were never married enter the number of years from age 18 (an indication of their adult status).

3 SATISFIED: A "satisfied"" response must indicate that the client generally likes the situation, not that he / she is merely resigned to it.

4 USUAL ARRANGEMENTS: Ask the client to describe the amount of time spent living in prisons, hospitals, or other institutions in the past three years. If this amount of time is the most significant, enter an "8". If the client lived in several arrangements choose the most representative of the three year period. If the amounts of time are evenly split, choose the most recent situation.

5 DURATION: Enter the number of years and months the client has lived under the usual arrangements (item 4). For clients who usually live with parents, enter the number of years residing there from age 18.

6 SATISFIED: A "satisfied"" response must indicate that the client generally likes the situation, not that he/she is merely resigned to it.

6A & B SUBSTANCE USE IN THE HOME ENVIRONMENT: Items 6A and 6B gives an indication of whether the client will return to a drug and alcohol free living situation. This is intended as a measure of the integrity and support of the home environment and does not refer to the neighbourhood in which the client resides. The home environment in question is the one in which the client either currently resides (in the case of most out-patient treatment settings) or the environment to which the patient expects to return following treatment.

This situation does not have to correspond to the environment discussed in items 4 to 6.

For the alcohol question (6A), code "Yes" only if there is an individual with an active alcohol problem (i.e., a drinking alcoholic) in the living situation, regardless of whether the client has an alcohol problem.

For the drug use question (6B), code "Yes" if there is any form of psychoactive drug use (excluding nicotine and caffeine) in the living situation, regardless of whether that individual has a problem or whether the client has a drug problem, and regardless of whether that individual is taking drugs on prescription or not.

NOTE: For an overview of drugs referred to in this question see the "Alcohol 1 Drug Use' Section of the ASI, and Appendix 5. "List of Commonly Used Substances".

7 SPEND TIME WITH: This response is usually easy to interpret. Immediate and extended family as well as in-laws are to be included under "Family" for all items that refer to "Family".
Any of the client's associates other than family members can be considered as "friends", and related problems should be considered "Social".

CURRENT ALCOHOL OR DRUG PROBLEMS: If the client spends most of his/her free time with family members or friends that have an active alcohol problem, or are involved in any form of psychoactive drug use (excluding nicotine and caffeine), this should be reflected in coding the answer categories 2 and / or 4 respectively.

GENERAL NOTE: Some clients may consider a girlfriend/boyfriend with whom they have had a longstanding relationship as a "member of the family". This is totally acceptable.

IMPORTANT: If you have coded this person as a "family member" here, also consider him/her as a member of the family in questions 19A, 20, and 22, and as a sexual partner in question 13.

8 SATISFIED: A "satisfied"" response must indicate that the client generally likes the situation, not that he/she is merely resigned to it.

9 CLOSE FRIENDS: Stress that you mean close. Do not include members of the family or a girlfriend/boyfriend who is considered to be a family member/spouse.

9A - 18 GENERAL INSTRUCTIONS FOR THE "RELATIONSHIP QUESTIONS": It is particularly important for interviewers to make judicious use of the W and "x" responses to these questions.

In general, a "Yes" response should be recorded for any category where at least one member of the relative category meets the criterion. For example, if the client has two brothers and has had serious problems with one

of them and developed a warm, close relationship with the other, than Items 9A (Brothers/Sisters) and 12 would both be coded "Yes". In contrast, a "No" response should ONLY be coded if all relatives in the category fail to meet the criterion.

An "N" should be coded for all categories where there is no relative for the category. However, it is possible for a client to have had serious problems with a father in the past, but because of death, did not have problems in the past month. The correct coding in this case would be "Yes" under lifetime and "N" under past 30 days.

An “X" code should be used for any situation where the client simply can't recall or is not sure for any reason. In general, it is far better to use an ""X", than to record possibly inaccurate information.

9A LASTING PERSONAL RELATIONSHIP: Item 9A assesses the extent to which the client has a history of being able to establish and maintain close, warm, and mutually supportive relationships with any of the people listed.

IMPORTANT: A simple "Yes" response is not adequate for these questions and some probing will be needed to specifically determine whether the ability to feet closeness and mutual responsibility in the relationship exists. Does the client feet a sense of value for the person (beyond simple self benefit)? Is the client willing to work on retaining/maintaining these relationships?

10-18 RELATIONSHIP PROBLEMS: These items refer to serious problems of sufficient duration and intensity to jeopardize the relationship. These problems include extremely poor communication, complete lack of trust or understanding, animosity, or chronic arguments. if the client has not been in contact with the person in the past 30 days it should be recorded as "N". As indicated above, "N" should also be entered in categories that are not applicable, e.g., in the case of a client with no siblings.

NOTE: Item 13 may include any regular, important sexual relationship.

IMPORTANT: Understand that the "Past 30 Days" and the "Lifetime" intervals in Items 10 to 18c are designed to be considered separately. The past 30 days will provide information on recent problems, while lifetime will indicate problems or a history of problems prior to the past 30 days.

18A-18C ABUSE: These items have been added to assess what may be important aspects of the early home life for these clients (lifetime answers) and to assess dangers in the recent and possibly future environments (past 30 days answers). in general, the instructions for these questions are similar to the other questions in this section. (See specific notes above and below). Again, it will be important to address these questions in a supportive manner, stressing the confidentiality of the information and the opportunities for the client to talk about this in subsequent treatment sessions with an appropriate provider.

EMOTIONAL ABUSE: Emotional abuse will generally be coded entirely on the basis of what the client reports and it is understood that it will be difficult to judge whether the "actual" abuse reported (or lack of it) would be considered abuse to another person. No attempt should be made to do this, since the intention here is to record the client's judgement.

PHYSICAL ABUSE: Physical abuse should follow the same general guidelines as emotional abuse with one caution, simple spankings or other punishments should not be counted as abuse, unless they were (in the eyes of the client) extreme and unnecessary.

SEXUAL ABUSE: Sexual abuse is not confined to intercourse, but should be counted if the client reports any type of unwanted advances of a sexual nature by a member of either sex.

19 DAYS EXPERIENCING CONFLICTS/ARGUMENTS: **Conflicts require personal (or at least telephone) contact.** Stress that you mean serious conflicts (e.g., serious arguments; verbal abuse, etc.), not simply routine differences of opinion. These conflicts should be to such extent that they jeopardize the client's relationship with the person involved.

20-23 PATIENT RATINGS: These refer to any dissatisfaction, conflicts, or other relationship problems reported in the Family/Social section.

Do include the client's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends.

Do not include problems that would be eliminated if the client's abuse problems were absent.

For Item 22, be sure that the client is aware that he/she is not rating whether or not his/her family would agree to participate, but how badly he/she needs counselling for family problems in whatever form.

**PSYCHIATRIC STATUS**

1 TREATMENTS: This includes any type of treatment for any type of psychiatric problem. This does not include substance abuse, employment, or family counselling. The unit of measure is a treatment episode (usually a series of more or less continuous visits or treatment days), not the number of visits or days in treatment.
If the client is aware of his/her diagnosis enter this in the "Comments" section.

2 PENSION: Pensions for physical problems of the nervous system (e.g., epilepsy, etc.) should be counted under Item 9 in the "Medical" Section, not here.

3-10 PSYCHIATRIC SYMPTOMS: These lifetime items are concerned with serious psychiatric symptoms over a significant period of time (at least two weeks). Therefore, the items concerning depression, anxiety and concentration (items 3, 4, and 5) are addressing significant periods of disturbance, not simply a day. The other symptoms (Items 6, 7, 9, and 10) are of sufficient importance that even their brief existence warrants inclusion.

Except for Items 7, 9, and 10: Make sure the client understands that these periods refer only to times when he/she was not under the direct influence of alcohol. drugs, or withdrawal. This means that the behaviour or mood is not due to a state of drug or alcohol intoxication, or to withdrawal effects. Our experience shows that the client will almost always be able to differentiate a sustained period of emotional problems from a drug or alcohol induced effect. Therefore, in situations where doubts exist, the client should be asked directly about his/her perception of the symptoms or problems.

IMPORTANT: The seriousness of Items 7, 9, and 10 warrant inclusion even if they were caused by or associated with alcohol or drug use. Reports of recent suicide thoughts or attempts should be brought to the attention of the supervisor from the treatment staff as soon as possible, even if this violates normal confidentiality guidelines.

IMPORTANT: Understand that the "Lifetime" and the "Past 30 Days" intervals are designed to be considered separately. The past 30 days will provide information on recent problems, while lifetime will indicate problems or a history of problems prior to the past 30 days.

3 DEPRESSION: Suggested by sadness, hopelessness, significant loss of interest, listlessness, difficulty with functioning daily, guilt, uncontrollable crying, etc

4 ANXIETY: Suggested by tension, feeling uptight, unable to feel relaxed, unreasonably worried, etc

5 COGNITIVE PROBLEMS: Suggested by serious trouble in concentrating, remembering and/or understanding, restricted to times when client was drug free and not suffering from withdrawal.

6 HALLUCINATIONS: Seeing things or hearing voices that were not there. Restricted to times when client was drug free and not suffering from withdrawal.

7 DIFFICULTY CONTROLLING: Or losing control. Rage, or violence. NOT Restricted to times when client was drug free and not suffering from withdrawal.

8 MEDICATION: Medication prescribed by a physician for a psychiatric or emotional problem.
Record "Yes" if the medication was prescribed, even if it was not taken by the client.

9 SUICIDE THOUGHTS: Times when client seriously contemplated taking his/her life. NOT Restricted to times when client was drug free and not suffering from **withdrawal.**

10 SUICIDE ATTEMPTS: Include discrete suicidal gestures or attempts. NOT Restricted to times when client was drug free and not suffering from withdrawal. Also, include if suicide was attempted by drug overdosing.

IMPORTANT: Ask the client if he / she has recently considered suicide. If the answer is "Yes" to this question, and/or the client gives the distinct impression of being depressed to the point where suicide may become a possibility, notify a member of the treatment staff as soon as possible.

10A NUMBER OF SUICIDE ATTEMPTS: See Item 10.

11 DAYS EXPERIENCING PROBLEMS: This refers to those problems listed in Items 3 through 10.

12 & 13 PATIENT RATINGS: Referring to item 11, have the client rate the severity of those problems in the past 30 days.

IMPORTANT: Be sure that the client understands that you do not necessarily mean transfer to a psychiatric ward, or psychotropic medication.

If no psychiatric or emotional problems have been mentioned in Item 11, ask a confirmatory question and code "not at all" - "0" for Item 12. For Item 13, emphasize that you mean additional counselling or treatment for those problems specified in Item 11. If psychiatric or emotional problems have been reported that are addressed adequately, again ask a confirmatory question and code a low score ("not at all").

14- 19 PATIENT SYMPTOMS: These are ratings by the interviewer based on his/her observations of the client. The interviewer should use his/her judgement based upon the client's behaviour and answers during the interview. Do not over interpret; only count the presence of overt symptoms in these categories. (See above for description).

## APPENDICES

1. EUROPASI INTRODUCTION
2. CRITICAL OBJECTIVE ITEMS
3. INSTRUCTIONS FOR USING "N" ON THE EUROPASI
4. OCCUPATIONAL CATEGORIES
5. LIST OF COMMONLY USED SUBSTANCES
6. ITEMS FOR CROSS-CHECKING THE EUROPASI
7. EUROPASI FOLLOW-UP INTERVIEW INSTRUCTIONS

## APPENDIX 1. EUROPASI INTRODUCTION

Points to include when introducing the EUROPASI:

- All clients get the same interview.
- All information gathered is confidential and will be used only by the treatment or research staff.
- The interview consists of seven parts, i.e., medical, legal, drugs, alcohol, etc..
- There are two time periods expressed, the past 30 days and lifetime data.
- Client input is important. For each area I will ask you to use a scale to let me know how bothered you have been by any problems in each section. Also, I will ask you how important treatment is for you in the area being discussed.

  The scale is:

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| not at all | slightly | moderately | considerably | extremely |

- If you are not comfortable giving an answer, simply decline to answer. Please do not give inaccurate information!

The interviewer should mention each of these points.

The most important considerations are that the client understands the purpose of the interview and that it is confidential.

IMPORTANT NOTE: Inform the client of any follow-up interviews that will occur at a later date.

## APPENDIX 2. CRITICAL OBJECTIVE ITEMS

**Medical Status**

1 Hospitalizations ever

3 Chronic medical problems

**Employment/Support Status**

1, 2, 3 Years of education and highest degree obtained

5 Longest period of regular employment

8 Usual employment pattern

**Drug/Alcohol Use**

1-13 History of use

1 5A, 1 5B Alcohol d.t.'s, drug overdoses

16 Treatment received

19, 20 Voluntary abstinence

**Legal Status**

3-6 Charges

7 Convictions

15, 16 Present charges

18 Present engagement in illegal activities

**Family/Social Relationships**

2, 3 Stability/satisfaction marital status

5, 6 Stability/satisfaction living arrangements

8 Satisfaction free time

10- 18 column: In your life

Serious problems ever

19A, 19B Serious conflicts

**Psychiatric Status**

1A Hospitalizations ever

3-10 Symptoms ever and symptoms past 30 days

## APPENDIX 3. INSTRUCTIONS FOR USING "N" ON THE EUROPASI

### General

If there are several boxes for an answer to a question, code "N" only in the first box. Do **not use "N" for the client's** rating scale and the interviewer severity rating. The only exception to this rule is the Employment/Support section, see the instruction below concerning question 21-23 of this section.

If a client reports that he/she has not had any problems in the past 30 days in a certain area (that means, "00" days problems), the two following questions (being troubled by these problems and the importance of treatment for these problems) should also be coded "0". However, if the client changes his/her mind, and says at this point he/she is troubled in this area and/or has a need for treatment, the question about number of days with problems should be asked again.

### Question A - K (left column, front page)

Question K: Code "N" if the interview is completed.

### General information

Q. 8-9: If q. 8 is coded "1 ", code "N" for q. 9.

### Medical status

Q. 1-2: If q. 1 is coded "00", code "N" for q. 2.

Q. 5-7: If q. 5 is coded "0", code "N" for q. 6 en q. 7.

### Employment/Support status

Q. 7: If the client has never worked, code "N" for q. 7.

Q. 9: If q. 9 is coded "00", or if the client is self-employed with no employees or co-workers, than Q. 18 in the Family/Social section should be coded "N" in the "Past 30 days" column.

Q. 21-23: If the client was unable to work in the past 30 days because he/she was in prison or in another type of controlled environment, by definition he/she cannot have problems with work in q. 21. In these cases code "N" for q. 21, 22 and 23. As this means that the client's rating is absent, the interviewer will have to make the severity rating based on the objective items only!

### Drug/Alcohol use

0. 01-13: If the client has never used a certain drug, or has never used a certain drug according to the criteria as specified in the manual, "N" should be coded in the first box of age of first use.

0. 14-14A-14B: If q. 14 is coded "0", than for q. 14A "N" should be put in the first box of that line and q. 14B should also be coded "N".

0. 16-17: If q. 16.1-16.9 are all coded "0" (meaning that the client has never been treated previously for alcohol and/or drug problems), code "N" in the first box for alcohol and "n" in the first box for drugs of q. 17.

18-20: If q. 18 is coded "00" code "N" for q. 19 and q. 20.
If q. 19 is coded "00", code "N" for q. 20.

### Legal status

Q. 12-14: If q. 12 is coded "00", both q. 13 and 1. 14 should be coded "N".

Q. 15-16: If q. 15 is coded "00", code q. 16 "N".

### Family history and Family/Social relationships

"N" may only be used in the family history section and in q. 9A- 18 of the family/social section.

Family history: See instructions in the EuropASI questionnaire and in this manual.

Q. 9A- 18: It is important to verify whether the client had an opportunity to have a relationship with the person/people referred to in each item. As a rule, if there was not an opportunity to experience

the relationship in question (e.g. if someone in a particular category is deceased or if there has been no contact), then an "N" is coded. If the client reports that there has never been a relationship in a particular category (like no children, never any friends, never a relationship with father, etc.) then "N" should be coded in both the "Past 30 days" and the "Lifetime" boxes.

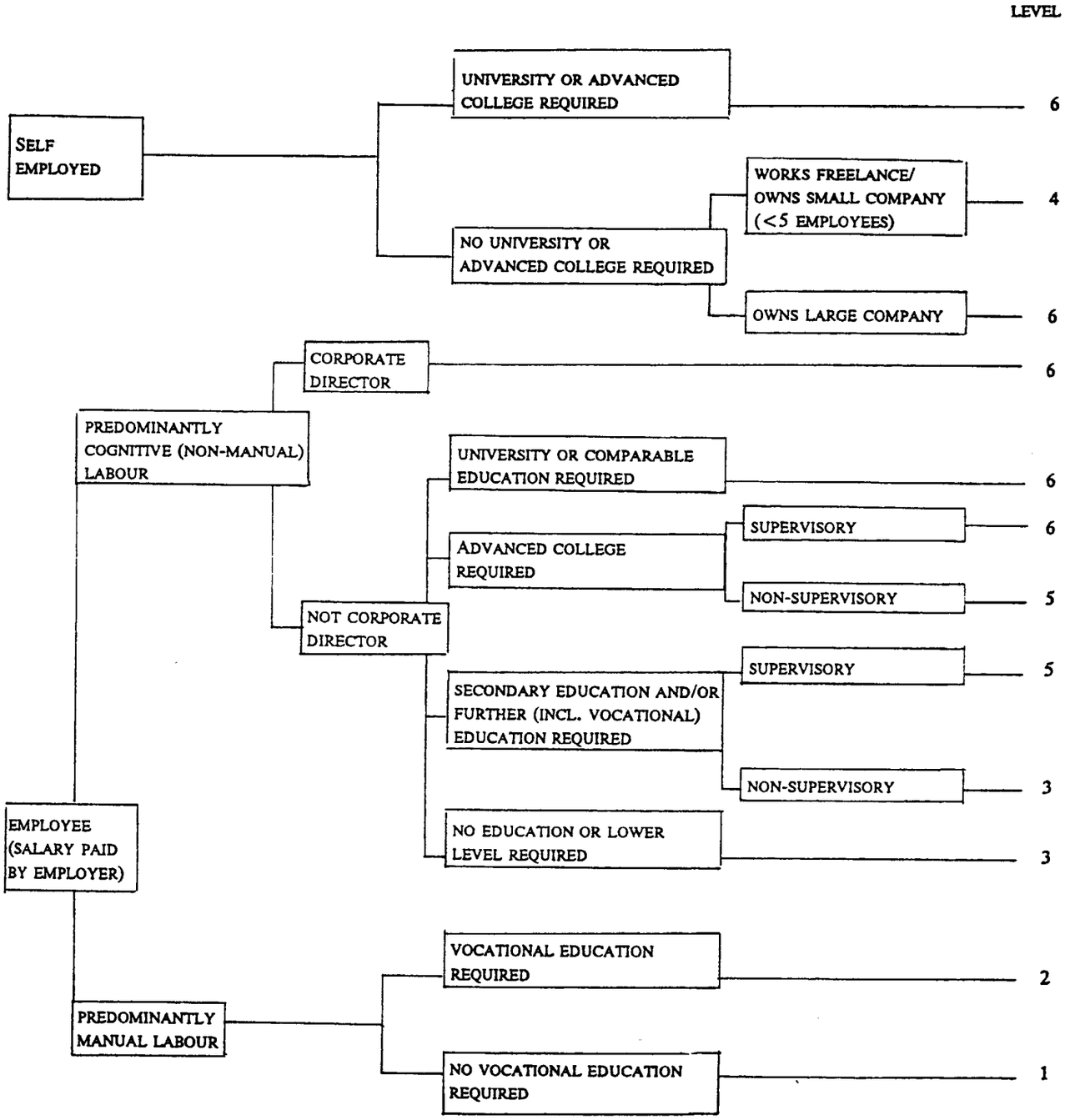
Q. 9: If q. 9 is coded "0", then the "Past 30 days" column of q. 16 should be coded "N". In such cases, the interviewer should inquire further to see whether there have ever been any close friends to determine if an "N" is also to be coded under "Lifetime" in q. 16.

Q. 18: If q. 9 of the Employment/support section is coded "00", or if the client is self employed with no employees or co-workers, than q. 18 in the Family/social section should be coded "N" in the "Past 30 days" column.

**Psychiatric status**

In this section no questions should be coded "N".

## APPENDIX 4. OCCUPATIONAL CATEGORIES




1 = UNSKILLED LABOUR
2 = SKILLED LABOUR
3 = LOW-LEVEL EMPLOYEES
4 = SMALL ENTREPRENEURS
5 = MID-LEVEL EMPLOYEES
6 = PROFESSIONALS

**APPENDIX 5. LIST OF COMMONLY USED SUBSTANCES.**

• ALCOHOL See Manual for definition

• HEROIN Brown sugar, horse, smack, other

• METHADONE Methadone, Dolophine, LAAM (l-alpha-acethylmethadone)

• OTHER OPIATES/ ANALGESICS (PAIN KILLERS): Buprenorphine, Codeine (Tylenol 2, 3, 4), Demerol, Dextropropoxyphene, Dia-Quel, Darvocet, Darvon, Dilaudid
Fentanyl, Lefetamine, Meperidine (Pethidine), Morphine, Nalbufine
Opium, Pantapon, Pentazocine, Percocet, Percodan,
(Robitussin, Actifed-C), Taiwin, Viminole, Others

• MEDICINE/PILLS **Barbiturates**: Amobarbital, Cyclobarbital, Pentobarbital,
barbital, Secobarbital, others
**Benzodiazepines**: Alprazolam, Bromazepam, Brotizolam, Chlordia-zepoxide, Clonazepam, Diazepam, Flunitrazepam, Flurazepam, Ketazolam, Lorazepam, Lormetezapam, Nitrazepam, Oxazepam, Triazolam, Temazepam, others
**Other Sedatives**: Chloral hydrate, Ethylchlorvynol, Meprobamate, others

• COCAINE Cocaine crystal, free-base cocaine, *crack, rock cocaine,* others.

• AMPHETAMINES Amphetamine, Benzedrine, Dexedrine, Dextroamphetamine
amphetamine, Methylphenidate, Phendimetrazine, others
Monster, Crank, Ritalin, Preludin, Speed, Ice *(Crystal)*

• CANNABIS Marijuana, Hashish, other

• HALLUCINOGENS Lysergic Acid Diethylamide (LSD, Acid), Mescaline, Phencyclidine
(PCP), Psilocybin *(Mushrooms),* Peyote, Green, Angel Dust, others.

• INHALANTS Amyl Nitrate (Whippets, Poppers), Ethyl ether, Nitrous Oxide
others; Glue and Solvents

• OTHER Methylenedioxy(m)ethamphetamine (MDMA, MDE(A); *ecstasy)*
Antidepressants: Arnineptine, Desipramine, Sinequan, others.
Antipsychotic drugs: Promazine, others

NOTE: Some non-psychoactive drugs may also be subjected to non-prescribed use by some clients.
These have to be registered in the "Comments Section". If prescribed for specific medical diseases
refer to the "Medical Status" section. Examples: Diuretics (e.g., furosemide), sympatholytics (e.g., clonidine), laxatives (e.g., anthraquinones), anticonvulsants (e.g., phenytoin), anti-inflammatoires (e.g., ibuprofen, paracetamol), antacids (e.g., ranitidine).

NOTE: Commercial brands sometimes include a mixture of psychoactive and non-psychoactive drugs
(e.g., anti-inflammatory drugs and barbiturates for headache, or antimuscarinnics and benzodiazepines for abdominal pain). In case of non-prescribed use of such mixtures, please code the Item of the proper psychoactive drug and note in the "Comments Section" the type of brand.

## APPENDIX 6. ITEMS FOR CROSS-CHECKING THE EUROPASI

1. Page 1, item 8; if the client tells you that he/she has been in a controlled environment in the last 30 days, make sure this information is reflected in the appropriate area of the ASI (e.g., if the client was in jail, this would be reflected under the Legal section; if in the hospital - under the medical section, etc).

2. Medical section (item 8); if the client tells you that he/she is taking prescribed medication, check to see that you have noted this medication under the Drug/Alcohol section. Also add the medication under the grid, where appropriate.

3. Medical section (item 9); if the client tells you in the that he/she gets a pension, check to make sure you have noted this under the Employment/Support section (item #13).

4. Drug/Alcohol section (item 15); sometimes clients will inform you of an O.D. that required hospitalization, which they forgot to tell you about under the Medical section. Go back and clarify items 1 and 2 under the Medical section.

5. Legal section (item 18); if the client admits to engaging in illegal activities for profit, check the Employment/Support section (item #15).

6. Family/Social Relationship section (item 4); sometimes a client will admit to currently living with someone. However he/she may not have informed you of this under the Employment/Support section. Some questions you may want to ask are: "Does this person work?", "Does this person help out with the bills?", pertaining to the Employment/Support section (items 14 and 18). If the client gives you his current living arrangements under Family/Social Relationship section (item 4), check to make sure the information correlates with item 3 on page 1.

7. Psychiatric section (item 2); if the client tells you of a psychiatric pension in the, check the Employment/Support section (item 13).

8. Check the client's age, against the number of years he/she has been using, as defined in the manual, drugs and alcohol and with the number of years he/she has been imprisoned. Compare the total years of substance use reported (Drug/Alcohol section, items 1 - 13) and the total number of years of incarceration (Legal section, item 12) to see if the client is old enough to have used the substances as long as was reported. If this seems unlikely, you may also want to ask: "Did you use drugs/alcohol (as defined in the manual) while you were imprisoned?"

CHECK TO SEE IF THE WHOLE INTERVIEW MAKES SENSE.

## APPENDIX 7. EUROPASI FOLLOW-UP INTERVIEW INSTRUCTIONS

These differ from initial evaluations in a number of ways:

- Only a subset of items are applicable and therefore used.
- Follow-up interviews are briefer.
- It is possible to get good information doing follow-ups over the phone.
- Interviewer Rating Scales can also be used in follow-up. It is not possible, however, to compare follow-up Interviewer Severity Ratings with initial (intake) Interviewer Severity Ratings.
- The items in the box below are used in follow-up interview.
- Items with an asterisk (*) should be rephrased to record cumulative data since the time of the last interview. Depending on the purpose of the follow-up interview, the interviewer should specify:
    - *since the last interview,*
    - *since you left treatment,*
    - *since date.*

It is recommended to use a separate follow-up form, containing only the (rephrased) follow-up questions.

### EUROPASI ITEMS TO BE ASKED (AND REPHRASED) AT FOLLOW-UP

FIRST PAGE, LEFT COLUMN: A, D, G, H, J, K.

GENERAL INFORMATION: 8, 9.

MEDICAL STATUS: 1*, 4*, 5*, 6-16.

EMPLOYMENT / SUPPORT STATUS: 1*, 2*, 3, 4, 7*, 8*, 9-26.

DRUG / ALCOHOL USE: 01-13: only “past 30 days” and “route of administration”, 14*, 14A*: only “6 months” and “past 30 days”, “6 months” should be rephrased, “past 30 days” remains as it is, 14B*, 15*, 16*, 17, 18, 21-28.

LEGAL STATUS: 2, 3-7*, 8-12*, 15-23.

FAMILY / SOCIAL RELATIONSHIPS: 1, 3, 4*, 6-9, 10-18: only “past 30 days”, 10A*, 11-22.

### HOW TO ACHIEVE HIGH FOLLOW-UP RATES:

- Inform client at initial interview, that follow-up evaluation will be conducted x-months later.
- Get names, addresses and phone numbers of more than one family member and/or friends. Be sure that they are different addresses and numbers. Check these numbers and addresses immediately, while the client is in treatment.
- Get information about other people the client is involved with, like Probation Officer, other Treatment Agencies, etc..
- Insure confidentiality - a non-revealing telephone number for the client to call when you leave messages for the client.
- Insure client confidentiality - let client know that the references will not be questioned concerning client's status, but would only be used in locating the client. Have a story handy to explain to curious relatives the reason for calling the client.
- Keep detailed records of all follow-up attempts including times attempted and the results. This helps to reduce overlap of attempts and aids in spreading out efforts.
- Can also mail a non-revealing but personalized letter stating times a client can call you, or for him/her to send back information when you can contact him/her.

BE SURE THAT PEOPLE WHO DO FOLLOW-UPS ARE NOT INVOLVED IN CLIENT'S TREATMENT.