



Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Increasing Cultural Sensitivity Of the Addiction Severity Index (ASI) An Example With Native Americans in North Dakota

SPECIAL REPORT



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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An Example With Native Americans in North Dakota

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This publication was prepared under contract no. 270-95-0016 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Gayle Saunders of CSAT served as the Government project officer. Additional support was received under training grant T-32-DA07241-04 from the National Institute on Drug Abuse (NIDA) and from the University of Pennsylvania/Veterans Administration Center for Studies of Addiction. Shandy R. Campbell of Johnson, Bassin & Shaw, Inc., which provided publication development services, served as the firm's project manager.

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The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of CSAT or any other part of the U.S. Department of Health and Human Services (DHHS).

Printed 1999

Acknowledgments

The authors wish to thank the clients at the North Dakota State Hospital for their participation in and support of this project. The following individuals participated in the data collection effort and in the conceptual development of this Special Report: Jerald Harmon, C.A.C.; Hal Krause, M.P.A., formerly with the Center for Substance Abuse Treatment; John Allen, Don Wright, and Tom Wirtz, North Dakota Division of Mental Health and Substance Abuse Services; Kerry Wicks and John Crowston, North Dakota State Hospital; and Mary Louise Defender Wilson, Dakota-Hidatsa Tribal Elder, who at the time of this study was the Director of the Native American Cultural Center at the North Dakota State Hospital in Bismark.

This Special Report includes materials adapted from earlier materials, including an unpublished document, the “Addiction Severity Index (ASI) Instruction Manual,” developed at the University of Pennsylvania/Philadelphia Veterans Administration Medical Center, Center for Studies of Addiction, under National Institute on Drug Abuse (NIDA) Grant No. P50-0A07705. Contributors to these materials were Alicia Bragg, John Cacciola, Barbara Fureman, Ian Fureman, Leslie Goehl, Ray Incmikoski, A. Thomas McLellan, Gargi Parikh, and David Zanis.

The *Instruction Manual* was later replaced by the *ASI User’s Guide*, which was developed by Ian Fureman. The *ASI User’s Guide* incorporated whole sections of the original manual. The *ASI Revised User’s Guide* in this volume, which is specific to the Native American Version developed for use with Native American clients in North Dakota, draws on this material as its base.

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A Note to the Reader

This document utilizes the most recent version of the Addiction Severity Index (fifth edition), developed by A. Thomas McLellan and colleagues at the University of Pennsylvania/Veterans Administration Center for Studies of Addiction. All of the instruments and the *Revised User's Guide* included in this document are in the public domain and may be reproduced or copied without permission from the authors.

Electronic, disk, or paper copies of the various versions of the Addiction Severity Instrument and corresponding materials may also be obtained from the Treatment Research Institute at the University of Pennsylvania via the ASI help line telephone 800-238-2433. These materials will be provided for the cost of shipping and handling.

The following additional materials are available through the ASI help line. An asterisk designates information available electronically or on disk.

*ASI Checker's Manual

*Short Reference Guide to the ASI

*ASI Common Questions and Errors

*ASI Follow-up Procedures

*ASI Composite Score Manual

ASI Instrument, Hispanic Version (for generic use in the United States)

ASI Biopsychosocial/Accreditation Instrument

Treatment Services Review (TSR) Instrument, User's Guide, and Q by Q [Question-by-Question]

Treatment Services Review (TSR) Instrument, Spanish Version (for generic use in the United States)

Risk for AIDS Behavior Questionnaire (RAB)

Risk for AIDS Behavior Questionnaire (RAB), Hispanic Version (for generic use in the United States)

Articles:

An improved diagnostic evaluation instrument for substance abuse patients, *Journal of Nervous and Mental Disease*, 1980

New data from the Addiction Severity Index: Reliability and validity in three centers, *Journal of Nervous and Mental Disease*, 1985

The Fifth Edition of the Addiction Severity Index, *Journal of Substance Abuse Treatment*, 1992

A new measure of substance abuse treatment: Initial studies of the Treatment Services Review, *Journal of Nervous and Mental Disease*, 1992

Private substance abuse treatments: Are some programs more effective than others? *Journal of Substance Abuse Treatment*, 1993

Training for and maintaining interviewer consistency with the ASI, *Journal of Substance Abuse Treatment*, 1994

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Foreword

This volume represents an important step in recognizing the worth of assessing the user of substances in a cultural context while at the same time collecting the standardized data that is so important for consistency of records, assessment purposes, outcome measures, research, and accreditation. The impetus for a modified instrument began when substance abuse treatment directors at the North Dakota State Hospital realized that traditional assessment instruments did not adequately address cultural differences, background, and spiritual and ceremonial practices of Native Americans in their State. The goal was to modify the Addiction Severity Index (ASI), a versatile instrument that has proven validity and reliability for outcome measures, with the addition of adaptations that would make the instrument a more precise measure of the problems and treatment needs of this population. The authors of this publication are experts on the Addiction Severity Index; indeed, the ASI was developed by one of the authors of this Special Report, A. Thomas McLellan, and his colleagues.

The Addiction Severity Index–North Dakota State Adaptation for Use With Native Americans (ASI-ND/NAV) is the instrument that was developed in response to the needs expressed by the treatment providers in North Dakota. This instrument is printed in this volume in chapter 4, along with an accompanying *Revised User’s Guide* that gives instructions to the person who is administering the ASI. (Of course, training is a prerequisite for administering the ASI.)

It is the expectation of the Center for Substance Abuse Treatment (CSAT) that the publication of this instrument will give rise to a great deal of discussion in the treatment field about adapting the ASI to Native American populations outside North Dakota. The authors include suggestions for further development of a Native American Version of the ASI. CSAT especially welcomes discussion that furthers appropriate cultural assessment of Native Americans. The publication of this document comes at an opportune time, with interest in increasing cultural competency at a high point, balanced by the recognition that both Native American clients and traditional counselors need encouragement in accepting the assessment process.

The Addiction Severity Index is widely used in substance abuse treatment programs throughout the country. CSAT is especially pleased that this Special Report contains the most recent version of the Addiction Severity Index in three different formats, as well as a Revised User’s Guide for the ASI-ND/NAV, and encourages the reader to freely copy these instruments and the *Guide*.

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Center for Substance Abuse Treatment

Preface

Mainstream instruments currently used to assess drug and alcohol problems often lack the cultural sensitivity to address the needs of patients from varying backgrounds and cultural or ethnic groups. The universal instruments now available do not take into consideration the unique cultural differences, background, and religious practices of specific populations. This difficulty is compounded when systems (such as treatment systems, accrediting systems, and State systems) require that providers use a specific (usually traditional) assessment instrument with all clients who present for care.

Substance abuse treatment providers have long recognized that the field needs an assessment instrument that can collect information specific to the individual client's culture, gender, and ethnicity. Such an instrument must be capable of providing standardized, comparative information. It must have proven validity and reliability and be useful for conducting assessments and measuring outcomes.

Programs treating Native American clients with substance abuse problems offer a specific example of this problem. These programs need an assessment instrument that can meet requirements for both general administrative and outcome information. This instrument must also be capable of addressing specific cultural issues and thus enable treatment care planning to be more effective with these populations. To overcome this problem, North Dakota substance abuse and mental health directors worked with the first author to develop a clinically and culturally relevant instrument for use with Native Americans—predominantly of Chippewa and Sioux heritage—seeking substance abuse treatment within their system. The goal was to adapt an existing assessment instrument that was reliable (and State-mandated), and to make it a more precise measure of the problems and treatment needs of those Native Americans presenting for treatment. This new instrument is modified from the Addiction Severity Index (ASI), already required for use in North Dakota for assessment and outcome purposes.

It must be emphasized that this specific adaptation of the ASI was developed for North Dakota, particularly Chippewa and Sioux Indians. Because Native American tribes demonstrate substantial differences among their substance use problems and treatment needs, we are not suggesting that this modified instrument will meet the needs of all Nations. Instead, this Special Report describes the *procedures* by which we adapted the ASI in an effort to meet the specific needs of the North Dakota treatment providers. Our hope is that other groups may be able to use similar methods to meet their own specific needs for clinical information.

Treatment providers in North Dakota who participated in this effort displayed a sincere commitment to offering services that are sensitive to unique cultural differences and varying ethnic backgrounds. The authors invite all readers to collaborate in the continued improvement of the instrument that resulted from this study, by sharing their comments, suggestions, and expertise.

Part I

Chapter 1—A Brief Description of the ASI

Chapter 2—Developing a Version of the ASI, Fifth Edition, for Native Americans in North Dakota

Chapter 3—Further Development of An ASI for Native Americans

Chapter 1—A Brief Description of the ASI

The Addiction Severity Index (ASI), used throughout the United States and in numerous other countries, is the most widely used assessment tool in the addictions field. It is a semi-structured assessment instrument designed for use with clients who present for substance abuse treatment. The ASI was developed in 1980 by A. Thomas McLellan, Ph.D., and colleagues at the University of Pennsylvania (McLellan et al. 1980). The ASI gathers information in seven important areas of a patient's life: medical, employment/support, drug and alcohol use, legal, family history, family/social relationships, and psychological problems. An eighth area, spiritual and ceremonial practices, has been added to the ASI adapted for North Dakota State, which was designed with consideration for Native American cultural and ceremonial practices.

Numerous published studies have shown the ASI to be both reliable and valid, but this applies only with "majority" populations (McLellan et al. 1985). The National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institute of Mental Health (NIMH), and National Institute of Justice (NIJ) have all encouraged use of the ASI for both clinical and research purposes.

The ASI was originally created to enable a group of clinical researchers to evaluate treatment outcomes in six substance abuse treatment programs in the Philadelphia area. Because these program modalities and treatment services varied, this original ASI had to be generic. Also, there was a need to collect the data as part of the clinical process and within a relatively short period of time. For this reason, the instrument had to focus on a minimum number of questions relevant to treatment care planning. Finally, since a major purpose of the original project was to measure outcome, the questions had to cover a broad range of potential areas that could be affected by substance abuse treatment. The format of these questions had to be suitable for repeat administration at followup contacts (McLellan et al. 1980).

The ASI is treatment oriented. It helps the interviewer to build rapport with clients as the interviewer gathers information, and allows interviewers use their own interviewing style. Interviews take about an hour to administer and result in a client profile indicating areas in which more information is needed or that need to be addressed in treatment.

When the ASI is used as an assessment tool, it not only assesses drug and alcohol abuse, it also screens for problems in other areas. The ASI is an effective tool for identifying clients with mental illness coexisting with substance abuse. On a 10-point scale from 0 to 9, interviewer severity ratings indicate the extent of a client's problems in seven areas (eight areas for the ASI-North Dakota State Native American Version). These severity ratings emphasize a client's unmet need for treatment. The person who administers the ASI has the option of developing a Severity Profile, which can be used to flag clients' specific problem areas. A high severity rating indicates that the client needs additional treatment or intervention.

Interviewer severity ratings, which are adjusted slightly to take into account the client's own rating of the problem's severity, are based on the following scale:

- 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

COMPOSITE SCORES

Composite scores were developed for measuring treatment outcomes. Because composite scores were developed as indicators of change, they take into account only questions that pertain to the previous 30 days. They use mathematical formulas to equally weight clients' responses to intercorrelated questions within each section. Composite scores are computed in each of the seven ASI problem areas (medical, employment/support, drug use, alcohol use, legal, family/social, and psychiatric).

DIFFERENT VERSIONS OF THE ADDICTION SEVERITY INDEX

This volume contains three versions of the Addiction Severity Index. The first version is the basic Addiction Severity Index, fifth edition, also referred to as the "Research Version." This is a reference to the fifth edition ASI in its original format, as devised by the clinical researchers. This basic instrument is shown on the following pages.

A second version of the ASI, the Clinical/Training Version contained in chapter 7, has the same content as the Research Version. However, the formatting of the Clinical/Training Version instrument is generally considered to be more friendly to clinicians, because it has instructions, hints, and space for comments included on the instrument. A third version of the ASI, the North Dakota State Adaptation for Use With Native Americans (ASI-ND/NAV), is found in chapter 5. This instrument is similar in format to the Clinical/Training Version.

INSTRUCTIONS

1. Leave No Blanks—Where appropriate code:

X=question not answered
N=question not applicable

Use only one character per item.
2. Space is provided after each section for additional comments.

**ADDICTION SEVERITY INDEX
SEVERITY RATINGS**

The severity ratings are interviewer estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment definitely needed, possibly life-threatening situation). Each rating is based on the patient's history of problem symptoms, present condition, and subjective assessment of his or her treatment needs in a given area. For a detailed description of severity ratings' derivation procedures and conventions, see manual.
Note: Severity ratings are optional.

Fifth Edition
Reformatted and renumbered 1999

**SUMMARY OF PATIENT'S
RATING SCALE**

- 0—Not at all
- 1—Slightly
- 2—Moderately
- 3—Considerably
- 4—Extremely

GENERAL INFORMATION

G1. I.D. NUMBER

G2. LAST 4 DIGITS OF SSN

G4. DATE OF ADMISSION
//

G5. DATE OF INTERVIEW
//

G6. TIME BEGUN :

G7. TIME ENDED :

G8. CLASS:
1—Intake
2—Follow-up

G9. CONTACT CODE:
1—In person
2—Phone

G10. GENDER:
1—Male
2—Female

G11. INTERVIEWER CODE NUMBER/INITIALS:

G12. SPECIAL:
1—Patient terminated
2—Patient refused
3—Patient unable to respond
N—Not applicable

NAME _____

CURRENT ADDRESS _____

G14. How long have you lived at this address?
Years Months

G15. Is this residence owned by you or your family? 0—No 1—Yes

G16. DATE OF BIRTH
//

G17. RACE
1—White (not of Hispanic origin)
2—Black (not of Hispanic origin)
3—American Indian
4—Alaskan Native
5—Asian or Pacific Islander
6—Hispanic—Mexican
7—Hispanic—Puerto Rican
8—Hispanic—Cuban
9—Other Hispanic

G18. RELIGIOUS PREFERENCE
1—Protestant
2—Catholic
3—Jewish
4—Islamic
5—Other
6—None

G19. Have you been in a controlled environment in the past 30 days?
1—No
2—Jail
3—Alcohol or Drug Treatment
4—Medical Treatment
5—Psychiatric Treatment
6—Other

G20. How many days?

ADDITIONAL TEST RESULTS

G21.

G22.

G23.

G24.

G25.

G26.

G27.

G28.

SEVERITY PROFILE

9								
8								
7								
6								
5								
4								
3								
2								
1								
0								
PROBLEMS	MEDICAL	EMP/SUP	ALCOHOL	DRUGS	LEGAL	FAM/SOC	PSYCH	

MEDICAL STATUS

- M1. How many times in your lifetime have you been hospitalized for medical problems? (Include ODs, DTs, exclude detox.) M11. How long has your physical disability been open for a physical disability? (Exclude psychiatric disability.) 0-No 1-Yes
- M2. How long ago was your last hospitalization for a physical problem? Years Months M12. How many days have you experienced medical problems in the past 30 days?
- M3. Do you have any chronic medical problems that continue to interfere with your life? 0-No 1-Yes *FOR QUESTIONS M7 & M8, PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE*
- M4. Are you taking any prescribed medication on a regular basis for a physical problem? 0-No 1-Yes M7. How troubled or bothered have you been by these medical problems in the past 30 days?
- M8. How important to you now is treatment for these medical problems? M9. How would you rate the patient's need for medical treatment?
- INTERVIEWER SEVERITY RATING**
- CONFIDENCE RATINGS**
- Is the above information significantly distorted by:
- M10. Patient's misrepresentation 0-No 1-Yes
- M11. Patient's inability to understand 0-No 1-Yes
- COMMENTS**

EMPLOYMENT/SUPPORT STATUS

- E1. Education completed Years Months E10. Usual employment pattern, past 3 years.
- E2. Training or technical education completed Months 1-Full time (40 hours/week)
2-Part time (regular hours)
3-Part time (irregular hours)
4-Student
5-Service/military
6-Retired/disability
7-Unemployed
8-In controlled environment
- E3. Do you have a profession, trade, or skill? 0-No 1-Yes E11. How many days were you paid for working in the past 30 days?
- E4. Do you have a valid driver's license? 0-No 1-Yes How much money did you receive from the following sources in the past 30 days?
- E5. Do you have an automobile available for use? (Answer No if no valid driver's license.) 0-No 1-Yes E12. Employment (net income)
- E6. How long was your longest full-time job? Years Months E13. Unemployment compensation
- E7. Usual (or last) occupation? E14. Welfare
- E8. Does someone contribute to your support in any way? 0-No 1-Yes E15. Pension, benefits, or Social Security
- E9. (ONLY IF ITEM E8 IS YES) Does this constitute the majority of your support? 0-No 1-Yes E16. Mate, family, or friends (money for personal expenses)
- E17. Illegal
- E18. How many people depend on you for the majority of their food, shelter, etc? E20. How troubled or bothered have you been by these employment problems in the past 30 days?
- E19. How many days have you experienced employment problems in the past 30 days? E21. How important to you now is counseling for these employment problems?
- FOR QUESTIONS E20 & E21, PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE*
- INTERVIEWER SEVERITY RATING**
- CONFIDENCE RATINGS**
- Is the above information significantly distorted by:
- E22. How would you rate the patient's need for employment counseling?
- E23. Patient's misrepresentation? 0-No 1-Yes
- E24. Patient's inability to understand? 0-No 1-Yes
- COMMENTS**

DRUG/ALCOHOL USE

	PAST 30 DAYS	YEARS REGULAR USE	ROUTE OF ADMIN.*			
D1. Alcohol—any use at all	<input type="text"/>	<input type="text"/>	<input type="text"/>	D14. According to the interviewer, which substance(s) is/are the major problem? (Code D1–D12 or 00–No problem; 15–Alcohol & Drug; 16–Polydrug.)	<input type="text"/>	<input type="text"/>
D2. Alcohol—5 or more drinks	<input type="text"/>	<input type="text"/>	<input type="text"/>	D15. How long was your last period of voluntary abstinence from this major substance? 00–never abstinent	<input type="text"/>	Months
D3. Heroin	<input type="text"/>	<input type="text"/>	<input type="text"/>	D16. How many months ago did this abstinence end? 00–never abstinent	<input type="text"/>	
D4. Methadone	<input type="text"/>	<input type="text"/>	<input type="text"/>	How many times have you:		
D5. Other opiates/analgesics	<input type="text"/>	<input type="text"/>	<input type="text"/>	D17. Had alcohol DTs?	<input type="text"/>	<input type="text"/>
D6. Barbiturates	<input type="text"/>	<input type="text"/>	<input type="text"/>	D18. Overdosed on drugs?	<input type="text"/>	<input type="text"/>
D7. Other sedatives/hypnotics/tranquilizers	<input type="text"/>	<input type="text"/>	<input type="text"/>	How many times in your life have you been treated for:		
D8. Cocaine	<input type="text"/>	<input type="text"/>	<input type="text"/>	D19. Alcohol Abuse	<input type="text"/>	<input type="text"/>
D9. Amphetamines	<input type="text"/>	<input type="text"/>	<input type="text"/>	D20. Drug Abuse	<input type="text"/>	<input type="text"/>
D10. Cannabis	<input type="text"/>	<input type="text"/>	<input type="text"/>	How many of these were detox only?		
D11. Hallucinogens	<input type="text"/>	<input type="text"/>	<input type="text"/>	D21. Alcohol	<input type="text"/>	<input type="text"/>
D12. Inhalants	<input type="text"/>	<input type="text"/>	<input type="text"/>	D22. Drug	<input type="text"/>	<input type="text"/>
D13. More than one substance per day (including alcohol)	<input type="text"/>	<input type="text"/>	<input style="background-color: #cccccc;" type="text"/>	How much money would you say you spent during the past 30 days on:		
				D23. Alcohol	<input type="text"/>	<input type="text"/>
				D24. Drugs	<input type="text"/>	<input type="text"/>

Note: See manual for representative examples for each drug class.

*Route of Administration: 1 = Oral, 2 = Nasal, 3 = Smoking, 4 = Non IV injection, 5 = IV injection

D25. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days? (Include NA, AA.)

How many days in the past 30 days have you experienced:

D26. Alcohol Problems

D27. Drug Problems

FOR QUESTIONS D28-D31, PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

D28. Alcohol Problems

D29. Drug Problems

How important to you now is treatment for these:

D30. Alcohol Problems

D31. Drug Problems

INTERVIEWER SEVERITY RATING

How would you rate the patient's need for treatment for:

D32. Alcohol Problems

D33. Drug Problems

CONFIDENCE RATINGS

Is the above information significantly distorted by:

D34. Patient's misrepresentation? 0–No 1–Yes

D35. Patient's inability to understand? 0–No 1–Yes

COMMENTS

LEGAL STATUS

<p>L1. Was this admission prompted or suggested by the criminal justice system (judge, probation/parole officer, etc.)? 0–No 1–Yes <input type="checkbox"/></p> <p>L2. Are you on probation or parole? 0–No 1–Yes <input type="checkbox"/></p> <p>How many times in your life have you been arrested and charged with the following:</p> <p>L3. Shoplifting/vandalism <input type="checkbox"/><input type="checkbox"/></p> <p>L4. Parole/probation violations <input type="checkbox"/><input type="checkbox"/></p> <p>L5. Drug charges <input type="checkbox"/><input type="checkbox"/></p> <p>L6. Forgery <input type="checkbox"/><input type="checkbox"/></p> <p>L7. Weapons offense <input type="checkbox"/><input type="checkbox"/></p> <p>L8. Burglary, larceny, B&E <input type="checkbox"/><input type="checkbox"/></p> <p>L9. Robbery <input type="checkbox"/><input type="checkbox"/></p> <p>L10. Assault <input type="checkbox"/><input type="checkbox"/></p> <p>L11. Arson <input type="checkbox"/><input type="checkbox"/></p> <p>L12. Rape <input type="checkbox"/><input type="checkbox"/></p> <p>L13. Homicide, manslaughter <input type="checkbox"/><input type="checkbox"/></p> <p>L14. Prostitution <input type="checkbox"/><input type="checkbox"/></p> <p>L15. Contempt of court <input type="checkbox"/><input type="checkbox"/></p> <p>L16. Other <input type="checkbox"/><input type="checkbox"/></p>	<p>L17. How many of these charges resulted in convictions? <input type="checkbox"/><input type="checkbox"/></p> <p>How many times in your life have you been charged with the following:</p> <p>L18. Disorderly conduct, vagrancy, public intoxication <input type="checkbox"/><input type="checkbox"/></p> <p>L19. Driving while intoxicated <input type="checkbox"/><input type="checkbox"/></p> <p>L20. Major driving violations (reckless driving, speeding, no license, etc.) <input type="checkbox"/><input type="checkbox"/></p> <p>L21. How many months were you incarcerated in your life? <input type="checkbox"/><input type="checkbox"/> Months</p> <p>L22. How long was your last incarceration? <input type="checkbox"/><input type="checkbox"/> Months</p> <p>L23. What was it for? (Use codes L3-L16 and L18-L20. If multiple charges, code the most severe.) <input type="checkbox"/><input type="checkbox"/></p> <p>L24. Are you presently awaiting charges, trial, or sentence? 0–No 1–Yes <input type="checkbox"/></p> <p>L25. What for? (If multiple charges, use the most severe.) <input type="checkbox"/><input type="checkbox"/></p>	<p>L26. How many days in the past 30 days were you detained or incarcerated? <input type="checkbox"/><input type="checkbox"/></p> <p>L27. How many days in the past 30 days have you engaged in illegal activities for profit? <input type="checkbox"/><input type="checkbox"/></p> <p style="text-align: center;">FOR QUESTIONS L28 & L29, PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE</p> <p>L28. How serious do you feel your present legal problems are? (Exclude civil problems.) <input type="checkbox"/></p> <p>L29. How important to you now is counseling or referral for these legal problems? <input type="checkbox"/></p> <p style="text-align: center;">INTERVIEWER SEVERITY RATING</p> <p>L30. How would you rate the patient's need for legal services or counseling? <input type="checkbox"/></p> <p style="text-align: center;">CONFIDENCE RATINGS</p> <p>Is the above information significantly distorted by:</p> <p>L31. Patient's misrepresentation 0–No 1–Yes <input type="checkbox"/></p> <p>L32. Patient's inability to understand 0–No 1–Yes <input type="checkbox"/></p>
<p>COMMENTS</p> <hr style="border: 1px solid black;"/> <hr style="border: 1px solid black;"/> <hr style="border: 1px solid black;"/>		

FAMILY HISTORY

Have any of your **blood-related** relatives had what you would call a significant drinking, drug use or psychiatric problem—one that did lead or should have led to treatment?

Mother's Side				Father's Side			Siblings				
	Alc.	Drug	Psych.		Alc.	Drug	Psych.		Alc.	Drug	Psych.
H1. Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H6. Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H11. Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H2. Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H7. Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H3. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H8. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H12. Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H4. Aunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H9. Aunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H5. Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H10. Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Directions: Use "0" in relative category where the answer is clearly no for **all** relatives in the category; "1" where the answer is clearly yes for **any** relative within the category; "X" where the answer is uncertain or "I don't know"; and "N" where there never was a relative in that category.

FAMILY/SOCIAL RELATIONSHIPS

F1. Marital Status
 1-Married
 2-Remarried
 3-Widowed
 4-Separated
 5-Divorced
 6-Never Married

F2. How long have you been in this marital status? (If never married, since age 18.)
 Years Months

F3. Are you satisfied with this situation?
 0-No
 1-Indifferent
 2-Yes

F4. Usual living arrangements (past 3 years)
 1-With sexual partner and children
 2-With sexual partner alone
 3-With children alone
 4-With parents
 5-With family
 6-With friends
 7-Alone
 8-Controlled environment
 9-No stable arrangements

F5. How long have you lived in those arrangements? (If with parents or family, since age 18.)
 Years Months

F6. Are you satisfied with these living arrangements?
 0-No
 1-Indifferent
 2-Yes

Do you live with anyone who:

F7. Has a current alcohol problem?
 0-No 1-Yes

F8. Uses nonprescribed drugs?
 0-No 1-Yes

F9. With whom do you spend most of your free time:
 1-Family
 2-Friends
 3-Alone

F10. Are you satisfied with spending your free time this way?
 0-No
 1-Indifferent
 2-Yes

F11. How many close friends do you have?

Directions for F12-F26: Place "0" in relative category where the answer is clearly **no for all relatives in the category**; "1" where the answer is clearly **yes for any relative within the category**; "X" where the answer is **uncertain or "I don't know"**; and "N" where there **never was a relative in that category**.

Would you say you have had close, long-lasting personal relationships with any of the following people in your life:

- F12. Mother
- F13. Father
- F14. Brothers/Sisters
- F15. Sexual Partner/Spouse
- F16. Children
- F17. Friends

Have you had significant periods in which you have experienced serious problems getting along with:

- | | PAST 30 DAYS | IN YOUR LIFE |
|-------------------------------|--------------------------|--------------------------|
| F18. Mother | <input type="checkbox"/> | <input type="checkbox"/> |
| F19. Father | <input type="checkbox"/> | <input type="checkbox"/> |
| F20. Brothers/Sisters | <input type="checkbox"/> | <input type="checkbox"/> |
| F21. Sexual Partner/Spouse | <input type="checkbox"/> | <input type="checkbox"/> |
| F22. Children | <input type="checkbox"/> | <input type="checkbox"/> |
| F23. Other Significant Family | <input type="checkbox"/> | <input type="checkbox"/> |

_____ Specify

- | | | |
|--------------------|--------------------------|--------------------------|
| F24. Close friends | <input type="checkbox"/> | <input type="checkbox"/> |
| F25. Neighbors | <input type="checkbox"/> | <input type="checkbox"/> |
| F26. Coworkers | <input type="checkbox"/> | <input type="checkbox"/> |

Has anyone ever abused you:
 0-No 1-Yes

	PAST 30 DAYS	IN YOUR LIFE
F27. Emotionally (made you feel bad through harsh words)?	<input type="checkbox"/>	<input type="checkbox"/>
F28. Physically (caused you physical harm)?	<input type="checkbox"/>	<input type="checkbox"/>
F29. Sexually (forced sexual advances or sexual acts)?	<input type="checkbox"/>	<input type="checkbox"/>

How many days in the past 30 days have you had serious conflicts:

- F30. With your family?
- F31. With other people? (excluding your family)

FOR QUESTIONS F32-F35, PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

- F32. Family problems
- F33. Social problems

How important to you now is treatment or counseling for these:

- F34. Family problems
- F35. Social problems

INTERVIEWER SEVERITY RATING

F36. How would you rate the patient's need for family and/or social counseling?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

- F37. Patient's misrepresentation? 0-No 1-Yes
- F38. Patient's inability to understand? 0-No 1-Yes

COMMENTS

The preceding pages presented a brief description of the ASI and the original ASI, Fifth Edition instrument. Numerous treatment providers and State agencies are currently using the ASI instrument to help meet multiple demands in this time of changing healthcare systems. Treatment providers need instruments that can:

- Help streamline paperwork
- Collect the specific information they need to meet the varying requirements of State, Federal, and accrediting agencies
- Guide assessments to obtain a comprehensive picture of each client's treatment needs

In addition, Federal, State, and managed care organizations are all pushing for greater accountability through the measurement of performance outcomes. Treatment providers face an increasing need to collect valid data that can be used as a baseline for outcome studies. The ASI, used for both clinical and research purposes, has a number of specific strengths and limitations as an assessment tool in this complex environment. These advantages and limitations are summarized in table 1.

Table 1. Advantages and limitations of the ASI

CLINICAL USES
The ASI offers a standard set of questions, which results in information to help clinicians—
<ul style="list-style-type: none">• Screen prospective clients• Guide intake to substance abuse treatment• Design intake summaries• Develop treatment care plans• Make referrals
RESEARCH USES
The ASI offers a standard set of questions, which results in information to help researchers—
<ul style="list-style-type: none">• Describe clients from specific treatment centers• Describe specific populations of clients• Quantify the level of problems• Measure the client's response to treatment• Compare improvement across groups of clients
STRENGTHS
Some strengths of the ASI:
<ul style="list-style-type: none">• Can be used to gather reliable, valid data• Is relatively brief• Can be computer-coded• Can be used for followup outcome studies• Has a history spanning more than 20 years of use in research and treatment• Is currently being used in many statewide studies and Federal grants, such as for CSAT's Target Cities grants and Treatment Outcome Performance Pilot Studies (TOPPS).
LIMITATIONS
The ASI has limitations in several settings (discussed in detail later). The ASI should be supplemented significantly:
<ul style="list-style-type: none">• To determine the appropriate level of care• To diagnose according to the DSM-IV• To assess adolescents• To evaluate treatment programs in controlled environments

WHY ADAPTATIONS OR ASI MODULES ARE NEEDED

The ASI was originally designed to capture the minimal amount of information necessary to evaluate the nature and severity of patients' problems when they present for treatment and at followup. For this reason, the ASI developers have always encouraged clinicians to add questions and/or additional instruments in the course of evaluating their clients.

A number of modifications to the ASI have been developed for special populations. For example, sets of questions or “modules” have been developed to assess the special needs of women (SAMHSA/CSAT, 1997), (Brown et al. 1995), the chronically mentally ill (Cacciola and McLellan 1994), and gamblers (Lesieur and Blum 1992). In addition, the Clinical Training Version of the Fifth edition of the ASI (Urshel et al. 1996) has been translated to provide a version for use with Hispanic patients (Morales 1997). Versions for use with incarcerated individuals, homeless populations, and other populations are being developed.

Treatment providers have numerous reasons—including clinical, research, accreditation, and cultural reasons—for adapting or norming the ASI.

Clinical Reasons

Adaptations can be necessary because the ASI does not adequately cover some important areas in particular populations (Brown et al. 1993; Carise and McLellan 1996). For example, the medical section of the ASI is adequate for gathering basic medical information in the general population. However, treatment centers that work with pregnant women or with the severely medically ill will need to add medical questions that are specifically suited to those populations. Adding questions to the ASI will enable the provider to more adequately assess the needs of patients in those programs.

Research Reasons

Adaptations are also needed for research purposes. These adaptations will permit evaluators and researchers to measure particular outcomes of interest in specific populations (McLellan et al. 1992). For many populations, an increase in medical care visits shown at followup could indicate an increase in the acuity of the patient's medical problems. However, such followup data may signify a very different finding among pregnant substance abusers. For example, in a 5- to 7-day detoxification program for pregnant substance abusers, followup information showing an increased number of visits to medical professionals for prenatal care would be desirable and clinically important.

Accreditation

Adaptations are also helpful for treatment providers who need to fulfill the requirements of two or more funding or accreditation agencies. For example, providers often need to meet requirements from both their State substance abuse agency and an accreditation agency, such as

the Joint Commission on Accreditation of Hospital Organizations (JCAHO). The ASI-Joint Commission Version (Carise et al. 1997) is an adaptation that fulfills a State's requirements while incorporating specific JCAHO requirements.

Cultural Reasons

The Addiction Severity Index—North Dakota Native American Version (ASI-ND/NAV) provides an example of an adaptation of the ASI for cultural reasons. If an instrument is not sensitive to important distinctions in cultural practices, common practices may be mistaken as "problems" and true problems may be missed. For example, some Native American religious or ceremonial practices are intended to bring about spiritual experiences. These practices and ceremonies may produce hallucinations as a result of heat exposure, dehydration from fasting, or lack of sleep. In the standard ASI, hallucinations are *always* considered evidence of a psychiatric problem. Unless it has been adapted to take into account Native American cultural practices or religious ceremonies, the ASI could offer inaccurate and possibly injurious information about a client's condition.

ORGANIZATION OF THIS SPECIAL REPORT

In part I, we first describe how we modified the ASI for Native Americans in treatment for substance abuse problems in North Dakota. We then present the resulting instrument, along with a *Revised User's Guide* (part II). Part III is a general discussion about how to modify the ASI to increase cultural sensitivity.

Chapter 2—Developing a Version of the ASI, Fifth Edition, for Native Americans in North Dakota

The development of this Special Report began with requests from treatment providers in the North Dakota State Hospital for a version of the Addiction Severity Index (ASI) that would be culturally sensitive to the Native American population in treatment for drug and alcohol problems in their State. Aware that the ASI does not sufficiently address the substance abuse treatment needs of Native Americans, the authors decided to modify the instrument. While the authors' ultimate goal is to develop an instrument or instruments that can be used throughout the country by clinicians who are helping Native Americans troubled by abuse of alcohol or other drugs, this first adaptation has proved to be more limited in scope. The final version of the modified instrument reflects information provided by Native Americans in treatment for substance abuse in the North Dakota State Hospital. Therefore, this adaptation may *not* be more widely applicable to a wider group of Native Americans. This is a subject that we will return to later in this Special Report. (See chapter 3.)

Very briefly, the first step in the modification was the development of a pilot instrument based on interviews—with clients in an inpatient hospital-based substance abuse treatment program in North Dakota, with clinical staff, and with experts versed in Native American culture. The pilot instrument was administered for a year, after which time it was again modified, based on the results of the previous year's work and comments from a field review. The resulting adaptation of the Addiction Severity Index, the North Dakota State Adaptation for Use With Native Americans, is contained in part II of this volume, chapter 4. A *Revised User's Guide*, in chapter 5, provides in-depth instructions for each question on this version of the ASI.

A more detailed description of the steps taken to develop the ASI-ND/NAV Version follows.

DEVELOPING A PILOT INSTRUMENT

As a first step in the development of the pilot instrument, in August 1995, the first author (D.C.), who is an ASI trainer, and Jerald Harmon, an ASI trainer working with Native Americans in Tucson, Arizona, traveled to the North Dakota State Hospital in Jamestown, where they conducted interviews with patients and treatment providers over a period of 5 days. The purpose of the visit was to gather information about living situations, lifestyle differences, cultural and tribal variations, community support, and any other topics that could increase the value of the ASI as the primary assessment document. Additionally, trained interviewers collected ASI data for the next year. This report presents the data collection procedures, the resulting instrument, the limitations of this type of adaptation, and suggestions and instructions for further development or new adaptations. This is important since there are likely to be many different issues encountered in other Native American populations. Thus, the *procedures* used to produce this version are likely to be more useful than the particular questions, for those working in other Native American settings and with other populations.

Methods

Over the course of 5 days at the State mental hospital in Jamestown, North Dakota, the first author and her colleague conducted interviews with Native American patients then in substance abuse treatment. These patients represented Chippewa, Sioux, Blackfoot, and other tribes. They also interviewed treatment providers who were working with Native Americans, as well as Mary Louise Defender Wilson, the director of the Native American Cultural Center located at the North Dakota State Hospital in Bismarck. Some treatment staff had extensive background working with Native Americans; the author queried this experienced group, as well as those Native Americans in treatment, about Native American living situations, lifestyle differences, cultural and tribal variations, community support, and other issues regarding culture and environment.

The authors asked all Native Americans in substance abuse treatment at the North Dakota State Hospital to participate in an ASI interview. During the 5-day stay, 11 of the 15 Chippewa, Sioux, and Blackfoot clients then in treatment initially agreed to participate in the development of the pilot instrument and participate in an ASI interview.

In all, 6 of the 15 Native Americans in treatment did not participate in the pilot study for various reasons. Two individuals in treatment did not participate because, they stated, they were too busy and were in their final stages of treatment. Two individuals who chose not to participate were unwilling to listen to the description of the study. One person who participated initially later experienced an increase in psychiatric symptoms. This client requested that we return the assessment document (we returned the ASI instrument to him). Finally, one participant requested that we stop the interview because of that person's discomfort related to withdrawal symptoms. Therefore, nine patients participated in the initial development of the pilot ASI–ND/NAV.

The Native American clients who completed an ASI interview also spent another 15 to 30 minutes with the interviewer, giving insight on which questions did not seem to apply to them, or questions that were left out of the interview that were important to them. They addressed the choices for answers that did not adequately cover the unique aspect of their culture, such as a question providing a list of traditional religious preferences to choose from, and a question about level of education that did not take into consideration the differences between attending school on a reservation, or in a Native American boarding school. The nine volunteers contributed a great number of suggestions and spoke about areas they felt were important to include during assessment to appropriately address substance abuse problems within the context of their culture. These data, combined with discussions from treatment providers and others, led to the development of a supplemental information sheet for the ASI. This supplemental sheet gathers information on tribal affiliation and enrollment, the number of years that the client has lived on reservations, and education experiences and settings (for the supplemental sheet, see box on page 17).

Supplemental Sheet for Data Collection

**ADDICTION SEVERITY INDEX
North Dakota/Native American Version (ND/NAV)**

Tribal Affiliation:

Specify: _____

Are you enrolled? (circle one) YES NO

How many years total did you live on reservations?

Specify: _____

During what ages did you live on reservations?

Specify: _____

Type of schooling attended:

(e.g. Native American boarding school, traditional school, educated on reservation, etc.)

Specify: _____

Do you have any comments or suggestions for improving this intake document to meet the needs of your population?

The pilot instrument was then developed, based on the nine original ASIs and interviews with treatment providers and the director of the Native American Cultural Center.

After participating in a 2-day training event on how to administer ASIs, staff began to collect ASIs on Native Americans who were entering inpatient, abstinence-oriented substance abuse treatment at the Jamestown site. This ASI collection effort continued for approximately 1 year. The clinicians involved had completed ASI training with the supplemental questions and had prior experience both in working with Native Americans and in administering the ASI.

A total of 76 pilot ASIs were administered through May 1996. The subjects were primarily from the Chippewa and Sioux tribes, while several came from three affiliated Blackfoot tribes. More information about the subjects is presented in Results of the 1-Year Study, later in this chapter.

DEVELOPING THE FINAL INSTRUMENT

At the end of the year, the authors modified the pilot instrument based on guidance from the interviewers, clients, clinicians, and experts in the field of substance abuse treatment and Native American culture. A number of suggestions made by field reviewers were incorporated into the ASI-ND/NAV. (See the appendix for a list of field reviewers.)

Feedback from many of the clients and clinicians interviewed clustered around several common themes, suggesting important areas for adapting the ASI interview, as well as specific treatment service needs among Native Americans. Many of the suggested client need areas were consistent with the previous literature, such as the need for help with family relationships, with vocational skills, and with domestic violence issues (Wilber and Congros 1995). The following section shows key topics discussed and how these issues were addressed in the development of the North Dakota Native American Version of the ASI.

Spirituality

Almost everyone whom we interviewed suggested adding questions or a section about spirituality. Consequently, we added a Spiritual and Ceremonial Practices section to the ASI. The questions in this section were developed to follow the same time frames and contexts as are used in the seven original ASI sections.

For example, as in the original ASI, the new questions use a number scale, severity ratings, and confidence ratings, and ask about behavior in the past 30 days. This allows for a consistent format for the questions; it also means that the new and original information will have maximum comparability with existing questions and that clients do not have to reorient their responses to a new time period.

Spiritual and Ceremonial Practices

New Section. The new section, Spiritual and Ceremonial Practices, begins with questions about a belief in a God, a Higher Power, or Creator. The interviewer asks what changes in his or her spiritual life the client would like help making. Other questions revolve around whether the client has a spiritual leader available for guidance, comfort level with spirituality, participation in Native-American specific activities, and language. Patient's Rating, Interviewer Severity Rating, and Confidence Rating are also included. See the box on page 20, which delineates the new section.

Questions Added to the ASI: Spiritual and Ceremonial Practices Section

S1. Do you have a belief in a “God,” “a Higher Power,” or “Creator”?

Concerning your spiritual life, what changes would you like help making?

- S2. Learning more about prayer?
- S3. Learning more about meditation?
- S4. Education about a particular religion/spirituality?
- S5. Changing attitude toward God/Creator?

S6. Do you have a spiritual leader or traditional/cultural person available for guidance?

[If S6=yes]

S7. Do you seek out and utilize this person from time to time?

S8. Are you comfortable with your spirituality and beliefs?

Do you regularly participate in:

- S9. Native American religious ceremonies/activities? (sweat lodges, sun dances, etc.)
- S10. Native American Church meetings?
- S11. Native American cultural activities?
- S12. Native American dance activities?

S13. Are you familiar with your Native language?

S14–S15. What is the primary language you speak (Native language, English, Spanish, other) at home, with friends?

S16. How many days in the past 30 days have you had concerns or problems with *spiritual or cultural* practices?

Patient's Rating

- S17. How troubled or bothered have you been by these problems with spiritual or cultural practices?
- S18. How important to you now is counseling for these problems/concerns (including learning Native American cultural practices and ceremonies)?

Interviewer Severity Rating:

S19. How would you rate the patient's need for spiritual or cultural counseling?

Confidence Rating

S20-21. Is the above information significantly distorted by the patient's misrepresentation or inability to understand?

Choices added in the General Information section. Two options were added to Question G18 in the General Information section that ask whether the client has a religious or spiritual preference. The options added to question G18 are:

- Native American spiritual practices (sun dance ceremonies, sweat lodges, etc.)
- Native American Church

Demographic questions added in the General Information section. The following three questions were added:

G35. Is this [your residence] located on a reservation?

G29. What tribe(s) do you consider yourself part of?

G36. Are you enrolled [in a tribe]?

Hallucinogens

Interviews with treatment staff and Native American clients suggested the need for questions in the Drug/Alcohol Use sections of the ASI regarding the use of hallucinogens. In addition, instructions to interviewers were added in the Psychiatric Status section of the *Guide* in order to allow for “non-psychiatric” hallucinations.

Questions Added in the Drug/Alcohol Use section. New instructions were given to include peyote as a hallucinogen on the list of drugs in the drug grid in this section.

Questions added include the following:

D42. Have you used any of the drugs listed as part of a religious practice or spiritual ceremony?

D43. Is this use approved or provided by tribal leaders or a medicine person?

D45. Is this use common practice in your traditional ways?

In addition to the questions concerning hallucinogens and the use of other drugs in religious or ceremonial practices, already described, the following question was added:

D44. Have any traditional Indian cultural practices, such as sweat lodges, sun dances, and prayer meetings been helpful for you in achieving or maintaining abstinence [from drugs and alcohol]?

The following questions were added after the original ASI questions, “How many times in your life have you been treated for alcohol abuse and drug abuse?” and “How many of these were detox only?”

- D36–37. How many of these [alcohol/drug treatments] provided Native American specific groups or focus?
- D38–39. How many of these [alcohol/drug treatments] included Native American treatment providers/counselors?
- D40–41. How many of these treatments were provided on reservations?

Psychiatric Status

Additional instructions were added to Psychiatric Status Question P6 about whether the patient had experienced hallucinations. The new material instructs the interviewer not to code hallucinations related to religious or ceremonial practices.

Other Factors

New questions were added to include a number of factors not in the original ASI. These factors have to do with whether clients have received alternative types of medical, drug, and alcohol treatments; whether they have received education in schools specific to Native Americans; and whether they currently receive income derived from Native American lands.

Questions added to the Medical Status section. Two questions were added:

- M16. Have you ever sought medical help from a tribal medicine person?
- M17. How many days in the past 30 days have you sought help from a tribal medicine person?

Questions added to the Employment/Support Status section. Two questions were added:

- E27. Years of education completed in:
 - ▶ BIA boarding schools (on your reservation)
 - ▶ BIA boarding schools (not on your reservation)
 - ▶ Tribal boarding schools
 - ▶ Church/Mission boarding schools
 - ▶ Non-boarding schooling, on reservation
- E28. How much income have you received in the past 30 days from government payment for land/land lease? [This is an item added to a list of questions regarding various sources of income in the past 30 days.]

Tribal Support for Recovery

During the interview process, clinicians expressed an interest in being able to assess the support for a drug-free lifestyle that clients perceived as being available from their tribes and on their reservations.

Questions added to the Family/Support section. A series of questions was added.

F61. Do you live with anyone who is supportive of your recovery?

After treatment, will you return to an environment that

F65. Is supportive of your recovery?

F66. Offers community services to help you in your recovery?

F67. Offers accessible self-help meetings?

Culturally Specific Living Situation

The North Dakota Native American ASI asks several questions about the extent to which the client has lived in culturally specific tribal situations. This version also asks about the client's satisfaction with this living situation.

Questions added to the Family/Social Relationships section. In all, five questions were added.

F58. Have you ever lived on a reservation?

F59. How many years of your life did you live on reservations?

F60. Are you satisfied living on reservations?

The following two questions were added as a sequel to the original ASI question, "How many close friends do you have?"

F76. How many of these friends are Native American?

F70. With whom do you feel the most comfortable? [Choices include Native American, white, other, or indifferent]

Excluded Questions

Not all of the questions from the ASI are included in the North Dakota State adaptation. There are three important exclusions. (1) Race categories, for example, were replaced with a question about tribal affiliation. (2) An inpatient care question that was not part of the original ASI was dropped from this version. (3) Questions about occupation were not included inasmuch as the Hollingshead scale, which in any event is generally outdated, is a poor fit for the Native American population. (See the box for a more complete listing of questions that are not included.)

Questions dropped from the Addiction Severity Index, Fifth Edition Research Version, in creating the North Dakota State Native American Version

G6 and G7, time elapsed for the interview.

G17 is a question about race. It is replaced by the following question about tribes:

G29. What tribe(s) do you consider yourself part of?

D99 (an optional question) “How many days have you been treated in an inpatient setting for alcohol or drugs in the past 30 days?”

E7, which asks for usual (or last) occupation, with the answers keyed to the Hollingshead Categories Reference Sheet, is not included for the reasons given above.

Modifying the User’s Guide

In addition to adapting the instrument, the authors also adapted the *User’s Guide* to the ASI-ND/NAV, resulting in the *ASI Revised User’s Guide: North Dakota State Adaptation for Use With Native Americans*. The revisions consist most importantly of additional instructions for the new questions and choices that we have outlined in this chapter. In some instances, instructions were clarified. In addition, the *Revised User’s Guide* has a new format. Because we realize that some clinicians will be using the *Guide* with other versions of the ASI, we have included questions that were not included on the modified instrument at the very end of the *Guide*.

The modified ASI-ND/NAV and the *Revised User’s Guide* are in part II, this volume.

RESULTS OF THE 1-YEAR STUDY

Interviewers completed a total of 76 ASI interviews. All but two of the subjects for whom data were available were enrolled in a tribe. The subjects had lived on reservations for an average of 17.7 years. The 76 respondents ranged in age from 19 to 68. Average age of the respondents was 35 years. See tables 2, 3, and 4 for more detailed information about the Native Americans who participated.

Table 2. Tribal groups represented

Tribal Group	Number of Individuals	Percent
Chippewa	32	42
Sioux	26	34
Three affiliated Blackfoot tribes	10	13
Other/mixed	3	4
Missing data	5	7
Total	76	100

Table 3. General information about respondents

	Number of Individuals	Percent
Enrolled in tribes	67	97*
Gender		
Male	60	79
Female	16	21
Early education (grades 1-12)		
Native American boarding school	13	17
Educated on a reservation	19	25
American public schools	37	49
Mixed/other	7	9
Total	76	100

*Based on the 69 individuals for whom information about tribal affiliation was available.

Table 4. Data from selected background items

Background item	Mean	SD	Percent
Medical Status:			
Lifetime hospitalizations	5.0	4.1	
Days of medical problems in past 30 days	11.8	8.5	
Employment/Support Status:			
Years of education	1.9	11.3	
Average number of dependents	1.6	1	
Percentage having driver's license			12
Drug/Alcohol Use:			
Years of heavy alcohol use	8	12	
Years of regular heroin use	1	0.2	
Years of regular cocaine use	3	0.9	
No. of previous treatments for alcohol	19	12	
No. of previous treatments for drugs	4	1	
Legal Status:			
Number of convictions	15	8	
Months incarcerated	31	20	
Family/Social Relationships:			
Percentage divorced/separated			39
Days of family problems in past 30 days	5	2	
Days of social problems in past 30 days	2	1	
Psychiatric Status:			
Number of psychiatric hospitalization	2.6	0.75	
Percentage reporting depression in lifetime			51
Percentage reporting lifetime trouble with violence			41
Percentage reporting attempting suicide in lifetime			22

Preliminary data on the Native American clients, shown in table 5, differ in some interesting ways from data gathered on other groups. The data gathered on other groups rarely show such a small range in the severity of problems across sections (McLellan et al. 1980; 1992). These other groups include substance abusers who are non-Native males, homeless, primarily alcohol abusers, incarcerated, and psychiatrically ill substances abusers. In the North Dakota Native American sample, though still very small, the range in severity of problems (as measured by the interviewer severity ratings) is less than that seen in other samples. With the current sample, all sections of the ASI averaged a moderate or higher severity rating. There were no sections in which the Native American sample showed few or no problems or no need for treatment. Table 5 compares scores from the Native American sample with data from several groups summarized in an article on the fifth edition of the ASI (McLellan et al. 1992). It should be noted that this article simply reports available data on relatively small samples of groups with varying characteristics—not true national norms.

Table 5. Average interviewer severity ratings from the Native American sample compared with three other groups

Status	Native Americans in North Dakota <i>n</i> =76		Public inpatient programs <i>n</i> =116		Incarcerated males <i>n</i> =260		Alcohol abusers <i>n</i> =129	
	ISR	(SD)	ISR	(SD)	ISR	(SD)	ISR	(SD)
Medical	3.1	(2.7)	1.9	(2.2)	1.9	(2.8)	2.4	(2.3)
Employment/Support	3.7	(2.2)	3.5	(1.9)	4.7	(3.0)	3.4	(2.1)
Drug	3.1	(2.8)	3.1	(1.1)	7.5	(2.1)	1.2	(2.0)
Alcohol	6.4	(1.7)	4.7	(1.5)	2.9	(3.2)	6.4	(1.0)
Legal	2.9	(1.8)	1.1	(1.5)	5.6	(2.4)	1.4	(1.9)
Family/Social	3.8	(2.1)	3.3	(2.1)	3.7	(2.7)	3.1	(2.0)
Psychiatric	3.3	(2.7)	3.1	(2.4)	2.8	(2.7)	3.4	(2.3)

ISR=Interviewer severity rating.
(SD)=Standard deviation.

LIMITATIONS OF THE STUDY

The goal of this project was to develop a culturally sensitive assessment instrument for use with Native Americans, predominantly Chippewa and Sioux, *presenting for treatment in the State of North Dakota*. Following is a list of some of the limitations of the project and of the resulting instrument.

Nonrepresentative Sample—Geographic Limitations

Data for this North Dakota/Native American Version of the ASI were collected from Native Americans from a small portion of the tribes in North America, specifically the Chippewa, Sioux, Blackfoot, and some mixed affiliated tribes. Clearly, the many other tribal groups in North America, such as the Navajo or Crow Nations, may have unique cultural practices that were not taken into consideration in creating this instrument. As indicated previously, this ND/NAV instrument is not necessarily generalizable to the numerous other tribes or Nations in North America. Chapter 3 discusses various ways in which this instrument could be expanded to represent the mores and cultural practices of other Native American tribes.

NEED FOR NORMATIVE DATA

Once a specific module of the ASI has been created for a particular group or sample, it is desirable to norm the instrument for this group. Normative tables will increase the usefulness and meaningfulness of the adapted instrument. Development of normative tables for special populations makes it possible to compare data for similar groups (Gottheil et al. 1992; McLellan et al. 1981). For example, a center that plans to offer specialized treatment for Native Americans can learn a great deal from the baseline and outcome data of a facility that currently provides such treatment. Normative data will allow the clinicians to compare client problem levels as well as to compare outcome results. Treatment center staff would be able to focus services in areas where there is a demonstrated need for program improvement, or to identify new areas of service need.

Normative tables perform an additionally helpful function. Such tables permit an individual treatment center to compare its treatment population at one point in time to its population at a later point in time. Based on this information, a treatment center is able to empirically describe the changes in its clients over time and to make necessary changes in the services provided. For example, a treatment center that provides services predominantly for mentally ill substance abusers may develop initial baseline norms for its population during the year the facility opens. Another set of norms, gathered in the second year of operations, may show that the psychiatric severity of the population has significantly increased. This type of information may lead to alterations in treatment staffing and services offered.

The treatment field will benefit if treatment providers collect and publish standard, normative data for various populations of substance abusers who seek treatment, including those from various Native American tribes. These data are not yet available. However, the widening use of the ASI could permit the development of these normative data in the near future. Publication of such new, normative data would increase the value and utility of the ASI instrument.

A NOTE ON RELIABILITY AND VALIDITY OF THE ASI MODULES

The ASI (5th edition) has been shown to be reliable and valid among a rather wide range of substance abusers presenting for treatment. These groups include substance-abusing people who are incarcerated, mentally ill, homeless, or pregnant, in addition to Native Americans and various other ethnic and special population groups. The ASI developers at the University of Pennsylvania/Philadelphia VA Medical Center have collaborated with many clinicians and researchers on how to use the instrument with different populations. Yet clearly, more complete reliability or validity studies of the ASI instrument still need to be conducted with specific populations.

More complete studies are needed because of various circumstances that are likely to reduce the value of the data gathered with the ASI. For example, under certain circumstances, subjects can be expected to provide honest answers to the ASI because they have little reason to give false information. Such a scenario exists for subjects who are self-referred, seek treatment voluntarily, and have the ASI administered by an independent and trained interviewer. On the other hand, some subjects are much more likely to give false information. This circumstance could occur, for example, when individuals are being evaluated for probation, parole, or for prison sentencing. Oddly, this misrepresentation may not always be in the direction we would expect. When evaluating incarcerated clients, an interviewer may expect that inmates will be likely to minimize their reported substance use, since letting authorities or providers know that drugs or alcohol are available within the system could result in unpleasant complications. However, what the interviewer may not know is that an inmate who reports extensive substance abuse problems may be transferred out of the traditional incarceration facility and into a more desirable incarceration/treatment unit.

Similarly, there is often reason to suspect denial and misrepresentation when the ASI is used with psychiatrically ill substance abusers who are not necessarily seeking—and may possibly be avoiding—treatment. Although the ASI has been designed with built-in consistency checks, which are of some benefit in these circumstances, the substance abuse treatment field currently has no suitable *alternative* instrument or procedure available that will *ensure* valid, accurate responses under all conditions.

Chapter 3—Further Development of An ASI for Native Americans

Because the information used to create the pilot instrument, the North Dakota State adaptation of the ASI for use with Native Americans, was collected in North Dakota only, this chapter contains suggestions of further development of an ASI to be used with Native American clients from other tribes who are presenting for substance abuse treatment.

SUGGESTIONS FOR FURTHER DEVELOPMENT OF A NATIVE AMERICAN VERSION OF THE ASI

We suggest that the following steps should be undertaken by a group of researchers who work within the following parameters.

1. Collect ASI data from representative samples of Native Americans seeking substance abuse treatment from the specific tribes of interest.
2. Broaden the scope of the project. Several additional themes that were outside the scope of the present project emerged in the data collection. These themes, which should be addressed in future development of this or any other instrument for working with Native American substance abusers, include:
 - Inclusion or addition of a legal section that addresses conflict with tribal law, jurisdiction, and proceedings
 - Increased assessment of problems of domestic violence, along with an assessment of desire for help with anger management
 - Requests for Native American treatment staff
 - Requests for increased availability to practice or learn about Native American religious and cultural ceremonies during treatment, including sweat lodges, sun dances, and other such practices
3. Expand the psychometric testing on the reliability and validity of the ASI instrument when modified.

Various studies have assessed the reliability and validity of the ASI 5th edition instrument (McLellan et al. 1992). While there is no evidence that simply adding questions to the instrument would diminish the reliability and validity of the data, comprehensive scientific studies have not been completed comparing the ASI data collected in its original form with ASI data collected

when additional questions are added. This is true even though numerous versions or modifications of the ASI have been created and are currently in use. Only one study has touched on this type of validity (Brown et al. 1993). This study shows that the predictive validity for the ASI-Female Version is very similar to the predictive validity for the original ASI. Further studies should focus on the test-retest validity of the original ASI items when administering an adapted ASI instrument.