PERSPECTIVES ON STAFF RESISTANCE TO USING THE ASI

Wicks S.J., M.Sc., clinical psychologist, Sweden.

Correspondence:
Steve Wicks,
Beacon,
Torkel Knutssonsgatan 14,V,
118 49 Stockholm.
Sweden.
Tel. +46 8 668 23 77
Fax. +46 8 429 85 37
beacon.stockholm@telia.com

ABSTRACT

The paper highlights a number of reasons as to why the ASI, despite having been introduced to Sweden in 1996, has not been more widely accepted by addiction clinicians within social services and health care. The author draws on several years' experience of being responsible for the introduction, training, and implementation of the ASI in a large catchment area in the southern part of Stockholm. Various problems are identified and discussed. The key role of managers in the addiction services, in planning training and facilitating implementation, is emphasised. It is suggested that while the ASI is the "good enough" clinical instrument, its use by health care and social service addiction units often draws attention to the need of training in other areas, e.g. motivational interviewing, treatment planning.

Key words: ASI, training, implementation.

BACKGROUND

Anyone who has become acquainted with the client/patient records of Swedish social service departments and health care services specialising in the addictions will have noticed a lack of systemised, clear and accessible information. In 1996, the Addiction Severity Index (McLellan et al.1992;) was introduced to Sweden and in 1997, when the author of the present paper had been trained in the use of the ASI and had started to use it with patients on a detoxification ward, he, naively, believed that the ASI would trigger a rapid and bloodless revolution in the addiction services. The ultimate goal was that all professional treatment staff within the addictions would use the ASI regularly and that this would result in structured treatment planning, with matching and evaluation being the rule rather than the exception. There are many reasons why these goals have not been attained and the major aim of this paper is to identify obstacles to the implementation of the ASI in the Swedish addiction services and to suggest how they can be minimised or removed. Special attention is given to ASI training.

IMPLEMENTATION

There are a number of fundamental questions to be addressed before allocating major resources to ASI training (Engström & Larsson, 1998). The investment of time, money and energy required to train staff can only be warranted if the ASI is not only to be integrated into the everyday work of the organisation but will provide benefits to the clients served by the organisation.

Staff scepticism about the purpose of introducing ASI: "Why should we use it at all?"
Many in the addiction field have been working for years with the minimum amount of structure and at the same time frequent re-organisations, largely motivated by cost-efficiency. The staff is today under pressure to produce increasing amounts of care. There is a fear that the ASI will be just another of these reforms, a research tool or, at worst, a weapon to be used in a brutal rationalisation of services. Other questions are: Does the introduction of the ASI imply that the staff has not been doing a good enough job? How can the ASI really help the clients? Although it would be difficult to find members of staff with a negative attitude to the concept of quality assurance, it needs to be explained in concrete terms if it is to be linked to a particular instrument.

It is therefore necessary to inform the staff from the outset of the advantages of using the ASI: a method of collecting the minimum information necessary for treatment planning in a systematic way; an interview that only takes about an hour; that the patient rating questions involve the patient from the start; that composite scores can be used for measuring change over time; that focus is not merely on alcohol/drugs but considers the client's whole life situation; and that it is internationally accepted and used.

Information should be disseminated in such a way that stimulates discussion amongst staff and should be given well in advance of ASI training so that possible doubts/fears etc. can be addressed prior to investing in training and concrete implementation measures.

One of the advantages of the ASI is that it can be used by different agencies. The information gained from the interviews can, with the permission of the patient, be used to provide referrals to other agencies. A common instrument contributes to the use of a common language between agencies, and this in turn can promote interagency co-operation. This has been one important motive in the Stockholm area. The ASI training courses have usually been attended by a mixture of social service and health service colleagues. This mixture will also minimise the risk of "agency variations" in definitions and procedures.

Training the wrong people: "Who is going to conduct the interviews?"
The standard ASI training course in Sweden consists of 2 consecutive days followed by either a half-day or full-day follow-up a few weeks later. Successful implementation of the ASI requires that all members of staff concerned have at least basic information about the ASI and its uses. However, this does not mean that all members of staff have to complete a full ASI training; in fact, such a policy is a waste of resources and results in much unnecessary frustration and loss of time and energy.

Many members of staff who will never have the opportunity to conduct an ASI interview in their everyday work are sent on 2-3 day ASI training courses when a shorter introduction to the instrument would suffice. The ASI's structure and the necessity of learning its coding procedures and accepting unfamiliar definitions may awaken a certain amount of resistance. "Blanket" training does not reduce this resistance. Therefore, one should invest time in examining the work and needs of the unit in question and deciding which staff members will be expected to conduct ASI interviews on a regular basis and concentrate on

giving them the full training. For senior management or staff members who are unlikely to conduct ASI interviews a general introduction to ASI and working knowledge of the instrument will suffice.

Fears that collected data will not be used: "What will happen to the information collected in the interviews?"

If the ASI is to be used regularly and with enthusiasm by staff then it is vital that the information gained from the interviews does not merely disappear into the client's record after the interview. The client has also invested time and energy in participating in the interview. The client should always be informed as to how the information is to be used and should be offered an appointment during which he/she will receive feedback. The information collected during the ASI can thus be used as a foundation for discussions regarding possible treatment interventions. Regular treatment planning seminars should be convened in which ASI interviews and treatment plans are co-ordinated and discussed.

Insufficient time-resources for using the ASI: "How will we find the time to carry out ASI interviews?"

However enthusiastic staff may be after ASI training this enthusiasm is short-lived if they return to a work situation in which there is no time to carry out ASI interviews. Beginners need time to practice and become confident and competent in the use of the instrument. Experienced interviewers rarely require more than one hour for the interview but even they require at least 30 minutes after the interview to consider severity ratings and to make sure that coding is correct and comments legible. If the patient is to receive feedback, and this should be the ambition in normal clinical practice, then time must also be allowed for preparation.

The management must timetable the use of the ASI allowing sufficient time for the interview, processing of the interview and feedback to the patient. This should not be left to the individual member of staff.

Continuous training and networking needed for quality of data: "How to guarantee good quality of data?"

It quickly became evident that it was unreasonable to expect "ASI proficiency" immediately after a 2-day training course. This has also been the experience in the USA (Fureman et al. 1994). The 2-day course was not enough without the three essentials for gaining proficiency, i.e. practice, practice, and practice! However, it was not sufficient to conduct a number of interviews, it was also necessary to receive feedback as to whether one had understood the coding and rating procedures etc.

One remedy to poor quality of interviews was to make it clear at the end of the 2-day ASI training course that participants were expected to submit a complete ASI interview to the trainer within one month for a written appraisal. The ASIs submitted were examined with regard to coding (including severity ratings), comments and general impression. An approved ASI interview resulted in a diploma and the management being informed that the person in question had attained proficiency in the use of the ASI.

The maintenance of proficiency can be facilitated by a network of ASI-co-ordinators, who should, among other things, follow the development of ASI and convene ASI supervision for colleagues.

Another way to improve the quality of the data is to develop the form to become more user-friendly, for instance by giving room for explanatory comments, and to use video-techniques in training.

CONCLUDING REMARKS

It is the author's opinion that the ASI, despite its limitations, is the "good enough" instrument, and if used correctly can help bridge the gap between the clinical and research worlds which will benefit patients and staff alike.

This paper is a collection of observations and ideas with regard to training and implementation. Although in no way wishing to belittle the responsibility of individual staff members, it seems to the author that management has a key role to play. If the ASI is to be used properly then management needs to make informed and wise decisions concerning training and the allocation of resources and time. It is therefore important that bosses at all levels attend appropriate ASI workshops/presentations prior to selecting staff for ASI training.

The author's experience suggests that the ASI should be introduced slowly, in stages, and with great clarity with regard to both purpose and use. It is important for management to ask the questions discussed above and have satisfactory answers before staff members are sent on ASI courses.

Although the question of feedback is also a training issue it should be considered at an early stage, i.e. during implementation discussions. The author's experience is that many of those conducting ASI interviews are frequently at a loss as to how to provide patients with feedback after the interviews. Providing feedback and using a feedback session to work with the patient's ambivalence raises the question of whether staff should also be introduced to motivational interviewing. Motivational interviewing (Miller & Rollnick, 1991; Miller 2000) lends itself very well to an ASI feedback session, and helps an ambivalent patient explore and resolve possible ambivalence about change.

REFERENCES

Engström, C., & Larsson, H. (1998) Implementation av Addiction Severity Index i den socialtjänstbaserade missbrukarvården. (Implementation of the Addiction Severity Index i social service based substance abuse care.) In Swedish. Umeå: **Projektrapport Umeå universitet**.

Fureman, I., McLellan, A.T., & Alterman, A. (1994). Training for and Maintaining Interviewer Consistency With the ASI. **Journal of Substance Abuse Treatment,** 11: 233-237.

McLellan, A.T., Kushner, H., Metzger, D., Peters, R., Grissom, G., Pettinati, H., & Argeriou, M. (1992). The Fifth Edition of the Addiction Severity Index. **Journal of Substance Abuse Treatment,** 9: 1-15.

Miller, W.R., & Rollnick, S.R., Eds. (1991) **Motivational Interviewing – Preparing People To Change Addictive Behavior.** The Guilford Press. New York. USA.

Miller, W.R. (2000) Motivational Interviewing: IV. Some Parallels With Horse Whispering. **Behavioral and Cognitive Psychology,** 28: 285-292.